# Judge a Man by His Questions Rather Than by His Answers

**By Jamie Wyatt, JD**

Communication is one of the most important facets of human life and interaction. The ability to exchange information is a skill learned early on in our lives. Yet, despite our early introduction to communication and the vital role it continues to play in our lives as we mature, it is frequently underestimated.

Non-communication or the failure to exchange or solicit information by not asking questions and to an extent, the right question, is often encountered in everyday life. The consequences of this can result in misfortunate outcomes for the parties involved, one of which includes the breakdown of collaborative efforts in the medical treatment arena. Such is the case with the death of Ann Thomas,[1] a 26-year-old student. She presented to the emergency room in the late evening over the weekend with a chief complaint of left abdomen and lower quadrant pain. No cardiac, respiratory or acute stress was noted. The patient had a pain level of 9/10, BP 141/67, HR 89, O2 saturation at 97%.

The emergency room physician, Dr. Harrison, began a workup ordering an abdominal/pelvis CT with contrast and an ultrasound. The CT returned an impression of an 11cm left-sided pelvic mass arising from the patient's left ovary. The ultrasound findings were consistent with a large ovarian cystic lesion. During the initial assessment while in the emergency department, Ms. Thomas never conveyed her history of severe sleep apnea nor her use of a CPAP device. Following the emergency room workup, Dr. Harrison, contacted the on-call OBGYN, Dr. Strobl. The emergency physician testified in her deposition that during the phone conversation, she detailed Ms. Thomas' symptoms and findings, including the patient's stable condition. She conveyed the test results and the physicians agreed upon a plan to admit the patient for pain management. Dr. Harrison testified that she mentioned she had given a dose of morphine (8mg) to the patient, but was not sure when it was given. Dr. Harrison wrote the admitting orders and then admitted Ms. Thomas under Dr. Strobl's care. According to both providers, it was Dr. Strobl's intention to have Ms. Thomas admitted to the floor overnight, and he would evaluate her in the morning and likely perform a surgical procedure absent a contrary indication.

While still in the emergency department and after the call with Dr. Strobl, Ms. Thomas had continued complaints of pain. In response to this, Dr. Harrison ordered another dose of morphine. The second dose ordered was 5 mg. Ms. Thomas was then admitted to the floor. When she arrived on the floor at 01:20 am, one of the nurses, Nurse Petty,

completed her floor assessment of the patient. She asked Ms. Thomas about her medical history wherein she noted that the patient was obese, suffered from severe sleep apnea, and was noncompliant with her use of a CPAP device. This is the first time Ms. Thomas told any of the providers that she had severe sleep apnea. Her oxygen saturation level was charted as 98%. Ms. Thomas's vitals were checked later at 03:25 am. At this time, it was noted that her oxygen saturation level was at 90% and that it had been 98% two hours earlier. This drop was never communicated to anyone. During this check, Ms. Thomas requested more pain relief, as her pain was a 7/10. At 03:45 am, Nurse Petty contacted Dr. Strobl and advised him that Ms. Thomas was requesting stronger pain relief. Dr. Strobl testified in his deposition that he knew the patient received a dose of morphine, but did not receive any information on dosage. During the call, Dr. Strobl ordered a stronger medication, Dilauded 1mg. During Nurse Petty's testimony, she explained that she did not provide Dr. Strobl with a pain score level or other information, including her history of sleep apnea. She simply explained the situation stating that the Morphine was not working. She told Dr. Strobl that Ms. Thomas had received Morphine, but provided no additional information. Nurse Petty had no recollection of any transfer of information besides that. Nurse Petty administered the Dilaudid. She checked on Ms. Thomas 30 minutes after administering the medicine and she woke her up to obtain the pain score. She checked on Ms. Thomas again at 05:20 am and saw that she was okay. In a later safety check at 07:10 am, Nurse Petty found Ms. Thomas unresponsive and a code was called. When Dr. Strobl arrived at 07:30am, he learned that a code had been called and that patient's respiratory suppression was likely caused by the opiates in the context of her sleep apnea condition. Unfortunately, Ms. Thomas expired shortly thereafter

Ms. Thomas's estate filed a lawsuit against the hospital, Dr. Harrison, and Dr. Strobl, alleging that Ms. Thomas died from hypoxia and cardiopulmonary arrest caused by respiratory depression, which was exacerbated by sleep apnea and the administration of Morphine and Dilaudid in the six hours prior to the code. The plaintiff alleged that the providers prescribed narcotics that were too strong and then failed to take appropriate measures to monitor Ms. Thomas after administering them to an opiate naïve patient with sleep apnea.

What can be learned from this case and Dr. Strobl's failure to solicit information from fellow providers?

1. The need to ask questions, to solicit information from others who are treating your patient. What medications were given, what were the doses, what were the vitals, is there a significant or noted change, what was the medical history? If necessary, dig for information;
2. Know your patient's condition before prescribing medications;
3. Ultimately, don't rely on others to give you the information you may need to get a full and clear clinical picture. It may be necessary to go into the hospital to check on the patient if there has been a phone call or two requesting your assistance on your patient.

The most profound lesson to be learned from this case is that you may be judged by what you should have known instead of what you actually did know. The debate may not be about what information you were given as a provider, but about what information you inquired about in your treatment of the patient. Failing to ask questions can produce culpability. As a provider, you should proactively inquire into the patient's medical history, types of medications administered, dosages, and any marked change in vitals that will alert you to an overall change in the patient's condition, as the information given may not be all the information needed to obtain a full clinical picture. It may still be necessary to ask more questions. The plaintiff's overriding theme in this case was non-communication. Although Ms. Thomas's history of sleep apnea was the genesis of the problem, the failure to solicit the necessary information to treat the patient creates an issue that will leave a jury to decide whether the medical care was appropriate, despite being based on an incomplete clinical picture. It is always an uncomfortable position in litigation when you are defending actions based on an incomplete clinical picture that could have been complete had the right questions been asked. In the end, as the provider, you will bear the responsibility for relying on someone else to give you the information you need to provide care to your patient. Dr. Strobl made the comment in his deposition "it would have been nice to have known" that Ms. Thomas had severe sleep apnea. Although he testified he would have ordered the same analgesic, he did say that he may have ordered monitoring for the patient. It is not difficult for a jury to assume that had he asked Nurse Petty, he would have known. This could have made all the difference. The hospital and ER physician settled the case prior to trial. Dr. Strobl went to trial with expert support. The jury found him to be liable for a small percentage of a six-figure verdict.

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

---