Only a Phone Call Away

Tommy Waddell,* a 55 year-old truck driver, finally sought care from neurosurgeon Andrew Lewis when his back pain became disabling. Waddell's history included spinal stenosis, prior disc surgery, DVTs (for which he took warfarin), diabetes, obesity, and other health issues. Physical therapy provided little relief, such that he ambulated with a walker and could not walk or sit more than fifteen minutes without severe pain. No longer able to earn a living, Waddell scheduled surgery with Dr. Lewis. Both Dr. Lewis and his nurse practitioner, Jason Clark, discussed the expected benefits and risks with Waddell prior to surgery.

Warfarin was stopped, and a seven-day Lovenox bridge was begun prior to spinal decompression, fusion laminectomy, and placement of a Jackson-Pratt drain on April 18. Though not documented in the chart, Dr. Lewis apparently left on a pre-arranged vacation shortly after the surgery, and care was primarily assumed by NP Clark, with Lewis' surgical partners available for consultation. Lewis himself was also available by phone, if needed. The patient did well for the first 24 hours, but during the evening of April 19, he had some difficulty voiding. Catheterization revealed residual bladder volume, for which he was given Lasix and IV push by the hospitalist.

In the early morning hours of April 20, Waddell was incontinent of urine. Clark ordered a straight catheter, and 900 cc was obtained. About 0830, a hospital nurse charted bilateral numbness, tingling, and weakness of the lower legs, but none of Waddell's providers were notified of this change. At 1000, the dressing was bloody, and NP Clark saw the patient just minutes later. Clark documented the bilateral numbness and weakness, back pain, and difficulty voiding but felt that Waddell had good sensation to touch with full strength in both legs. The patient was later noted by a physical therapist to have difficulty with "push and pull," due to lower leg weakness. About 1400, a hospitalist documented that Waddell was unable to move his toes, along with decreased strength and sensation in his lower legs. At 1600, physical therapy documented the patient was unable to flex his ankles. None of these changes were communicated to Lewis, his partners, or NP Clark.

NP Clark saw Waddell during morning rounds on April 21, acknowledging the nursing notes about bilateral numbness, but Clark still felt the patient had good sensation to light touch, except for the feet. About 1300, physical therapy noted that Waddell was unable to stand and had no movement of either ankle. Twenty minutes later, nurses notified Dr. Lewis (apparently still on vacation) about a decrease in blood pressure and increased bleeding at the surgical site. Dr. Lewis in turn called NP Clark to see the patient. The dressing was reinforced and pressure continuously applied until NP Clark arrived to place a deep suture at the site where the drain had been removed. A CT of the lumbar spine showed a hematoma versus abscess at L2-3, and NP Clark was notified of these findings at 1600. The nurses also notified Clark at 2220 when Waddell had difficulty voiding and

was unable to flex his ankles or wiggle his toes. Shortly after midnight, a Foley retrieved 600cc of urine. The patient had no associated discomfort or sensation upon insertion of the catheter. At 0100 on April 22, Waddell complained of feeling that his legs were “on fire.”

About 0930 on April 22, nurses documented swelling of the patient’s lumbar incision and no movement of the ankles or feet. There is no documentation any of this was communicated to Dr. Lewis, his covering partners, or NP Clark. A physician’s assistant, Janice Holmes, saw Waddell shortly afterward while making rounds on behalf of Dr. Lewis; she ordered a CT myelogram which revealed spinal compression and possible hematoma. Waddell was diagnosed with cauda equina syndrome and promptly taken back to surgery for spinal decompression and hematoma evacuation. Dr. Lewis immediately returned to the hospital to assist his on-call partner with the surgery.

Mr. Waddell had some sensation restored to his feet by the following day - but no movement. On April 24, he was able to lift his knees but still lacked movement in his feet. However, the patient was incontinent of both bowel and bladder, was impotent, and unable to walk when discharged to a physical therapy institution for rehabilitation. Unfortunately, Waddell has not shown much progress and remains incontinent as well as impotent; he still requires a wheelchair for mobility and is totally disabled.

As the reader may imagine, suit was filed against numerous care providers. Plaintiffs alleged that the hospitalist and nurses were negligent by failing to notify Dr. Lewis or his partners about the changes in Waddell’s neurological status. Likewise, physical therapists documented loss of motion but also failed to notify a surgeon. Though the surgery itself was done correctly, plaintiff alleged that Dr. Lewis was negligent for failing to have his partners round on the patient during his absence, and also negligent in his supervision of NP Clark. Because NP Clark was an employee of the neurosurgery group, plaintiff alleged the group was negligent in not having established protocols for advanced practice providers, by failing to properly train its nurse practitioners (especially in recognizing complications), and for failure to properly communicate with each other. Note that when the nursing staff did call Dr. Lewis about the brisk bleeding, he sent the same nurse practitioner who had been providing care; he apparently did not notify his on-call partners of this or any other complication of which he may have been aware.

How could this tragic outcome have been avoided? Swelling, bleeding, hematoma…all of these issues are known potential complications of spinal surgery, even the extreme of cauda equina syndrome. Neurosurgery experts opined the damage was likely irreversible by the time Mr. Waddell first experienced urinary incontinence and paresthesia. However, one phone call to sound an alarm may have changed the outcome by lessening the severity of Mr. Waddell’s injuries. Dr. Lewis or the nurse practitioner asking one of the on-call surgeons for a consult, proper written protocols in place for advanced practice providers, a better understanding of NP Clark’s experience level, and documentation of a hand-off to another surgeon---all of these components may possibly have led to a better outcome for both the patient and the involved providers.

*All names have been changed to protect the identities of the parties.

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