Risk Management Review

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Wrong Site Orthopaedic Surgery Leads to Suboptimal Outcome and Malpractice Lawsuit

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Introduction

As knowledge and technology advance, the delivery of healthcare is becoming increasingly complex, requiring greater teamwork and better communication. Despite best efforts, mistakes will occur. How these mistakes are handled can be critical in ensuring a favorable patient outcome and avoiding a professional liability lawsuit.

This interesting case from the Northwest illustrates how a surgical error was mishandled, resulting in a claim that was not defensible.

Facts

The patient was a 63-year-old male who had a long history of osteoarthritis, including degenerative disease in both knees. He presented to an orthopaedic surgeon, Doctor A, for consultation because the pain in his knees was becoming intolerable and was affecting his mobility.

Following an examination and appropriate testing, Dr. A recommended bilateral total knee replacement, beginning with the right knee.

The patient was agreeable to this recommendation; however, he requested surgery on the left knee first because it was causing more pain. Dr. A agreed, and the surgery was scheduled. On the date of the patient's surgery, a manufacturer's representative was in the operating room (as was the custom). However, this particular representative was not the one with whom Dr. A normally worked.

During the procedure, Dr. A took various measurements. The manufacturer's representative entered the measurements into a computer program, which then indicated which implant components were appropriate for the case. When the femoral measurements were complete, the manufacturer's representative retrieved the appropriately sized femoral component from the hospital's stock. However, it was the femoral component for a *right* knee.

This error was not discovered during the surgery or the immediate postsurgical period.

Approximately 2 weeks later, the patient began complaining of a "loose" feeling in the knee, and he consulted with Dr. A. Initially, Dr. A thought the problem was inadequate tensioning of the ligaments, and she indicated to the patient that a second surgery would be necessary. During a careful review of the patient's record that evening, Dr. A discovered the error that had occurred. However, she did not subsequently disclose it to the patient.

The patient did well immediately following the second surgery (in which the left femoral component was inserted). However, about 3 months later, he began to complain of intense pain in his left knee. Dr. A treated the patient's pain for about 4 months without much improvement. At that time, the patient self-referred to Dr. B, whose practice was not associated with Dr. A's.

After evaluating the patient, Dr. B concluded that the components used on the patient's knee were the wrong size, and he did a second revision surgery. Following this surgery, the patient suffered intermittent pain; however, he mostly recovered function in his knee, except for a modest limp.

In the process of Dr. B treating the patient, the patient's son overheard Dr. B tell his assistant that "a plumber could have done a better job on this knee." Sometime after the son heard this remark, the patient requested a copy of his medical records from Dr. A, and he learned for the first time that the first revision surgery had actually been to replace the incorrect femoral component.

A lawsuit was commenced against Dr. A, the hospital, and the device manufacturer. The case against Dr. A was settled with an indemnity payment in the mid-range and defense costs in the high range. The hospital and device manufacturer also contributed to a larger, global settlement of the entire case.

Discussion

In this case, the judgment against the doctor was the result of errors in both the clinical and nonclinical management of the patient's case. The first error that occurred was the selection of the incorrect femoral component.

Although it is common practice for a manufacturer's representative to be in the operating room during knee replacement surgery — and for the representative to determine which implant components the surgeon should use — the operating surgeon is ultimately responsible for inserting the correct prosthesis. Good practice suggests that, prior to the insertion, at least one additional person should verify that the correct prosthesis has been selected.

The second issue in this case was Dr. A's failure to disclose information about the error once it was discovered. Inevitably, errors will occur during the course of medical treatment, and some might be discovered during subsequent treatment. The way in which these mistakes are handled when they are discovered is critical. If the source of the error can be identified quickly and easily, an investigation should be done right away. However, regardless of whether the exact cause is identified immediately, the error should be disclosed to the patient or caregiver as soon as possible.

The format of the disclosure discussion will vary depending on the circumstances of the case, but a complete and truthful disclosure of the known facts needs to occur promptly. If the complete facts relating to the error are not known at the time of the disclosure discussion, subsequent conversations will be necessary to complete the disclosure process.[1]

Medical Protective's clinical risk management consultants are experienced with the disclosure process and can assist insureds in preparing for disclosure discussions by, among other things, recommending what documents should be reviewed and available and suggesting how to handle difficult questions. If time allows, Medical Protective insureds should contact a MedPro risk management consultant prior to engaging in disclosure.

From the documentary evidence, it appears that Dr. A did not deliberately fabricate an untrue story about the ligaments being too loose; however, when she learned that the real problem was the incorrect femoral aspect, she did nothing to provide the patient with the correct information.

Being untruthful with a patient is problematic in many ways. First, it is most likely unethical — a determination by a Board of Medicine that a doctor has been untruthful with a patient might be grounds for sanctions. Second, being untruthful about the real reason for the second surgery could negate the informed consent process because the patient has not received complete, accurate information. Finally, being untruthful with a patient might make it necessary to settle a case that may otherwise be defensible, and — in some circumstances — it may even be grounds for punitive damages.

The final issue in this case was Dr. B's remark to his medical assistant, which occurred within earshot of the patient's son. Although a physician might have opinions about another doctor's work, it is critical to express those opinions in an appropriate way and in an appropriate place. Dr. B's remark is a variation of the classic inappropriate question to a patient — "My God, who did this to you?" Such remarks serve no beneficial purpose, and they have been known to create very problematic situations.

1. Medical Protective has a guideline on disclosure of unanticipated events, which is available to all insureds. For a copy of the guideline, contact your assigned risk management consultant or call our helpline at 800–4MEDPRO (1–800–463–3776).

As we know, it was Dr. B's remark that prompted the patient to request a copy of his medical record and ultimately discover the original error. Although Dr. A was responsible for the original wrongdoing, Dr. B's remark certainly did not help the situation. If this case had proceeded into full discovery, Dr. B certainly would have been deposed, specifically about this remark. This could have put Dr. B in the awkward position of potentially becoming an expert witness in support of the plaintiff.

Summary Suggestions

The following suggestions may help doctors potentially avoid medical errors, or, if they do occur, properly communicate them to the patient:

- Operating surgeons are ultimately responsible for using the proper prosthetic device. Because of the difficulty of "switching out" a wrong device, *at least* one additional person should verify that the correct prosthesis was chosen prior to insertion.
- If a medical error is discovered, a complete, truthful disclosure of the known facts to the patient/caregiver should occur as soon as appropriate. The responsible party should not be deceptive when communicating any information to the patient/caregiver. Being intentionally untruthful most likely is unethical and may lead to allegations of fraud.
- On the rare occasion when a prosthetic device is wrongly implanted, the reimplantation surgery should be arranged with the patient's convenience in mind. Further, the responsible parties may want to consider covering the cost of the revision procedure.
- All healthcare workers should be aware of their surroundings when discussing any protected health information, regardless of whether the comments are negative. Any negative comments, which should be kept to a minimum, must always be communicated with the utmost care.

Conclusion

Medical errors can and do happen; despite our best efforts, they will continue to occur in the future. When they do occur, how they are handled plays a critical role in maintaining patient satisfaction and avoiding malpractice litigation. Honesty is always the best policy, and a sincere and empathetic approach to the problem is the best way to maintain a strong doctor–patient relationship.