# The Tale of Two Appendectomies

**By Kathleen W. Smith, JD**

Appendicitis is a well-known medical condition. According to the National Institutes of Health, five to nine people out of every 100 will develop appendicitis during their lifetime.[1] It is most common in younger patients, teenagers, and individuals in their 20s, but appendicitis can happen to patients of any age. *Id.* It is the most common cause of acute abdominal pain requiring surgery. *Id.* Although appendicitis and appendectomy are common medical events, they are generally understood to be once-in-a-lifetime medical events. The patient in this closed claim, however, required *two* appendectomies. Her medical misadventure provides us with several helpful lessons on the important topic of medical documentation.

On February 3, 2014, Mrs. Green developed acute abdominal pain. She presented to the Emergency Department of her local hospital and, after examination and imaging, was diagnosed with appendicitis. Her care was referred to the on-call general surgeon, Dr. Blue, who was able to schedule Mrs. Green for an appendectomy that day. Intra-operatively, Dr. Blue found a severely inflamed abdominal cavity. The surgery took twice as long as is customary for Dr. Blue's appendectomies. Regardless, Dr. Blue was able to perform the surgery without apparent complication and discharged Mrs. Green home the next day.

After discharge, Mrs. Green was followed closely by Dr. Blue in his office for waxing and waning complaints of abdominal pain, nausea, and fever. Mrs. Green returned to Dr. Blue for seven post-operative follow-up appointments throughout February and March. She was prescribed several courses of antibiotics.

Before Mrs. Green's third office visit, Dr. Blue received the surgical pathology report from the appendectomy. The report found "acutely inflamed fibroadipose tissue" but "no appendiceal architecture within the resection." The report was filed in Mrs. Green's office chart but was not signed, initialed, or dated by Dr. Blue. During the third office visit, Dr. Blue discussed the findings from the pathology report with Mrs. Green and recommended returning her to surgery. Mrs. Green, feeling better by this time and recovering well from the appendectomy, was reluctant to undergo a second operation. She advised Dr. Blue that she preferred to wait and let a little more time pass, but she agreed to revisit his recommendation at her next appointment. Dr. Blue, through the scribe he used to assist with his medical record preparation, documented in the visit note that Mrs. Green was "advised to go back in with laparotomy and check to see if anything is wrong, but patient requested not to do anything until the next office visit."

Dr. Blue raised the issue again with Mrs. Green during an appointment in March. By this time, her complaints were very mild and almost fully resolved. Mrs. Green also had a spring vacation planned for the following month that she was looking forward to taking. Mrs. Green again declined Dr. Blue's recommendation to further investigate the pathology findings, advising that she was feeling better and did not want to have a second surgery. Mrs. Green agreed that she would let Dr. Blue know if her problems returned. Dr. Blue's scribe documented this conversation in the office record as follows: "Dr. Blue will order CT or laparoscope if patient still has trouble with pain and fever. Patient said she is feeling better today but will keep us informed if she has any more problems."

Eventually, Mrs. Green's abdominal complaints resolved. She returned to her normal rhythm of life and did not return to Dr. Blue. That is, until October 7, 2016, when Mrs. Green again developed acute abdominal pain and again returned to the Emergency Department, this time at a different local hospital. There, after examination and imaging, Mrs. Green was again diagnosed with appendicitis. Mrs. Green was dumbfounded by this diagnosis, advising the emergency physician that Dr. Blue removed her appendix two years and eight months ago. Regardless, Mrs. Green was taken back to surgery and was found to have a perforated appendix. Given the extent and impact of the infection, her recovery from the second appendectomy was complicated and prolonged, but, after some time, Mrs. Green fully recovered to her normal state of health.

Mrs. Green filed a lawsuit against Dr. Blue, alleging that he failed to remove her appendix during the first appendectomy. The lawsuit also pled fraudulent concealment and alleged that Dr. Blue failed to inform Mrs. Green that her appendix had not, in fact, been removed. Mrs. Green claimed that Dr. Blue never discussed the pathology report with her, testifying as such at her deposition. Conversely, Dr. Blue testified in his deposition that he did discuss the pathology findings with Mrs. Green, not once but twice, and that he documented these conversations in the medical record. Dr. Blue explained that his discussion with Mrs. Green about the pathology results is implied by his documentation, arguing that it only makes sense that he would have explained why he was recommending a second surgery in conjunction with his recommendation for more surgery.

Discovery was conducted in the case, and expert witnesses were disclosed by both Mrs. Green and Dr. Blue. The case was being prepared for trial when the parties agreed to participate in a voluntary mediation. After negotiations, the parties reached an agreement to settle the case. While he maintained that he did discuss the pathology report with Mrs. Green, Dr. Blue realized that this was a key issue in the lawsuit, and his supporting documentation on this point was not strong. It can be difficult and somewhat of a gamble to predict how a jury will ultimately decide a "he said-she said" issue. Dr. Blue also recognized that, even though he had standard of care support from expert witnesses, it was going to be a challenge for him to explain to a jury how he performed an appendectomy on Mrs. Green but did not end up removing her appendix. For these reasons, Dr. Blue felt more comfortable resolving the case through a settlement than a trial.

This closed claim demonstrates several important points about documentation:

1. Blue received the surgical pathology report from the hospital in paper form, and the record was included in his office chart for Mrs. Green. However, there was no indication on the report that Dr. Blue actually *received and read* the report before it was filed in the chart. This played into Mrs. Green's version of events that Dr. Blue never discussed the pathology report with her. Perhaps, according to Mrs. Green, Dr. Blue never saw the report before it was filed in the chart? A better approach would have been for Dr. Blue to sign or initial and date the report contemporaneously upon reviewing it and then file it in the chart. Doing so would have supported his assertion that he did receive and review the report.

2. The major weakness in the case was Dr. Blue's failure to document his conversation with Mrs. Green informing her of the findings of the surgical pathology report. No doubt, this was an awkward conversation for Dr. Blue to have with Mrs. Green. Memorializing the conversation in the medical record would have been equally awkward. However, failing to document this conversation did nothing to change the fact that Mrs. Green's appendix had not been removed. Such was the true reality of the situation. Documenting the conversation using clear, precise, straightforward language was all Dr. Blue could do at this point to best manage this unfortunate circumstance. Further, from a legal standpoint, by documenting this conversation, Dr. Blue was also recording Mrs. Green's discovery of the alleged negligence. This begins the running of the statute of limitations, which is the period of time within which a plaintiff has to file her lawsuit.

3. Another weakness in the case was Dr. Blue's documentation of his discussions with Mrs. Green recommending the second surgery. His documentation did not *clearly* explain what was discussed with the patient and why. This made the medical

record open to subsequent interpretation and manipulation, allowing Mrs. Green to take advantage of the imprecise documentation to construct an alternate version of events that better benefited her interests in the lawsuit. The documentation also failed to explicitly describe Mrs. Green's refusals for surgery and why. Anytime a patient refuses to follow the recommended medical advice, **it is imperative that the provider fully and thoroughly document the patient's refusal.** Use clear, precise, straightforward language in the documentation.

4. The last documentation point involves Dr. Blue's use of a scribe. Likely, the scribe's involvement in the documentation explains why the language used in the medical record was not medically specific or precise. Having someone else prepare your documentation can be an efficient time saver; however, still invest the time needed to carefully review the documentation and make any necessary revisions before finalizing and signing the record. A small investment of time by Dr. Blue when the medical record was created would have substantially improved the defensibility of the claim several years later.

Most likely, this lawsuit would not have been filed had Dr. Blue's chart contained clear documentation (1) that he informed Mrs. Green about the pathology results; (2) that he recommended a second surgery in response to the pathology findings; and (3) that, fully informed of this, Mrs. Green decided not to follow Dr. Blue's recommendation to have a second surgery. This closed claim gives a strong illustration of how medical record documentation can end up at the center of a lawsuit. Moreover, this closed claim demonstrates how damaging absent or weak documentation can be to a doctor's ability to defend their care.

So, how does one end up having an appendectomy twice? For Mrs. Green, her appendix was in a retrocecal position, so it was not able to be visualized until her colon was lifted. Additionally, her abdomen was significantly inflamed at the time of her first appendectomy. Finally, Mrs. Green was morbidly obese. These three factors complicated the surgical picture for Dr. Blue, making it difficult for him to accurately determine the location of her appendix. Fortunately for Mrs. Green, she is now definitely appendix-free.

[1] Definition & Facts for Appendicitis,"https://www.niddk.nih.gov/health-information/digestive-diseases/appendicitis/definition-facts