Inadequate Medical Clearance Results in Devastating Outcome for Patient

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Introduction

This issue of Risk Management Review discusses an activity that occurs every day in the practice of medicine, and that many might consider quite routine: medical clearance for surgery. Medical clearance is an important step in the optimal care of patients. As this interesting case from the Southwest illustrates, poor patient outcomes can occur when clearance is not properly handled.

Facts

The patient was a 67-year-old male who had an extensive history of medical problems. He had smoked a pack of cigarettes a day for 40 years. Since his fifties, he had been treated for hypertension and hypercholesterolemia. In his sixties, the patient developed type 2 diabetes, which initially was treated with oral medication and then with insulin injections. In addition, the patient suffered with peripheral vascular disease, a hiatal hernia, and degenerative joint disease with lower back pain.

In March 2005, the patient had a cerebrovascular accident (CVA), resulting in temporary right-sided hemiparesis. He was initially treated with Coumadin® and also underwent physical therapy. The patient recovered very well, but additional testing showed that he had almost complete occlusion of the carotid arteries. As a result, he had a carotid artery bypass graft procedure. After the procedure, the Coumadin was discontinued, and the patient was put on a regimen of Plavix® and acetylsalicylic acid (ASA). He continued to do well for several years.

At the end of 2009, the patient saw Dr. A, an ophthalmologist, because of a cataract on his left eye. During the initial exam, Dr. A concluded that the patient was not a good candidate for the use of a topical anesthetic during cataract removal surgery for three reasons: (1) the cataract was moderately mature, (2) the patient’s pupil was only midsized (even with dilation), and (3) the patient was unable to hold his head still during the exam. Instead, Dr. A decided that retrobulbar anesthesia was the most appropriate option for the patient.
presents a significantly increased risk of intraocular hemorrhage, Dr. A preferred to discontinue the patient's use of Plavix and ASA prior to surgery.

Dr. A sent a medical clearance form to Dr. B, the patient's internist, requesting that the patient be discontinued from Plavix and ASA for 2 weeks prior to the surgery. Dr. B was somewhat uncomfortable with discontinuing the anticoagulants for that long; however, he approved this plan, and the patient was advised to discontinue these medications at the appropriate time.

On the 8th day after discontinuing the medications, the patient experienced a significant acute ischemic CVA and suffered almost complete right-sided hemiparesis. As a result, he suffers from urinary incontinence and requires complete daytime assistance with the normal functions of living (his wife cares for him in the evening). He will likely need assistance for the remainder of his life.

A medical malpractice suit was filed against Drs. A and B. The suit alleged that the discontinuance of the Plavix and ASA for the prescribed length of time posed an unacceptable risk of CVA to the patient and, as such, was a deviation from the standard of care. With Dr. A's consent, the case against her was settled with a payment in the low range and expenses in the high range. A payment in the midrange was made on behalf of Dr. B.

Discussion

This case presents several points for discussion. The first is the relationship between the doctor requesting medical clearance for surgery and the doctor whose clearance is sought. In this case, the generally accepted wisdom suggests that Dr. B had the "last word," and Dr. A had the right to rely on his recommendations.

This makes sense because Dr. B had a long-standing relationship with the patient and understood his medical history and current condition far better than Dr. A, who had only seen the patient on one occasion. This point of view is consistent with the concept of the "patient-centered medical home," which is supported by the Affordable Care Act.

One of the failures in this case was the fact that the two doctors never actually spoke about this patient. When cases with suboptimal outcomes of treatment are retrospectively reviewed, it is very common to identify lapses in communication as a causative factor.

One would not expect Dr. A to initiate this discussion, as the specific purpose of the clearance request was to verify the appropriateness of her proposal to discontinue the patient’s medications. She would have no way of knowing about Dr. B's discomfort unless Dr. B communicated it to her in some way.
If such a conversation had occurred, Dr. B could have explained his concerns to Dr. A and inquired whether a full 2 weeks off the medication was necessary to minimize the possibility of an intraocular hemorrhage. Without knowledge of Dr. B’s concerns, Dr. A was justified in instructing the patient to discontinue the medications for the prescribed time in preparation for the procedure.

If the doctors had conversed and agreed that taking the patient off Plavix and ASA for 2 weeks would increase the patient’s risk for a CVA, the next step would be for Dr. A to have a thorough informed consent discussion with the patient. In this discussion, she would explain the anticipated risks and benefits of the patient’s treatment options.

One of the options that could have been discussed was the option to go forward with the original plan (discontinuing the medications for the 2-week period), recognizing the increased risk of a CVA, but the reduced risk of an intraocular hemorrhage. A second option might have been to discontinue the medications for a shorter period (thereby decreasing the risk of a CVA, but increasing the risk of an intraocular hemorrhage). Of course, the third option was to not attempt the cataract removal at all, choosing instead to live with the cataract.

All of these options should have been explained to the patient so that he — after consulting with one, or preferably both, of the physicians — could have made a decision about how to proceed that was most consistent with his willingness to risk the CVA to improve his vision. Educating patients about their options and providing them with the information they need to make the decision that best suits them are the crux of informed consent.

Another factor in this case also complicated its defensibility. In a letter to the patient’s wife (written to her after the patient’s second CVA), the patient’s physiatrist explained his view of the patient’s rehabilitation options. Within that letter, the physiatrist (who was not a defendant in the case) stated the following: “unfortunately, his anticoagulation was stopped.”

The physiatrist’s use of the word “unfortunately” appeared to be critical of the plan formulated by Drs. A and B to discontinue the anticoagulants. The utmost in discretion is required when communicating with patients about the outcomes of their treatment; this is especially important when other providers have rendered that treatment.

**Summary Suggestions**

The following suggestions may be beneficial to doctors when seeking or providing medical clearance for surgery and coordinating patient care:

- When reviewing a case for medical clearance, it is wise for the approving physician to consider whether the requested changes in the treatment regimen are the minimum necessary to
accomplish the proposed treatment. If the approving physician is not completely comfortable with the proposal, he/she should discuss the plans in direct conversation with the physician who is requesting clearance.

• Direct communication — via phone, email, etc. — between the doctor requesting medical clearance and the approving doctor is beneficial whenever proposed treatment presents significantly increased risk to the patient.

• Informed consent is an important part of shared decision-making. This process is particularly critical when a proposed procedure is inherently high risk. When no “good choice” exists (i.e., all of the choices involve significant potential downsides), the patient should be given the opportunity to make the final decision after being fully informed.

• When corresponding with patients about the care rendered by other doctors, providers should carefully consider the correspondence from the patient’s point of view. Sometimes, what are intended to be innocuous statements can result in another doctor being unintentionally “thrown under the bus.”

Conclusion

With the constantly increasing complexity of modern medicine, accompanied by ever-increasing specialization, communication between physicians with differing concerns for the patient’s welfare has never been more important. Careful attention to the timing, means, and thoroughness of communication between providers increases the likelihood of safe and optimal treatment of the patient’s condition.