Medicolegal Case Studies in Gynecology

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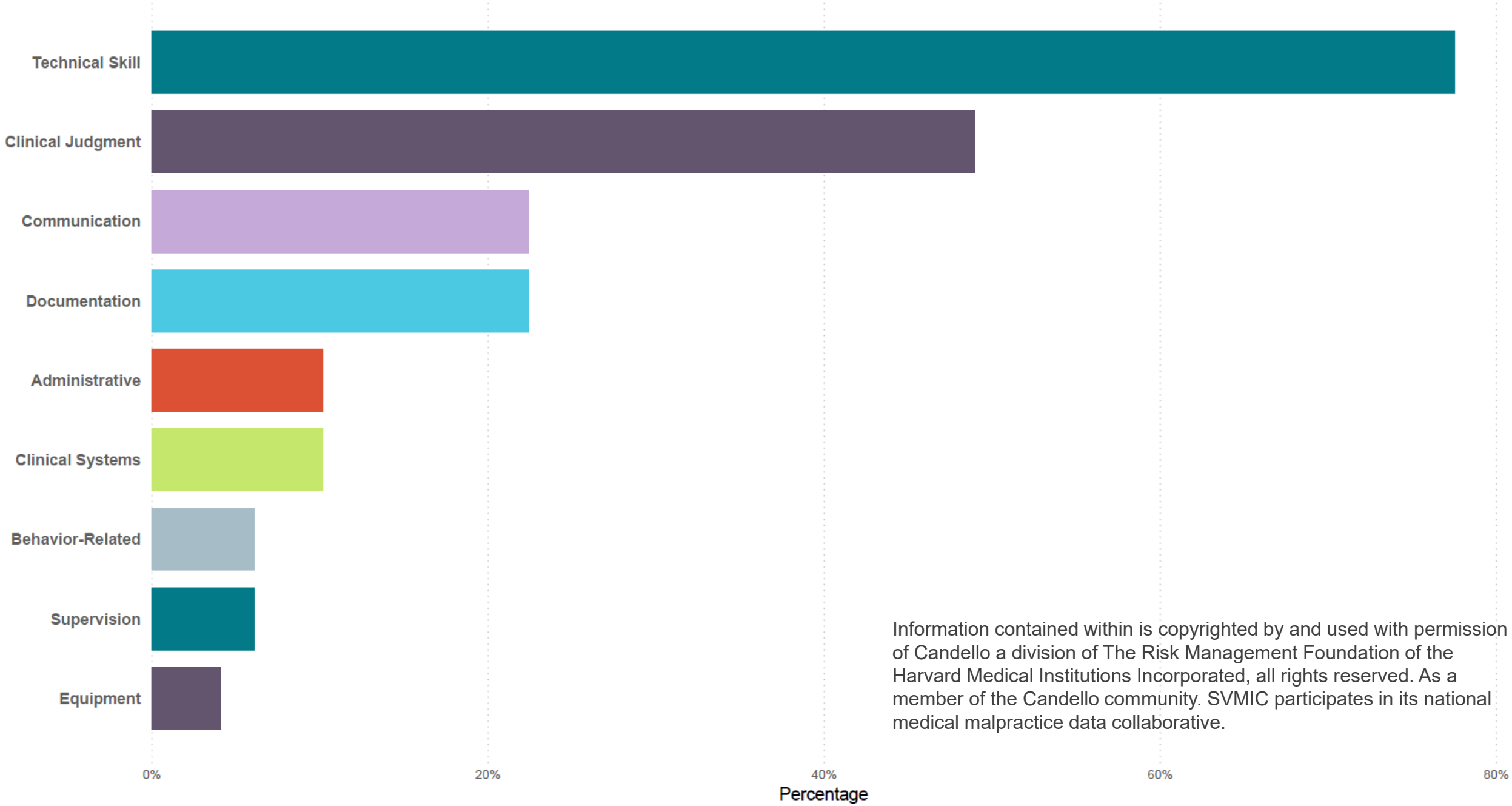
Session Overview

- Snapshot of GYN claims data
- Examine malpractice case studies with multiple defensibility and patient safety issues
- Consider strategies to effectively manage risks, improve patient outcomes, and reduce the likelihood of legal issues

GYN - Contributing Factors



Major Injuries

- Puncture/Perforation
- Emotional Trauma
- Laceration/Tear
- Malignancy
- Foreign body
- Hemorrhage
- Burn
- Sepsis
- Adverse reaction
- Need for surgery/procedure
- Nerve damage

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Case Examples

44 year old, history of c-section, BRCA positive/HR positive breast cancer, bilateral mastectomy and chemotherapy.
Due to ongoing pelvic pain, patient underwent hysterectomy with BSO by GYN with resident assisting. During the procedure, she suffered two bladder injuries - one was discovered and repaired intraoperatively. The second one was discovered later post-op by urologist.

Issues:

- Technique
- Poor documentation
- Informed consent
- Unclear if GYN or resident created the injury

70 year old with endometrium cancer underwent hysterectomy. GYN left a portion of Endo catch bag in patient during hysterectomy that resulted in the development of a large abdominal/pelvic abscess. Patient developed sepsis and ultimately died.

Issues:

- Patient assessment
- Delay in Diagnosis
- Multiple medical visits without Dx
- Retained foreign material

33- year old with history of endometriosis and perforation of uterus during a D&C, suffered perforation of uterus and small bowel during endometrial ablation by GYN.

Issues:

- Improper technique
- Failure to ensure patient safety
- Practicing beyond scope
- Communication among professionals
- Improperly utilized equipment

45 year old, scheduled to undergo hysterectomy with endometrial cancer staging. She requested to keep her ovaries. Unfortunately, the patient's ovaries were removed.

Issues:

- Informed Consent
- Technical Performance
- Documentation

26 year old with a migrated Nexplanon device attempted removal by NP in the office suite. After failing to locate, imaging was ordered and GYN took over. Patient suffered an ulnar nerve injury.

Issues:

- Patient assessment
- Failure/delay in ordering diagnostic test
- Selection and management of therapy
- Practicing beyond the scope/expertise
- Failure/delay in referral
- Technical performance

64 year old presented to the office for a regular injection of Depo-Estradiol 5mg (1ml) for hot flashes. The unlicensed Medical Assistant administered the wrong dosage of 5ml IM after questioning the RN about needing two syringes but being told to administer it. GYN was not on site when patient was given the injection.

Issues:

- Practicing beyond scope
- Poor communication
- Medication error
- Lack of supervision and training
- Billing/collection/insurance issues

22 year old new patient presented to office for a gynecological examination and pap smear. That same day, an existing patient with the same last name was scheduled for a culposcopy and endometrial biopsy. The patient was 50 years old and of a different race. A multitude of errors resulted in the procedures being performed on the wrong patient.

Issues:

- Lack of patient identification
- No timeout prior to procedure
- Patient assessment
- Lack of informed consent
- Documentation

45-year-old with a history of Stage IV endometriosis and pelvic pain underwent a laparoscopic-assisted vaginal hysterectomy and BSO by GYN and assisted by a resident. The bladder was injured intra-operatively and was immediately recognized. Urology consulted and repaired bladder through laparotomy. Catheter was in place for 3 weeks post-op. Patient developed incisional infection from the laparotomy and contends she did not authorize the resident's participation. The second page of the consent form was missing from the medical record.

Issues:

- Documentation
- Informed Consent
- Technique
- Post-op infection

58 year old with breast implants 15 years prior, presented for annual mammogram that revealed a new nodular density. Radiologist recommended MRI. Report was sent to patient who expected GYN to call or schedule the MRI. GYN allegedly did not receive the report, and did not track the result. Patient did not receive any further evaluation. She returned a year later with a palpable breast lump, and was diagnosed with metastatic breast cancer.

Issues:

- Failure to Appreciate & Reconcile Sign/Symptom/Test Result
- Lack Of/Failure In Patient Follow/Up System
- Poor Provider to Provider Communication

Improving Technical Skills

- Simulation
- Advanced training
- Adherence to facility policies/protocols
- Adequate training on all equipment

Improving Clinical Judgment

- Assess the patient and review information available to order appropriate tests/referrals
- Consider differential diagnoses
- Select, monitor and manage medication/other therapies
- Consider protocols and guidelines
- Delegate only to appropriately educated and trained staff
- Determine appropriate practice setting
- Caution when performing concurrent procedures

Improving Communication

- Effective communication with patients and the healthcare team is critical
- Support a culture of safety (Speak Up, approachable, time-out, etc.)
- Educate patients throughout their treatment
- Obtain informed consent
- Verify understanding with team members and patients

Informed Consent Elements

- Details of the nature of the patient's condition and diagnosis
- Indications and benefits for the proposed treatment plan, procedure, or medication, as well as the anticipated prognosis
- A description of the proposed treatment, or procedure, including medication that will be prescribed, and its purpose
- The probable outcome of the treatment or procedure, particularly if it is difficult to predict, and the patient's expected post-procedure/treatment course
- Potential modifications or extensions of the treatment or procedure
- The most likely and severe risks and side effects of the procedure and treatment or medication, preceded by a general inclusive statement, such as "including but not limited to"
- Reasonable alternative methods of treatment or no treatment, including the risks, benefits, and the prognosis associated with each alternative or with no treatment

Effective Communication

Does the Patient ...

1. Understand the diagnosis and treatment plan?
2. Have the means to adhere to the treatment plan?
3. Understand when to contact you if symptoms change or simply for clarification?
4. Know when to return to the clinic or follow up?

Improving Documentation

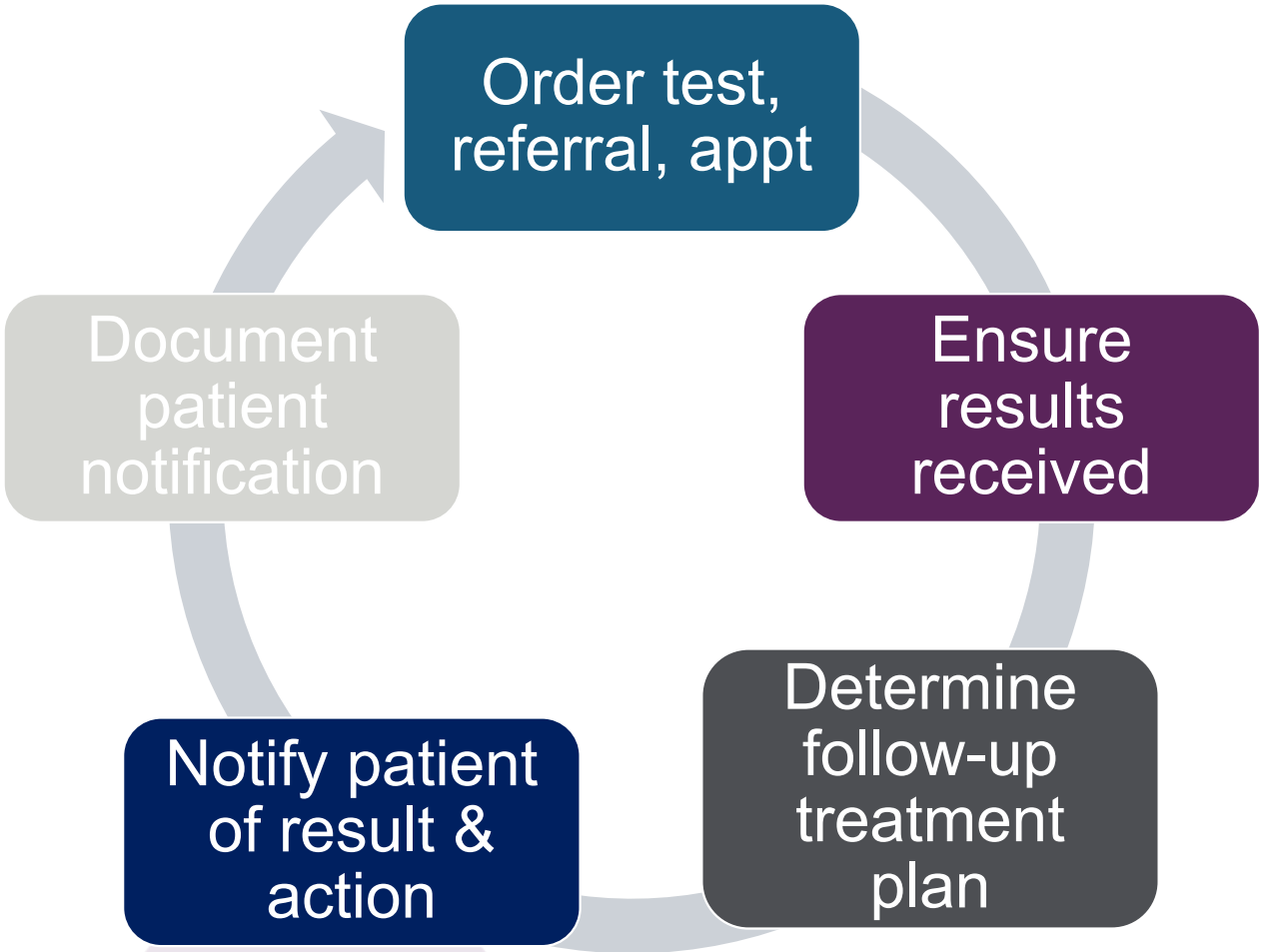
- Avoid inadequate or omitted documentation
- Avoid inappropriate documentation
- Do not comment on another clinician’s care in the record
- Only document care performed
- Timely and accurate documentation
- Be aware of electronic health record (EHR) issues

Systems Failures

- Failure to track:
  - Test results, missed appointments, hospital discharge, referral
- Failure to follow up or notify patients of abnormal test results
- Mishandled phone messages
- Scheduling/requisition mishaps
- Contaminated specimens
- Misread test results

Improving Systems - Closing the Loop

A closed-loop process ensures results & plans are communicated to the correct person through the appropriate channels and in a timely manner.



Questions?

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