Clarifying Communication

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“The single biggest problem with communication is the illusion that it has taken place.”
– George Bernard Shaw

A recurring theme in SVMIC newsletters, seminars, etc. is the importance of effective communication. The emphasis is often centered around communicating with patients, but there are other situations in which the importance of communication should be emphasized – these are when healthcare providers are communicating with each other. The following closed case is an example in which more detailed communications would have better served the patient.

A 76-year-old male patient presented to the hospital to undergo right ankle fusion surgery. The patient’s medical history was significant for a stroke with right-sided weakness, peripheral vascular disease with stents to the common iliac and peroneal arteries, and an injury to his ankle while playing college basketball. He had difficulty walking over the years and used a brace on his right ankle. The patient also had a history of prostate cancer,

nerve damage from prostate surgery, and urinary incontinence. A robotic urinary control system had been implanted four years earlier to address his urinary incontinence.

The patient was discharged from the hospital to a rehabilitation center a few days after the ankle surgery. The discharge instructions included, “Non weight bearing to right lower extremity. Foley catheter should stay in place until he is able to stand on left leg to use robotic bladder device.” (You will recall that the patient’s surgery was on his right ankle.) The rehabilitation center’s chart contained a telephone nursing note regarding the patient’s admission that was slightly different. The note said, “Robotic urinary device must be weight bearing before F/C comes out.” A note made by another nurse at the rehabilitation center said, “Res has indwelling robotic urinary device that will be utilized when res can stand and bear weight.” The chart included an apparent verbal order a few days later from a nurse practitioner to an LPN stating, “FC to stay in place until res is wt. bearing. Res has urinary control system in place.” The patient was discharged from the rehabilitation center about a month after admission. A discharge order from a physician included the entry, “SN may take out Foley cath with next visit.” A home health nurse visited the patient 5 days later and attempted to remove the Foley catheter but was unsuccessful. A cystourethroscopy was performed, and it showed the patient had a complete erosion of the artificial urinary sphincter cuff into the distal urethra bladder. The artificial urinary sphincter was removed, and the erosion site was repaired. Another artificial urinary sphincter was placed a few weeks later.

A lawsuit was filed by the patient against the rehabilitation center, the nurse practitioner who gave the verbal order to the LPN, and the nurse practitioner’s supervising physician. The patient alleged the defendants failed to properly read and interpret the order from the physician who discharged the patient from the hospital to the rehabilitation center. The lawsuit asserted that the discharge order specifically stated that the Foley catheter should stay in place until the patient was able to stand on his left leg to use the robotic bladder device. The lawsuit further stated that the patient was able to stand on his left leg and use the robotic device for urine control purposes at or soon after his admission to the rehabilitation center. The lawsuit alleged that the nurse practitioner improperly interpreted this order to mean that the Foley catheter was to stay in place until the patient was weight bearing on his surgically repaired right leg, which he was not able to do until his discharge from the rehabilitation center about a month after the ankle surgery. As a result, the Foley catheter remained in place for an extended period of time and resulted in calcification and increased pressure inside the urethra, causing a urethral erosion, which then caused his robotic bladder device to fail.

The rehabilitation center settled out of the case, and the supervising physician was voluntarily dismissed by the patient, leaving the nurse practitioner as the only defendant to go to trial. Although the nurse practitioner had expert witnesses who were supportive of her care, the defense of the case was difficult based on the difference in the language used in the discharge instruction and the nurses’ notes regarding the Foley catheter. To repeat, the discharge instruction stated, “Foley Catheter should stay in place until he is able to stand on left leg to use robotic bladder device,” while one nurse’s note said, “FC to stay

until res is weight bearing res has a urinary control system in place," and the other nurse's note said, "Res has indwelling robotic urinary device that will be utilized when res can stand & bear weight." It is apparent that at some point, the understanding of the order was changed from taking the catheter out when the patient could bear weight on his left (non-operative) leg to taking the catheter out when he could bear weight on both legs. Better communication, or clarification, between the healthcare providers in this case would have likely led to an earlier removal of the Foley catheter with a better outcome for the patient. The litigation may have been avoided completely if the discharge instructions from the hospital had been clarified by a subsequent provider.

This case was tried over four days, and the jury returned an unusual, but not unheard of, verdict. The jury found that the nurse practitioner had deviated from the standard of care in her treatment of the patient, but also found that the treatment was not a substantial factor in causing an injury to the patient. There was competing expert testimony regarding when the urethral erosion likely occurred. In a medical malpractice case, it is not enough for the patient to prove that the defendant deviated from the standard of care, but the patient must also prove that the defendant's treatment was a substantial factor in causing an injury to the patient. It isn't very often that a defendant is found to have deviated from the standard of care and still wins the case, but it does happen from time to time, and that is what happened in this case. The jury determined the patient was not entitled to any damages, and the case was dismissed without any payment being made to the patient.

The lesson learned from this case is to ask for clarification. If something about an order seems odd or amiss, it is incumbent upon the healthcare provider to seek clarification from the physician or practitioner who issued the order. In this case, simply seeking clarification would have avoided the patient's injuries and the subsequent lawsuit.
