Section V, Question 1.

GYN Case at GWU Involving Dallas W. Johnson, MD

While serving as an Assistant Professor faculty member in the Department of OB/Gyn at George Washington University Hospital (GWUH) in Washington, DC, on 11/2/2004, a gynecologic surgery team that included a senior Obstetrics and Gynecology (OBG) resident physician, a second year OBG resident, and a first year OBG resident, and I treated a 40yo multiparous women with a history of multiple Cesarean sections (5). She presented through the Emergency Department (ED) with severe pelvic and lower abdominal pain. I was consulted and, following admission, she underwent laparoscopic lysis of extensive pelvic and abdominal adhesions and a left salpingo-oophorectomy without complications.

At the time of surgery and before leaving the operating room (OR), I ran the patients small and large intestines to thoroughly inspect the patient's bowel for any signs of injury and I found none. I performed the surgery using the harmonic scalpel and cold scissors to reduce/eliminate the likelihood of thermal injury to her bowel. After obtaining the patient's medical records several weeks after her hospital discharge, I learned that during the night following her surgery and prior to discharge, without my knowledge, blood cultures had been obtained from the patient secondary to febrile morbidity. I was not consulted, and antibiotics were not started

The first-year resident physician discharged this patient to home the day after surgery. This patient was discharged to home without my knowledge, without consulting me, before I had examined the patient, and without informing me of the patient's hospital course between the time she left the OR and the time she was discharged to home. No one from GWUH notified me the patient was being discharged prior to her discharge. The decision to discharge the patient and her discharge occurred between 8 am and 4 pm on a day when I was in my clinic at the George Washington University Medical Center, which is less than one block from the GWUH, and completely available and accessible. Upon my return at about 4 pm to the hospital to examine the patient to assess her post-operative condition the day after surgery, I discovered she had already been discharged and her inpatient chart had been disassembled and sent to the Medical Records Department. No explanation as to why the patient had been discharged without informing me or the condition of the patient at the time of her discharge from GWUH was provided.

Two days after her discharge and the day before this patient was taken to another hospital ED in extremis, the results of her cultures were known to the GWUH laboratory to be *Staphylococcus aureus*. This information was never communicated to me. I learned this information when I reviewed the patient's medical records weeks after her demise.

Three days after I operated on this patient her daughter called to inform me her mother was unable to urinate. I instructed the daughter to immediately bring her mother to the GWUH ED where I would be waiting. Instead, the patient was taken emergently to another hospital closer to her home. I was never informed by the patient's family, the treating hospital, or the treating surgeon that the patient was being treated at a different hospital (Howard University Hospital). At that hospital, surgery was performed, and the surgeon's operative report recorded finding abscesses in the abdominal cavity. The report specifically stated no fecal material was found in the

abdominal/pelvic cavity. Cultures of the abdominal cavity abscesses revealed only the presence of *Staphylococcus aureus* bacteria. *Staph aureus* is a common skin organism rather than a bowel organism indicating the infection that caused this unfortunate woman's demise likely came from her skin and not from her intestine as a result of a bowel injury. In spite of an allegation of an unrecognized bowel injury, there was no credible evidence such an injury occurred to this patient. The pathologist's post-mortem examination report noted the only abnormality of the patient's bowel was the site of the resection and reanastamosis performed by the surgeon at the second hospital. The pathology report concerning the portion of bowel removed at that surgery showed the bowel to be intact and without any evidence of perforation. The only reasonable conclusion would be that this patient did not have a bowel perforation and died as a result of overwhelming *S. aureus* sepsis, the source of which was the patient's skin or some area other than her bowel, areas over which I had no control.

I was prevented from treating the patient for her infection by the failure of the GWUH laboratory to notify me of the existence of the infection. I was also prevented from treating this woman's life-threatening infection by the failure of the resident physicians to inform me of the patient's febrile morbidity during the night following her surgery, that blood cultures had been drawn, and that antibiotic therapy had not been started. Timely antibiotic therapy would have very likely resulted in this lady's survival. Prior to settling this case by GWUH I was never consulted regarding settlement. I was informed it had been settled for the plaintiff in August 2008. I only learned that monies had been paid to the plaintiff when I performed a self-query of the National Pratcioner Data Bank (NPDB) in January 2009.

Dallas W. Johnson, MD, FACOG