The Best Advice - Say Nothing

By Kathleen W. Smith, JD

“If you can’t say anything nice, then just don’t say anything at all.” My mother gave me this advice – fairly frequently – during my childhood, when reprimanding me for arguing with my younger sister. My sister and I would raise our voices and yell ugly things at each other (although, to be honest, I was responsible for more of the yelling, delivered with that particular level of meanness reserved for a younger sibling). Implicit in my mother’s advice was this: just don’t say the mean thing, the hurtful thing, the hateful thing. Instead, simply say nothing. Even though my mother’s advice was given in childhood as a solution for childish sibling arguments, her advice stayed with me as I grew older and my conversations matured in meaning and consequence. It is solid advice. It is advice that Cardiologist A should have followed in this closed case. Had she, she probably could have prevented the lawsuit in the first place.

On October 2, 2012, Mr. Jones[1] underwent a left heart catheterization by Cardiologist A. After the uneventful catheterization procedure, Mr. Jones was transferred to the cardiac floor for an overnight stay. The sheath was left in place and was pulled by a nurse on the cardiac floor without any reported complication. Pressure was applied to the area, and no

bleeding was noted. As the evening progressed, Mr. Jones complained increasingly of headache. His blood pressure was also poorly controlled. Mr. Jones then began complaining of nausea, which culminated in an episode of vomiting. With the nausea and vomiting, he was unable to remain still in bed. Approximately 2 ½ hours after the sheath was pulled, Mr. Jones was first noted to be bleeding from the access site. Nursing efforts to stop the bleeding were not successful, and a hematoma developed. Thirty minutes after the bleeding was first noted, the nurse called Cardiologist B, who was on call for her partner, Cardiologist A, and reported the hematoma. Cardiologist B ordered a bedside ultrasound and gave additional instructions for the nurses to better control the hematoma. Once the ultrasound results were reported to Cardiologist B, the vascular surgeon was notified and was at Mr. Jones' bedside within an hour. Mr. Jones was promptly taken to surgery, where the hematoma was successfully evacuated. He experienced a full recovery from these events.

When Cardiologist A returned to the scene later in the morning on the day after the heart catheterization procedure, instead of being reassured that the complication had been successfully managed, she responded by blaming the nurse for causing the complication in the first place, due to her poor sheath-pulling technique. According to the nurse's testimony in the lawsuit that was subsequently filed, Cardiologist A called her to Mr. Jones' bedside and "loudly and irrationally" voiced her blame. Cardiologist A then proceeded to document in the Discharge Summary that the hematoma was caused by the nurse's poor sheath-pulling technique.

Not surprisingly, Mr. Jones filed a lawsuit alleging that the hematoma occurred because of negligent medical care. Cardiologist A was named as a defendant to the lawsuit, as was her partner, Cardiologist B, their medical practice, and the hospital.

There are several lessons to be learned from this closed case.

1. Cardiologist A's comment was likely written in anger and was overly influenced by emotion, not facts.

Unanticipated complications can cause emotions to flare, especially when the complication is serious or time-sensitive. When other caregivers are involved with the patient, human nature can cause one to blame the other caregiver. Here, Cardiologist A was very quick to judge what happened, immediately blaming the nurse. She jumped to her conclusion without first learning the relevant facts. A better reaction from Cardiologist A would have been to first inquire about Mr. Jones' condition after the sheath was pulled and until the bleeding was first discovered. Cardiologist A would have then learned that the access site was stable for 2 ½ hours after the sheath was pulled. Bleeding was not noted until after escalating complaints of headache in the setting of uncontrolled blood pressure and nausea that culminated in an episode of vomiting wherein Mr. Jones was noted to be moving around significantly in bed. Any of these factors, alone or combined, could have caused or contributed to the development of the hematoma. Instead of reacting calmly and investigating what happened, Cardiologist A jumped straight to blame. As it turned out, her conclusion was inconsistent with the key facts.

2. Cardiologist A's comment gave life to nursing standard of care and causation theories that might not otherwise have been viable.

In a medical negligence case, the plaintiff must establish by expert medical proof both (1) that the care at issue deviated from the standard of care, and (2) that the outcome was caused by the negligent care. Hematoma is a recognized complication of a cardiac catheterization procedure. It can occur for a number of reasons and in the absence of negligence. It is an unfortunate, but non-negligent, defensible complication. Arguably, Mr. Jones' claim was without merit because he experienced a known, recognized complication of the procedure. However, with one sentence in the Discharge Summary, Cardiologist A gave Mr. Jones both (1) a standard of care criticism of the nurse's care and (2) an explanation of the negligence that caused the complication to occur. The comment was certainly relied upon by Mr. Jones and his experts to further his position in the case. Additionally, the defense was put in the awkward position of presenting alternative theories to refute Cardiologist A's comment and providing alternate, non-negligent explanations of what caused the hematoma. Cardiologist A's comment ended up fueling Mr. Jones' case against all defendants. Without it, Mr. Jones's case would have remained what it always was -- an unfortunate but recognized complication that occurred in the absence of medical negligence.

3. Cardiologist A's comment resulted in this prolonged lawsuit filed against herself and others.

Not only did this unfortunate comment negatively impact its author, but it had far-reaching implications to others; and it took years for the matter to resolve. In addition to Cardiologist A, partner Cardiologist B, their joint medical practice, and the hospital where both physicians practiced were named as defendants to the lawsuit. It is reasonable to assume that there were business ramifications felt by Cardiologist A's private practice and hospital practice as a result of this situation. Further, the lawsuit was quite long-lasting, taking six years and significant procedural ups and downs to eventually resolve. After some time, the

original lawsuit was dismissed without prejudice by Mr. Jones, who subsequently refiled it. Fortunately, the defendants were granted summary judgment (the trial judge determined the plaintiff's evidence was insufficient to establish a claim of negligence) in the refiled lawsuit. However, Mr. Jones appealed the grant of summary judgment to the defendants. It took more than one year of waiting before the summary judgment was affirmed on appeal, and the case was concluded. Although it was ultimately a happy litigation ending for the defendants, this came after six years of dealing with all the stress, all the hassle, all the disruption of a lawsuit that might otherwise never have been filed.

The key takeaway from this closed case is to think before you speak – think before you dictate that note that is critical of another provider's care; think before you speak critically of another provider to a patient or their family; think before you accuse another provider of doing something wrong when caring for a mutual patient. Once you have a clearer and calmer head, you will likely regret your criticism and blame, and, as Cardiologist A experienced, it might end up hurting you more than anyone else. Sometimes, the best advice is to just say nothing.

[1] The patient's name has been changed.
