Throwing Stones

By Tim Behan, JD

Words matter. Words may matter even more in the medical profession. Health care providers work in glass houses. What is said, how it is said, and most importantly, how it is interpreted by the listener, can lead to serious and time-consuming consequences. You may think your words are benign or comforting, but, when a medical event has a poor outcome, those words can lead to years of trouble. Sometimes it's the speaker who suffers. Many times, it is another health care provider who becomes the target. Sometimes it is both. The following case illuminates this point. The physician involved did not intend to cause harm to his peer by his words. However, those hearing the words interpreted them to mean something other than what was intended.

Elliot Smith[1] was 15 years old when he presented to the emergency room at a rural Tennessee hospital. He had been involved in an ATV four-wheeler accident within the previous hour. He complained of left groin pain and of a laceration to the back of the left leg. He may have lost consciousness as well. Elliot was immediately seen by our insured ER physician, Dr. Tom Scott. The initial exam showed that the patient had a bruise on the lateral aspect of his left quadricep and a puncture wound on the posterior aspect of his left leg. He also had superficial cuts to his left forearm and elbow. Dr. Scott performed x-rays to verify that there were no fractures or foreign objects. He noted that there was subcutaneous air reported on the x-ray, which led him to believe that the puncture wound was deep, so he cleaned the wound and then placed a drain. He advised the family to take the patient to see his PCP the next day or to return to the hospital for further evaluation if his condition changed. The patient's vital signs were within normal limits, and the boy was discharged home.

The patient returned to the hospital the next day because the PCP's office was closed. The noted purpose for the return visit was to recheck the puncture wound. The wound was clean, and all looked fine. The bandages were changed, and vital signs were again normal. Dr. Scott told him to change the dressing daily and to see his PCP soon. This was Dr. Scott's last involvement with Elliot, and all still seemed well with him. Four days later, Elliot saw his PCP. At this time, she noted that the patient was running a low-grade fever which caused her to refer him to a surgeon at the hospital who saw Elliot that same day. The surgeon put him on Augmentin, removed the drain, and scheduled exploratory surgery for four days later. During this surgery, he debrided and irrigated the wound. The surgeon noted that Elliot was afebrile but that the swelling and drainage had increased despite the dressing changes and antibiotics, which were continued after surgery. A culture did not grow any bacteria, and Elliot continued to be treated by the surgeon over the next month. His symptoms ebbed and flowed, which resulted in an infectious disease (ID) consult. The

ID physician could not identify any bacteria. The surgeon continued to treat the swelling that was occurring as well as drained fluid from the wound, and Elliot appeared to be getting better.

But a few weeks later, the patient was again admitted to the local hospital, this time with complaints of cough, headaches, vomiting, and fever. Shortly after admission, the patient's condition worsened, necessitating a transfer to a children's hospital an hour away. By the time Elliot arrived at the children's hospital, he was in septic shock and disseminated intravascular coagulation (DIC). For the next three months, Elliot was under the care of many different specialties at this institution. Despite all their efforts, Elliot suffered irreversible damage to both his lower legs leading to bilateral below-the-knee amputations.

Fortunately, Elliot eventually recovered enough that no other damage occurred and was released home. Unfortunately, one of the many doctors involved in the care made the comment to Elliot's parents that, "Maybe if Dr. Scott had put Elliot on prophylactic antibiotics at the time of the initial presentation, the likelihood of Elliot losing his lower legs would have decreased." While this was an equivocal statement, the Smiths interpreted it as "Elliot lost his lower legs because Dr. Scott did not put him on antibiotics." This remark led the parents to seek a plaintiff attorney and litigation followed. The medicine was complicated, and the case was vigorously defended. Eventually, the matter was successfully resolved although it caused significant stress for Dr. Scott. The effect of an unsolicited comment by a physician, not in Dr. Scott's specialty, led to years of worry. Due to their son's devastating outcome, the parents may have filed a lawsuit even if this comment had not been made. However, there is no doubt that this one unnecessary comment directly led them to litigation.

This is not an isolated story. It is possible that being critical, either intentionally or unintentionally, can turn the target back onto a fellow physician and bring him or her into a lawsuit. The common theme when this happens is that the interpretation of the physician's words appeared to be critical of another. This is almost never the intent. The doctor who made the offhand comment admitted in his deposition that he did not know the standard of care of ER physicians and was merely speculating. But, how the parents interpreted those words led to the legal events described above. While it is easy to read a medical record from another provider in another specialty with hindsight, it is impossible to know all the facts, circumstances, and communications that led to things that are not in the record, and the standard of care is different for every specialty. Many times, it is a situation of not knowing what you don't know. That's when assumptions take over and come into play, but assumptions are not facts and do not replace being there in the moment when that other health care professional was interacting with the patient. That is why it is important to comment only on what it is known. It is not about ignoring questions about another's care. It is about keeping boundaries firm and commenting only about your role and your care and directing the patient to ask their questions about others to those people. When this happens, the stones that destroy glass houses become rocks that protect them.

[1] All names have been changed

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