Don't Just Assume...Or You May End Up As a Defendant

By Kathleen W. Smith, JD

Bear with me, but I *presume* you are familiar with the colorful colloquial saying about what happens to us when we *assume*. (If not, just Google it. I will spare you the quote itself, in an effort to maintain some level of decorum.) Despite this "advice," we make assumptions daily. We assume that events will occur as they are supposed to occur. We assume that people will do what they are supposed to do. For the most part, fortunately, our assumptions materialize and all is well. The problems arise, however, when our assumptions do not develop as we predicted. Medicine is no exception to this assumption trap, and when a physician makes an assumption about a patient's care, that assumption can end up making a plaintiff out of the patient and a defendant out of you.

In this example case, Ms. White[i] was a young, morbidly obese, one pack-per-day smoker patient who underwent an abdominal gynecologic surgery on January 15, 2017. She was given a prophylactic antibiotic pre-operatively. On post-operative day one, January 16, 2017, Ms. White's abdominal incision was confirmed to be clean and dry with the steri-strips intact, she was stable and recovering well from the surgery, and she was discharged home.

Five days later, on January 21, 2017, Ms. White returned to the ER complaining of fever and drainage from her abdominal wound. Dr. Smith, a gynecologist in the same group as the original surgeon, re-admitted Ms. White to the hospital, where he ordered a culture of the abdominal wound, prescribed IV Ampillicin and Flagyl, and performed a dressing change with clean-out and repacking of the wound. Ms. White remained in the hospital for the next two days, receiving IV antibiotic therapy. During this time, her condition improved overall. By January 23, 2017, Dr. Smith determined that Ms. White was ready for discharge, and he placed a telephone order for her discharge. Another partner in the group, Dr. Jones, was physically present at the hospital when Dr. Smith gave the telephone discharge order. Accordingly, Dr. Jones went ahead and carried out the patient's discharge for Dr. Smith.

The following day, January 24, 2017, the hospital's laboratory released the final report for Ms. White's January 21st wound culture. The report advised as to the culture and sensitivity of the bacteria infecting her abdominal wound, which was, unfortunately, not sensitive to the antibiotics that she was prescribed. The final wound culture report was not disseminated beyond the hospital walls. Neither Dr. Smith nor Dr. Jones were made aware

of its findings.

Two days later, on January 26, 2017, the patient returned again to the ER with continued and progressing complaints of fever and drainage from her abdominal wound. The infection was found to be quite advanced. Although Ms. White required extensive surgical and wound care over a prolonged period of time, she was ultimately able to recover from the infection. Ms. White subsequently filed a lawsuit over her care, and named Dr. Smith, Dr. Jones, their group, and the hospital as defendants.

Not surprisingly, the wound culture report became a key medical record in the lawsuit. Ironically, although the wound culture report played such a significant role in the lawsuit, it appears to have been completely overlooked by the physicians when they were actually treating the patient. Likely, the doctors assumed that the results of the culture would be reported to them, one way or another, regardless of whether the patient was still an in-patient or whether she had already been discharged from the hospital. Nevertheless, the physicians' assumptions about the outstanding wound culture set in motion serious complications for this patient, which served as the basis for her lawsuit against them. Although we could not save Dr. Smith and Dr. Jones from the consequences of their assumptions, you can learn from their lesson and avoid making it in the future.

1. Do follow up on outstanding test results. If the testing was important enough to order, then it is important enough to follow up on. Ultimately, the ordering physician will be charged with bearing some degree of responsibility for knowing the results of the testing he ordered, regardless of what others did or did not do concerning its final report.

2. If there is a partner or call group assisting with the patient's care, do make the covering physician aware that there are test results still outstanding. It may not be immediately apparent to a covering physician that the test has been performed, but the results have not yet been returned. This allows the covering physician to be aware that there is a piece of information still unknown about the patient, and it enables the covering physician to follow up on the status of the outstanding results, too.

3. When preparing a patient for discharge, consider whether there are still any test results outstanding. If so, consider whether the discharge is not yet timely. If it is ultimately determined that discharge is appropriate despite an outstanding test result, make sure there is a plan in place for discovering the results of the outstanding testing. Further, when appropriate, enlist the patient in the follow-up plan and make sure that the patient understands any role she may have in learning the results.

4. When discharging a patient from the hospital with tests outstanding, consider whether to leverage your existing in-office tracking system. While it may generally be true that the hospital's laboratory would or should inform you of the results of inpatient testing, do not rely only on this. Such an assumption may be detrimental to your patient's health, and may result in you being named as a defendant in a lawsuit that you could have otherwise avoided.

[i] All names have been changed
