Documentation, Disclosure, and the Defensibility of Care

By Stephanie Walkley, JD, BSN

Carl McDonald[1], 77-year-old retired postal worker, with a history of coronary artery disease, MI, and atrial fibrillation underwent cardiac ablation with intracardiac echocardiography by cardiac electrophysiologist, Owen Samford, MD. During the ablation, Mr. McDonald developed pericardial effusion. The intravenous heparin stopped. Using fluoroscopy, Dr. Samford performed an emergent pericardiocentesis evacuating approximately 500 ml of fluid and then placed a pericardial drain. Mr. McDonald was given PRBC before being transferred to the CVICU in stable condition.

Shortly after arriving in CVICU, the CVICU nurse contacted Dr. Samford regarding ongoing bleeding from the pericardial drain. Dr. Samford was performing another procedure, so he ordered a stat consultation by one of the critical care physicians so that Mr. McDonald could be assessed before he could get there. The critical care physician got to the bedside very quickly and found Mr. McDonald had lost almost 1 L of blood. A stat cardiothoracic surgery consult was ordered. .

When the cardiothoracic surgeon arrived, Dr. Samford was already at the bedside withdrawing pericardial fluid via syringe. Mr. McDonald's blood pressure had begun to fall. He needed an emergent sternotomy, so the cardiothoracic surgeon took him to the OR. During the surgery, the surgeon found and repaired a small right ventricular perforation. He also evacuated a significant bloody effusion. Mr. McDonald left the OR with three new chest tubes and returned to the ICU. Fortunately, he had a relatively quick recovery after the sternotomy and was discharged home a few days later.

Several months later, Dr. Samford received a letter from Mr. McDonald asking for an explanation of the events related to his cardiac ablation. Dr. Samford put the letter aside and forgot about it until he received a demand letter from Mr. McDonald's attorney asking for compensation. At this point, Dr. Samford contacted SVMIC and defense counsel was assigned to represent Dr. Samford and his group.

The defense attorney reached out to Dr. Samford and scheduled an initial meeting so that they could go through the medical record and timeline of events. During this meeting, Dr. Samford apprised his attorney of information not in the medical record. To begin with, Dr. Samford advised that he had nicked Mr. McDonald's right ventricle during the cardiac ablation. He immediately recognized the problem and repaired it without difficulty. Regrettably, as previously mentioned, there is no mention anywhere in the medical record, including Dr. Samford's procedure note, that there had been an injury and repair to the right ventricle during the ablation.

The lack of documentation did not stop there. According to Dr. Samford, he learned that either one of the CVICU nurses or the hospitalist had set the pericardial drain to suction rather than keeping it to gravity drainage. There was no order for changing to suction in the medical record. The notes regarding the pericardial drain and chest tubes were confusing and unclear throughout the hospitalization. Dr. Samford placed the blame for Mr. McDonald's bleeding and need for the sternotomy on whomever set the pericardial drain to suction

The defense attorney asked Dr. Samford whether he had shared any of this undocumented information with Mr. McDonald. Dr. Samford advised that he had not. He tried to explain that he was trying to be a "team player" and "not throw anyone under the bus" with respect to the suction error; however, he did not have a plausible answer as to why his procedure note lacked any mention to the right ventricular injury he made and repaired. In addition to Dr. Samford's lack of documentation and disclosure, it appeared, based on chart review, that no provider or hospital representative informed Mr. McDonald about any of these things.

The lack of documentation and disclosure to Mr. McDonald about the events occurring during his care made the case indefensible. In fact, it may have increased the amount of liability exposure for everyone involved. The prudent move appeared to be to settle the case pre-suit. If the case had proceeded to litigation, once discovery revealed the lack of documentation and disclosure, there would have likely been allegations of fraudulent concealment and conspiracy to cover the missteps of the physicians and nurses. At the

recommendation of defense counsel, the matter was settled on behalf of Dr. Samford and his group.

This case underscores the need for accurate and complete documentation of pertinent clinical information in the medical record along with the need to disclose significant information to the patient. In this case, there was no valid reason for Dr. Samford to omit the perforation and repair he made to the right ventricle in his procedure note. The fact that he felt the injury was sufficiently repaired and that Mr. McDonald was stable did not absolve him from the duty to make a complete and accurate note.

As for the issues surrounding suction, although Dr. Samford's intentions of not pointing the finger at other providers may seem admirable, the entire team did not handle the situation well if that is indeed what happened. No one is suggesting that Dr. Samford should have put a scathing note in the medical record detailing what he understood to be the cause of Mr. McDonald's extensive bleeding in the CVICU. However, if he believed that to be the cause of the injury, then he could have brought his concerns to the attention of the hospitalist, CVICU nurse manager, or even perhaps hospital risk management. If he had done so, he may have learned that someone had informed Mr. McDonald of the error. If no one had disclosed it, then a decision could be made as to whom and how the information would be conveyed.

Thorough, contemporaneous documentation is key to good continuity of care for patients. Straightforward communication regarding important clinical events is also imperative. Good documentation and communication are also very significant factors in the defense of healthcare liability claims. A clinical mistake is not necessarily evidence of negligence, but if there is a lack of sufficient documentation and communication, then the case might not make it to an evaluation on the merits of the medicine.

[1] Names of all parties involved have been changed.
