Time Well Spent

By Stephanie Deupree, JD, BSN

Kelly Johnson, a 45-year-old G0P0[1], presented to the office of gynecologist Dr. Belinda Smith after being referred for evaluation of chronic pelvic pain.[2] Mrs. Johnson had an extensive history of gynecological problems including endometriosis and ovarian cysts. Prior to her appointment with Dr. Smith, Mrs. Johnson had seen multiple gynecologists over the last several years and had numerous operations. In addition to her gynecological and chronic pain issues, Mrs. Johnson suffered from an anxiety disorder. Her daily medication regimen included Xanax and Lortab.

During the appointment, Dr. Smith examined Mrs. Johnson and reviewed her medical records from other providers. Mrs. Johnson expressed the desire to be free of pelvic pain. Following the exam and record review, Dr. Smith discussed various surgical options. Mrs. Johnson did not make any decisions regarding treatment that day.

A few weeks later Mrs. Johnson returned to see Dr. Smith. At this visit, Mrs. Johnson wanted to go over her surgical options again. Dr. Smith recommended laparoscopic right salpingo-oophorectomy. After some discussion, Mrs. Johnson agreed to proceed with the

surgery and signed a consent form that listed the procedure as “laparoscopy of right tube and ovary with lysis of adhesions.”

Three weeks later, on the morning of the scheduled afternoon surgery, Mrs. Johnson and her husband called Dr. Smith’s office and spoke with her nurse. The Johnsons advised the nurse that after some thought and deliberation Mrs. Johnson wanted to have a hysterectomy. They asked the nurse to get a message to Dr. Smith as soon as possible. The nurse was able to contact Dr. Smith and relay this new information and request.

Upon arrival to the hospital, Mrs. Johnson, who did not take her usual morning Xanax, began experiencing panic attacks. She was upset because she thought she would be given something soon after arriving. She asked for medication to help her with the panic attacks and was given Versed.

A couple of hours later, Dr. Smith saw Mr. and Mrs. Johnson together in the preoperative holding area. They both inquired about whether she had received their message about wanting to proceed with the more extensive surgery. Concerned with whether the patient had been given any medication since her arrival that could influence her ability to consent, Dr. Smith asked the nursing staff if Mrs. Johnson had received any medication. The nurse assigned to Mrs. Johnson informed Dr. Smith that Mrs. Johnson had not received anything that would affect her ability to consent. Unbeknownst to Dr. Smith, the medical record would later reveal that Mrs. Johnson had received Versed prior to their meeting in preoperative holding. Mrs. Johnson appeared completely lucid and conversed appropriately.

Dr. Smith discussed hysterectomy in depth with the Johnsons. After providing a full explanation of the risks and benefits of the procedure, Dr. Smith took the previously signed consent form and added “removal of uterus and left ovary.” She had both Mr. and Mrs. Johnson and the nurse initial this addendum to the consent. Dr. Smith did not write a progress note to memorialize her discussion with the Johnsons regarding their requested change in surgery and the detailed informed consent discussion that followed.

Dr. Smith proceeded with performing the hysterectomy as well as removing both fallopian tubes and ovaries. The surgery went well without any problems or complications. Mrs. Johnson stayed in the hospital overnight and was discharged home the following day.

When Mrs. Johnson returned for her first postoperative office visit 10 days later, she never mentioned any shock or dismay about the hysterectomy. Many weeks later, during her final postoperative visit, Mrs. Johnson remarked for the first and only time about the hysterectomy. After being denied a refill for a pain medication, Mrs. Johnson expressed anger over having the hysterectomy because it had not resolved her pain. Dr. Smith did not hear from Mrs. Johnson again.

The next time Dr. Smith saw Mrs. Johnson’s name was in a lawsuit complaint, which alleged medical malpractice, medical battery, and lack of informed consent. Mrs. Johnson averred that she was shocked to learn that she had had a hysterectomy after waking up in

the recovery room. Similarly, Mr. Johnson purportedly learned of the hysterectomy from his wife days later. The crux of the lawsuit was that Mrs. Johnson was heavily medicated and could not consent to the change in procedure. Furthermore, the Johnsons claimed that the surgery deprived Mrs. Johnson of the opportunity to harvest her eggs for future IVF so that either she or a surrogate could carry a pregnancy to term.

The filing of the complaint began multiyear litigation that culminated in a 7-day jury trial. The Johnsons did not make particularly favorable witnesses. Nonetheless, their attorney put on proof through medical experts in support of their allegations. Fortunately, Dr. Smith did an exceptional job during her testimony. Defense counsel presented gynecology and pharmacology experts at trial—the gynecology expert supported Dr. Smith on the standard of care while the pharmacology expert was able to show that the timing and dosage of the Versed for this particular patient should not have negatively impacted her at the time she consented to the hysterectomy. Ultimately, the jury found in favor of Dr. Smith and returned a defense verdict.

There were several things in the evidence that inured to Dr. Smith's benefit. First, the nurse in Dr. Smith's office documented her conversation with the Johnsons on the morning of surgery very well. Second, in this unusual circumstance, having the patient, the patient's husband, and the nurse initial the addendum to the consent bolstered the defense of the case.[3] In the absence of a progress note from Dr. Smith regarding an informed consent discussion about hysterectomy, these pieces of documentation became especially important in the defense of the medical battery and lack of informed consent claims. Third, the medical records of other providers helped cast doubt on the allegations the Johnsons made about their desire to start a family through assisted reproductive technology. The importance of adequate documentation cannot be overstated.

Although Dr. Smith prevailed after several years of litigation, this entire case may have been avoided if some relatively simple measures had been taken. Perhaps the easiest and most obvious issue that could have been avoided was having the patient sign her consent after the administration of Versed. Even though Dr. Smith should have been able to rely upon the hospital nurse to give her accurate information about any medications that had been administered, the more prudent course would have been to verify exactly what medications had been given and when. If Dr. Smith had learned that Mrs. Johnson had received Versed one would hope that she would not have proceeded with the change in procedure or have the patient sign anything. As a general rule, patients should not have informed consent discussions with their providers or sign any documents, particularly consent forms, after they have received any medication that could potentially impact their capacity for decision-making.

Further, the surgery, although medically indicated, was done on a purely elective basis. It was not a medical emergency and time was not of the essence. On occasion there may be circumstances that warrant changing the planned procedure on the scheduled surgery day. When choosing to forge ahead, it is imperative to take the time to have an informed consent discussion just as you would in office. Likewise, take the time to write or dictate a

note prior to the procedure. Time stamps for notes concerning informed consent made after the procedure can appear self-serving, especially if problems arise during the procedure. The physician should use his or her medical judgment to decide if changing the procedure necessitates rescheduling. This must be determined on a case-by-case basis.

In closing, remember that thorough documentation is often the best defense! Take the time to document the medical record appropriately and thoroughly. The time it takes to write or dictate a progress note is far less than the time it takes to defend a lawsuit.

[1] G0P0 refers to a gravida 0 para 0 patient – a female who has never been pregnant and never delivered a child.

[2] The names of the patient and physician have been changed.

[3] Although having a spouse's consent is unnecessary and would seem to be a throwback to a more draconian era, in this very limited case it proved helpful during litigation. Neither Ms. Deupree nor SVMIC recommend or suggest that any female patient requires the consent of a spouse for any medical procedure. Noting the particular facts of this case does not constitute an endorsement or recommendation of having health care providers obtain consent from a patient's spouse in a non-emergent situation. In most cases, a competent patient in a non-emergent situation is the only one that may give consent.
