Self-Inflicted Wounds

By Jeff Williams, JD

Lisa Owens was a sixty-year-old female.[1] By most standards, she had a good life. Mrs. Owens had a loving husband, adult-aged children and young grandchildren. Mrs. Owens and her husband were both at the twilight of their respective careers and were looking forward to retirement, which meant spending more time with their grandchildren and a lot more leisure travel. But, Mrs. Owens' health was sub-par and had been so for quite some time. Morbid obesity was the genesis of her health problems. Being overweight for most of her adult life eventually caused chronic back problems, sleep apnea, a host of heart problems, fibromyalgia and other health issues.

Mrs. Owens' back pain had become so unbearable there were days that she could not walk without the assistance of a cane. The time had come to see a specialist about her debilitating back pain. Enter Dr. Linda Houser, a neurological surgeon, practicing in the same town for over twenty years. During that time Dr. Houser had seen thousands of patients with diagnoses nearly identical to that of Lisa Owens: chronic back pain and other health issues, the common denominator being morbid obesity. She had performed many surgeries involving her patients' spinal column without any major issues.

Dr. Houser diagnosed Mrs. Owens with disc herniation of the lower lumbar region and concomitant canal stenosis. This all contributed to the pain radiating throughout her lower body and was the primary cause of her inability to walk without assistance on a frequent basis. After some attempts at conservative treatment, Mrs. Owens indicated her desire to pursue surgical intervention. The surgery would be a lumbar decompression and microdiscectomy. She chose the surgery despite Dr. Houser's warnings that due primarily to her poor physical condition and health, she was at-risk of complications during the surgery, including but not limited to death.

Dr. Houser sent Mrs. Owens to her cardiologist for an assessment and surgical clearance from a cardiac standpoint. The cardiologist issued a letter clearing her for the surgery, but indicated that the patient was a moderate risk for a cardiovascular event during and subsequent to the procedure. The hospital performed a sleep apnea assessment pre-operatively, which placed the patient in a high risk category, consistent with her history of sleep apnea.

Dr. Houser performed the lumbar laminectomy without issue. Mrs. Owens was then transferred to postoperative care. She was given high dose I.V. narcotics in the immediate postoperative period. Upon admission to the floor, her vital signs were stable. After a few hours, the patient requested that the nurse remove the pulse oximeter. The nurse obliged

as she had worn it long enough to meet the hospital's postoperative protocol. The next day Mrs. Owens was found unresponsive in her hospital bed and shortly thereafter, she expired. The cause of death was most likely severe anoxic brain injury as result of respiratory arrest.

After her passing, a wrongful death lawsuit was filed against Dr. Houser, the hospital and other providers. The primary allegation directed towards Dr. Houser was that she breached the standard of care by not ordering telemetry monitoring subsequent to the procedure. The allegations in the lawsuit insinuated that Dr. Houser was simply going through the motions preoperatively and failed to be forward thinking enough to order appropriate postoperative monitoring. The allegations against the hospital were primarily focused on the nursing staff's failure to appropriately administer and monitor the pulse oximeter that was placed on the patient while in recovery.

As this case developed, there were indicators that the patient should have been placed in the cardiac-telemetry unit immediately after the surgery, as the patient had pre-existing heart problems. But, Dr. Houser had performed procedures like this for years on patients similar to Lisa Owens without such a catastrophic outcome. Indeed, had Dr. Houser ordered telemetry monitoring for every one of her patients similarly situated to this patient, certain units in the hospital may well have a shortage of beds. Of course, this is not a defense in a wrongful death case. Lawsuits often have this familiar tenor: "If the doctor would have done _____. Then, the patient would not have suffered harm." This is viewing patient care in hindsight. The practice of medicine is complex by its very nature. In a lawsuit, the allegations against the physician are made with the benefit of hindsight. This can be vexing to a physician that has been sued, as no doctor has ever been afforded that benefit while treating a patient.

This case was settled amicably amongst the parties without the necessity of trial. Use this story as a cautionary tale going forward. Good patient experiences in the past may not serve as an accurate predictor of future outcomes. Carefully review sleep apnea evaluations (e.g. STOP-BANG or similar assessment), which could influence your postoperative orders, including the need for pulse oximetry or cardiac-telemetry unit. When writing postoperative pain medication orders, indicate which medication should be used for each type of pain (mild, moderate, severe) and take into consideration whether the patient is opiate naïve when deciding medication types and amounts. Patients oftentimes present with co-morbidities that predict a greater chance of a shortened life. The reality is that the co-morbidities in which Lisa Owens suffered from have become more prevalent in modern society. With each patient encounter, take a step back, try not to become desensitized by the patient who has health problems that you have seen time-after-time.

Think back to your first patient. You lacked experience, but you were likely very alert while treating Patient #1. Assess each patient as if he or she was your first. This approach may serve as a safeguard to assure you are making a complete assessment of the patient's medical needs presently and into the future. In so doing, you will hopefully avoid the second guessing that comes along with adverse outcomes and zealous plaintiff's lawyers.

[1] Names and identifying details have been changed for confidentiality.
