



# *the* Reporter

TEXAS MEDICAL LIABILITY TRUST  
General surgery 2008

## Failure to diagnose complications General surgery closed claim study

*By Louise Walling,  
Risk Management Representative*

### Presentation

A 36-year-old woman with a history of morbid obesity came to a general surgeon with the intention of seeking care for weight reduction. The patient's primary concerns were non-insulin dependent diabetes, respiratory problems, and mobility challenges. Her surgical history included one previous gastric surgery, a partial wrap fundoplication. The patient's body mass index was greater than 40 and she appeared to be a good candidate for gastric bypass surgery.

Five weeks later, she met with the general surgeon for a preoperative evaluation. At this visit the patient was extensively counseled and given literature from the American Society of Bariatric Surgery. The patient indicated that she wanted to proceed with the surgery. Preoperative testing included an upper GI, an EGD, pulmonary function tests, and a laboratory work up including arterial blood gases.

### Physician action

A Roux-en-Y gastric bypass was performed one week later in a community hospital. The patient tolerated the procedure well, but on the third postoperative day her pulse rate was elevated in the 120s and her WBC was 11,000. That same day a Gastrografin

swallow ordered by the defendant was interpreted as negative for evidence of a leak. However, this study was over-read the following day by a radiologist who felt a leak was possibly present. The general surgeon ordered a CT scan that he interpreted as showing no indications of a leak, but fluid was noted in the chest and abdomen. A chest tube was placed and approximately 600 cc of fluid was returned.

Because the patient continued to show abnormal vital signs and lab values, the general surgeon performed exploratory surgery on the fourth postoperative day. Nearly a liter of brown fluid was found in the abdomen. He decompressed the bowel and was unable to locate any obvious leaks. An air test was done showing no significant bubbling at the anastomosed site. The general surgeon concluded there had probably been a leak, but it had spontaneously sealed. He placed two drains after a thorough abdominal irrigation. A gastrostomy tube was placed, and a nasogastric tube was inserted and passed through the anastomosis without difficulty. During the surgery the patient's pulse rate returned to normal; her O<sub>2</sub> saturation was 100%.

When the patient arrived in ICU for postoperative care, her condition deteriorated. Her pulse rate increased to 140 to 150 and her O<sub>2</sub> saturation decreased to 90 to 92%. Her blood pressure had to be supported with intravenous fluids and dopamine.

The surgeon was concerned with the patient's abdominal sepsis, hypotension, tachycardia, and hypoxia. He consulted with the patient's primary care physician. The decision was made to transfer the patient to a tertiary care facility.

Once transferred, it was determined that she was septic and critically ill. Infectious disease and pulmonary consults were obtained. The patient underwent a second exploratory surgery. A disruption of the anastomosis and extensive necrosis was found that necessitated a wide excision and loss of major muscle

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*This closed claim study is based on an actual malpractice claim from TMLT. The case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.*

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component structures of the left upper quadrant. The gastric bypass was taken down and a repair of the anastomosis was performed. The spleen was resected as it appeared necrotic. Necrotizing fasciitis developed, and the patient subsequently required multiple surgeries.

Ultimately the patient recovered, but she continues to experience ongoing bowel problems and has been deemed totally disabled.

### Allegations

A lawsuit was filed against the general surgeon. The allegations included:

- giving false representations to induce the patient's consent for surgery;
- failure to perform the surgery in a hospital adequately equipped to manage intraoperative and/or postoperative complications;
- negligence in performing the surgery; and
- failure to diagnose the leak sooner.

A lawsuit was also filed against the hospital where the surgery occurred.

### Legal implications

Two general surgeons who reviewed this case did not support the defendant's actions. They expressed concern about the one day delay in taking the patient back to surgery since a pulse rate in excess of 120 is a sign that a leak may have developed. These surgeons believed that the defendant should have detected and repaired the leak before closing the abdomen. Another surgeon stated that an omental patch placed over the area of the suspected leak may have prevented further complications.

One surgeon was supportive of the defendant's actions, stating that the standard of care was met. However during his deposition, this surgeon agreed that an experienced bariatric surgeon would most likely have taken the patient back to surgery a day earlier.

### Disposition

Given the two unsupportive consultant reviews and the alleged permanent injuries sustained by the patient, this case was settled with the consent of the general surgeon. The hospital also settled.

### Risk management considerations

An extensive history and physical exam were documented in the patient's chart a week before the procedure. The general surgeon also documented an informed consent process that included giving the patient literature from the American Society for Bariatric Surgery. He reported that the patient had been given a test on the information. He listed the known risks including death, and documented that the patient verbalized awareness and wanted to proceed. Since this extensive informed consent discussion was documented in the patient's medical record a week before the surgery, it would be difficult to prove the patient was given false information during the consent process.

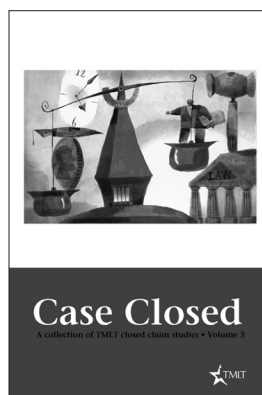
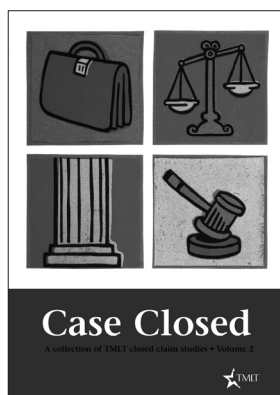
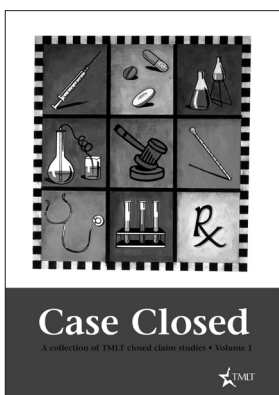
Though the defendant initially interpreted the Gastrografin swallow and CT scan of the chest and abdomen as negative, the over-reads by the radiologist the following day indicated the possibility of a leak. Perhaps a stat order for the radiology studies followed by a call to the radiologist to confirm or refute the initial impression would have generated a faster response to perform a second exploratory surgery.

The defendant's choice of facility was also challenged. Roux-en-Y bariatric surgery performed in any facility brings into question the level of education and experience of the nurses. A high quality and safe bariatric program requires a highly trained and skilled team of health care professionals. Standing orders for postoperative monitoring should state strict parameters including when to notify the surgeon.

Managing the postoperative care of any morbidly obese patient has its own set of challenges. Vigilant management of the patient's care by each member of the medical team before, during, and after the procedure creates the best outcome for the patient and physician.

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# TMB enforces new rules for medical record documentation

by Jane Holeman and Jon Porter

For years, the Texas Medical Board (TMB) rules regarding medical record documentation merely required that physicians maintain “adequate medical records,” defined as “any records documenting or memorializing the history, diagnosis and treatment of any patient.”<sup>1</sup> Recently however, TMB staff determined that this rule was incomplete and failed to convey the importance of the medical record. As a result, the TMB radically rewrote the rules defining the requirements for “adequate” medical records.

## What exactly does the TMB require?

The rule governing medical record documentation may be found in either the Texas Administrative Code Section 165.1, or in the Board rules posted on the TMB’s web site.<sup>2</sup> The Texas Administrative Code is the legal designation for the TMB’s rules. The rule states medical records must be “. . . complete, contemporaneous and legible.”<sup>1</sup> Therefore, documentation must include complete details for each patient encounter, be created close to the time the physician treated the patient, and be legible to the average person.

## Contemporaneous

The TMB rule does not specifically define “contemporaneous.” However, by practice, most TMB members emphasize that documentation should be completed immediately after, if not during, the actual patient encounter. If a physician chooses to complete the records at the end of the day instead of after the patient encounter, it appears that he or she would be in compliance, assuming the physician did not see a considerable number of patients that day. However, many TMB members are of the opinion that the records then become too general, and it is likely the physician may forget relevant information.

## Legible

Legibility has long been an issue for physicians. The advent of electronic medical records and transcribed records is beginning to have a positive impact. However, for physicians who still handwrite notes, illegibility will likely be viewed by the TMB as a lack of compliance with Board rules. When evaluating standard of care issues, all records are reviewed by at least two TMB consultants. These consultants must be able to read the records.

Use caution when employing templates or preprinted forms that contain “check boxes” to designate systems as normal or abnormal. This includes emergency department records and the forms suggested by Medicaid. These forms are often intended to facilitate documentation by “prompting” the physician to address multiple aspects of the patient encounter. However, often the space for handwritten entries is limited, resulting in illegible notes. When using such forms, write legibly and use an additional page to fully describe findings, if necessary.

## Complete

The Board requires that each patient encounter must be documented and include the following:

- a. reason for the encounter and relevant history, physical exam findings, and prior diagnostic test results;
- b. an assessment, clinical impression, or diagnosis;
- c. plan for care, including discharge plan; and
- d. the date and legible identity of the observer.<sup>1</sup>

There is an expectation that an appreciable connection be made between each of the above four requirements, and that the connection is explored and documented. Therefore, physicians need to demonstrate how they got from the objective and subjective findings to the diagnosis and treatment.

The rule also requires that “past and present diagnoses should be accessible to the treating and/or consulting physician.”<sup>2</sup> This means that records should be readily available to physicians treating the patient.

Furthermore, the rationale for (if not apparent) and the results of diagnostic testing and other ancillary services should be included in the medical record.<sup>1</sup> This may even include an explanation of the results and how they affect the treatment of the patient.

The rule also requires that the patient’s progress be documented, including response to treatment, change in diagnosis, and the patient’s noncompliance.<sup>1</sup> Defending a standard of care case by alleging the patient was noncompliant may be disregarded if there is a lack of documentation in the record supporting that stance.

Finally, the TMB has traditionally required that physicians document patient follow-up instructions in the medical record. Again, it is recommended that a comment be included regarding how the follow-up instructions were provided to the patient.

## Informed consent

The new rules also require documentation of informed consent. Documentation needs to demonstrate that the physician provided the patient (and/or the patient’s family) with education on the diagnosis and treatment, as well as the risks of any treatment. Board members have been critical of physicians who did not document that the diagnosis was adequately explained to the patient, including the differential diagnosis and the affect on the method of treatment.

## Treatment plans

The TMB rules also require an appropriate written treatment plan for patients.<sup>1</sup> However, the Board fails to define “appropriate.” As the rules are written, include the following in the plan section of a SOAP note:

1. treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
2. any referrals and consultations;
3. patient/family education; and
4. specific instructions for follow up.<sup>1</sup>

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In certain situations, the Board members may expect to see a treatment plan containing more information than what is listed in the four requirements. They actually may request a formal “treatment plan.” This is a written course of action given to the patient with both subjective and objective measures to which the physician and patient agree in order to achieve their stated medical goal.

Generally, TMB members expect a formal treatment plan for patients who have complex or chronic medical conditions. A treatment plan is a requirement when treating patients for issues of chronic pain.<sup>3</sup> The treatment of chronic pain has very specific rules and requirements that are not covered in this article. Physicians who provide treatment for chronic pain, should closely review the TMB rules on that subject and contact people with expertise on this rule, such as TMB staff, attorneys specializing in representing physicians before the TMB, or physicians specializing in pain management.

### *Referrals and consultations*

If the physician determines that a referral or consultation is necessary, the rules require that it be documented in the medical record. A copy of the referral or consulting physician’s report should be placed in the medical record. To facilitate patient safety and continuity of care, it is recommended that the referring physician provide a copy of the patient’s medical record or a summary of the patient’s care to the consultant.

Physicians being investigated by the TMB are often unable to demonstrate that they have reviewed the records of prior treating physicians. The TMB rule states that records received from other health care professionals involved in the care of the patient shall be maintained as part of the

patient’s medical records.<sup>1</sup> This means that physicians are required to maintain not only the records they create, but also those they have received from other physicians.

### *Patient education*

There have been instances during informal settlement conferences where a physician has written nothing more than “patient education” in the medical record. In those situations, the Board has emphatically told the physician that the documentation was inadequate. TMB members require that the documentation provide some indication of what was discussed and how the patient was educated.

### **Conclusion**

The rules for medical records are complex and can cause confusion. Carelessness and lack of knowledge of TMB rules have resulted in TMB sanctions for many physicians. Taking time to create and maintain appropriate medical records can help physicians provide better patient care and avoid TMB complaints.

### **Sources**

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