Glass Houses

The adage about “people who live in glass houses” still holds true.

This claim involved an obese 45-year-old-male who presented to his general surgeon with a ventral hernia. History included multiple abdominal surgeries and known adhesive disease. The patient was admitted to the local hospital, a small facility that had no ICU or step down unit, no on-site radiologist, and no OR staffing after 3 PM on a weekday. Hernia repair was accomplished but with great difficulty due to lysis of very extensive adhesions involving most of the small bowel. Recovery seemed largely unremarkable, and the surgeon was proceeding with discharge on post-op day seven, when the patient suddenly experienced severe abdominal pain mid-day. Nursing staff observed a hard abdomen and absence of bowel sounds. The surgeon was in the OR and asked an emergency physician to examine the patient. That physician recommended transfer based on a tense and tender abdomen, absent bowel sounds and shallow breathing. Impression was acute abdomen -- possible intestinal perforation. The surgeon then ordered a CT scan. After reviewing the imaging and the preliminary radiology report, the surgeon concluded that a perforation was not demonstrated, though free air was shown. He elected to keep the patient overnight. The patient seemed stable through the night but was observed to be unresponsive about 8 AM on post-op day eight. A code was called, and air transport was initiated, but the patient tragically died during transfer. Cause of death was suspected to be a bowel perforation.

Following the patient’s death, the surgeon agreed to consult with the patient’s next of kin and her attorney. Without seeking legal advice, the surgeon signed a formal statement that pinned blame in no uncertain terms on the radiologist who had interpreted the CT scan. In essence, the statement said that the surgeon’s primary suspicion had been a bowel perforation, but the CT results had allayed that concern by indicating that free air present in the abdomen was a normal amount of postoperative air, not unexpected. According to the statement, because the radiologist had misled the surgeon by failing to raise the possibility of a perforation, an immediate and life-saving transfer to a major medical center was not accomplished.

A lawsuit ensued, and perhaps unsurprisingly the surgeon was named as a defendant, along with the radiologist, the emergency physician and the hospital. Finger pointing among the defendants was abundant. Plaintiff’s experts criticized everyone except the emergency physician, who was dismissed from the case. Most of the expert fire was targeted at the surgeon, whose pre-suit statement was put into evidence. The radiologist testified that he had interpreted the CT scan after being told by a hospital-employed radiology tech that the patient had undergone surgery “a few hours” before the study. The radiologist observed a moderate amount of free air, consistent with surgery in that time frame. Thus, his preliminary report was relayed to the surgeon indicating “free intra-

abdominal air post-op." Shortly thereafter, his final report was dictated into the chart, noting post-surgical free air "related to abdominal surgery a few hours ago." The surgeon was reassured by the preliminary report. It was not clear whether the surgeon had taken note of the final report with its clear signal that the radiologist was laboring under a misunderstanding as to when the surgery had occurred. There was no direct communication between surgeon and radiologist. The radiologist further testified that if he had been aware that surgery had been done seven days prior, he would have suspected a possible perforation, and he would have called the surgeon immediately. In focusing their criticisms on the surgeon, plaintiff's experts noted that he had personally reviewed the CT imaging and noted the presence of free air, as conceded in his pre-suit statement. Seven days from surgery, free air should have prompted an immediate transfer. Plaintiff's expert also said that unless a perforation could be quickly and definitively ruled out, it was malpractice to leave this patient in this particular hospital, considering its limitations.

Stones thrown in "glass houses" can be amazingly counter-productive, as was the case in this lawsuit. Such cases rarely work out well for the defense.
