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## The Ins and Outs of Colorectal Malpractice Dr. Stephen Cohen

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**Pat:** This is Pat Iyer with Legal Nurse Podcast and today we're going to be talking about a subject that drives a fair number of medical malpractice suits and affects all of us. And that is the mysterious area of what happens in your colon and rectum and how those things can go awry. I'm talking today with Stephen Cohen who is a board-certified colon and rectal surgeon, the first such person in Atlanta, Georgia. He is an innovator, a pioneer, and a pacesetter when it comes to innovative colorectal techniques. And in addition to having his medical degree, Dr. Cohen realized that medicine is big business and he got his MBA degree, as well, so he sees the world from a little bit of a different lens.

Today we're going to be talking about disorders of the anal rectal area and I wanted to welcome Dr. Cohen.

**Stephen:** Thank you very much, Pat. It's really an honor to be here and talking to everybody listening to this podcast. And hopefully, I'll be able to help guide, navigate an area that can be a little bit challenging for all of us dealing with it.

**Pat:** What makes it challenging?

**Stephen:** Well, the problem is you know this part of the body, everybody kind of fears it and I'm not quite sure why. Maybe it's because I like it more than other people, I feel comfortable examining the area. But you know, I'm involved in teaching and training and educating medical students and residents. And I will tell you, they fear examining this area and I think it's because they don't do it enough. And you must be comfortable knowing what the different disease processes that can afflict patients. And remember, you know you can't examine yourself, so anything that hurts back there or bleeds all patients assume it's hemorrhoids. But if I see a hundred patients who say their hemorrhoids bother them, 50-percent of the time it's something else like a rectal abscess, like an anal fissure, like a squamous cell

carcinoma, or something in the rectum that can present like hemorrhoidal disease and that's important.

**Pat:** I think those are great points. How common are those types of problems?

**Stephen:** These types of problems afflict everybody. The good news for a colorectal surgeon like me, everybody has an anus. We all have the same diseases. So, you know everybody has hemorrhoids. I love when I'm giving talks to ask in the audience how many people here have hemorrhoids, and nobody raises their hands. We all have hemorrhoids. That's what we call the blood vessels that live around the anal canal. You're not bothered by your hemorrhoids, but certainly you know women who get pregnant are bothered by their hemorrhoids, obesity, alteration in bowel habits. And we humans, we walk upright. Gravity doesn't help and many people are constipated, so hemorrhoids are common. But I will tell you, that you know anal fissures, which is a crack or a tear in the lining of the anal canal is common. So are many disease states that can be down there and it's something that we deal with on every day, but patients don't realize that there's other things other than hemorrhoids that can give you these kinds of problems.

**Pat:** Let's talk about some of those other things because I think that's what drives the litigation perhaps, and I may be oversimplifying it. The case of the fissure or the abscess can be serious and uncomfortable. But from my perspective, it's the missed carcinoma that seems to really be the driving force for litigation. When I think about the number of cases that I see written up, (I see) the person complaining of bleeding and the physician doesn't make the appropriate referral or doesn't make the appropriate diagnosis. Can you talk a little bit about that because I know you do expert work and I know you've had experience looking at those kinds of cases?

**Stephen:** Yeah, so that's an important point. So, if you're not familiar with the kind of diseases that can occur around the anal canal, you know as a colorectal surgeon I get asked to review a lot of cases where exactly that happens, and the fissure is a perfect example.

I was recently involved in a case, a 52-year-old man comes in with rectal pain, with every bowel movement. It's been going on for three months. It's not a lot of bleeding, just when he wipes. He went to his

primary care doctor and based on the history alone of rectal pain with bowel movements, no tissue protruding, one bowel movement a day so no change in the bowel habits. He had already had his colonoscopy a few years ago. Without examining the patient, the physician put the patient on topical therapy. He said, "Listen, soak in a hot tub, use your topical cream. You're going to be... It sounds like a fissure." Never examined the patient.

Three months goes by, the patient comes back again. "Doc, I've been using the cream. It's not helping." Again, doesn't examine the patient, a different kind of cream. Fast-forward 18 months, the patient presented with a squamous cell carcinoma of the anal canal.

Common things are common. To not examine the patient when they have a symptom in a certain body part, definitely is not standard of care. You will miss something. And I tell this story, and this is a true story.

So, one of my first days as a third-year medical student with a new bright white coat (that says) Mr. Cohen, because they didn't want to let us call ourselves doctor when a third-year medical student. They said, "Go examine the patient in Room 3."

So, what did I do?

It's a little old lady, she's bent away from me. She was already undressed. I lifted the gown and without looking, put my finger in and she says, "You're in the wrong place." And that's not meant to be funny, it's meant to be "You got to look and see what's going on."

So, fissures, which is a crack, or a tear, is normally in certain locations. If I see a fissure in a different location, that standard of care requires biopsy because that can be cancer. That can be squamous cell carcinoma. HIV patients get ulcers back there, a different treatment. So, the examination is important. You must look at the patient and treat them accordingly. And if they don't improve with medical care in a timely fashion, then they get advanced to the next level, either endoscopic exam or a specialist to see what is going on and how do we treat this.

**Pat:** And tell us a little bit about that specialist referral. And I guess what concerns me is the general practitioner, for example, who feels

confident to be able to handle this and doesn't make the referral. What's the thought process behind that?

**Stephen:** The thought process behind when to refer really depends on what the issue is. If you have somebody that's already over the age, which is now down to 45, that they've already had their colorectal cancer screening, you're confident they don't have a colon cancer because somebody's already looked in there. You examined the patient as a primary care doctor and you have hemorrhoids, and you have symptoms of hemorrhoids, which is the most common bright red or painless rectal bleeding and it responds to medical therapy. That's fine. It's when that patient with what your presumptive diagnosis is, whether it's hemorrhoids or fissure, that does not respond to medical therapy. That's the time for the referral. So, it's really the follow-up. The diagnosis is important, step one, the follow-up, did the patient improve, and what's the next step.

**Pat:** I know that as legal nurse consultants, we get involved in a fair number of cases and not just in your specialty, but in other areas of medicine where the test results come back or the recommendation for the referral exists, but something happens. The patient falls through the cracks. The results get in the chart and nobody notices them, or the referral request is supposedly filled out but it's not - where the patient doesn't know to go to a specialist. Can you tell us from your perspective reviewing cases where that type of miscommunication lies? How does that affect your analysis as an expert witness?

**Stephen:** I've also been involved in cases very similar to that. Either they sent in their stool cards and they were positive, and they were not sent for colonoscopy, or they had a CT scan that showed an abnormality that was not followed up. I mean, the onus definitely falls back to the provider who's giving that care. Because you know we're all busy, we all have high volume practices, but if there's no process in place to follow-up that patient, the liability falls back on the provider. I have been involved in cases where that happens and that is not standard of care. If you are the physician or the provider who's ordering the test, it is your obligation to follow-up with that test and make sure the results get communicated to the patient and documented.

And as you know, documentation, back to square one, that's where most of these medical legal issues come in because it's not properly

documented. You know now with the electronic medical record and patients getting on portals, and they can see all their information, it's much more helpful I think because I do that in my... for my own. You know I'm a consumer of health care too. It's great that I can log into my portal and I can see my lab tests and that's very helpful. But many times, it still falls back on the provider to ensure that the patient has that information and the appropriate referral has been made or not depending on what the situation is at the time.

**Pat:** Given that patients have so much access to their medical information on portals, do you see any possibility of attorneys turning around and saying to their adversary, "Your patient had the results and saw that the stool culture was positive. Wasn't it the responsibility of the patient to call the doctor and follow-up?"

**Stephen:** Now that's a very good question, but I would say, "Absolutely not". So, it's the physician, it's the provider, whether it's a physician, nurse practitioner or PA who has the education, experience, and training to know what the next step is. I do not expect my patients, who have not gone to medical school, to know what I'm supposed to do with the answer with the results. And many times, I have a conversation with the patient who has an abnormal lab value that doesn't mean anything, but that's why they're coming to see me. I mean, you know, chloride is a little elevated or one of their liver function tests is two points over the normal limit and it has the high signal by it. That's not for them to interpret, so I do not expect the patient to interpret their results. That's why they have us and that still should fall back to the provider who's ordering the exam.

**Pat:** Do you find increasingly that patients are challenging you or referring to information they found on the Internet as they are trying to interpret what you're saying or what the test results show?

**Stephen:** So, sometimes. I mean, personally, I encourage that because there's no doubt that the more information the patient has the better interaction, better communication. If I can't successfully explain it to the patient where they understand, then I don't know what myself. So, I know a lot of doctors that say, "Don't Google your information." Why not? I mean, the information is out there. That's fine. If you as a provider don't feel comfortable with your knowledge base that you can explain to the patient that what they read on the Internet is not necessarily the

case because of one, two and three, then you probably should go back and read a little bit more.

So that, I encourage that. That's fine. The Internet's not going anywhere, obviously, so I think that's a good. And again, the more information a patient has, the better everyone is going to be.

**Pat:** Can you share an example with us of a case that you reviewed that really sticks out in your mind as what we call in the risk management world the "Swiss Cheese Model"? Where one thing happened and if somebody had done something different, it would have stopped the process. But it went right through the chain with a series of errors. Does anything stick out in your mind that illustrates that concept?



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**Stephen:** Only one case, I got lots of those. So, let me tell you, yeah, one that still drives me crazy today. So, one of the treatments for hemorrhoidal disease is... So, when you have hemorrhoidal disease, okay, which is painless rectal bleeding, maybe some prolapse of tissue. You have three options to treat it. I have medical therapy, which is soaking in a hot tub, relaxes the sphincter muscle, topical creams and suppositories. That's step one. You know, fixing your bowel movement, a soft bulky non-straining bowel movement. If that doesn't work, then we go to the next level. The next level is office procedures. I can... The most common thing we do is rubber band ligation. That's an outpatient painless procedure. I tie off the hemorrhoid. It causes an ischemia of the hemorrhoids, lack of blood flow. It falls out. It fixes the problem. When office procedures don't work, then we'd go to surgery. So, when I present that to the patient, let's start with... we always start with the easy thing and then we go on to the more difficult thing.

There was a 34-year-old patient, I was asked to review this chart, who was otherwise healthy, absolutely no medical problems who failed medical therapy and went to his doctor for office-based treatment, which is rubber band ligation. No problem. Had an outpatient procedure, and we do this awake. I mean, I can work in your anal

canal and you're not going to feel it because of where we put the band above the hemorrhoids. We call it the dentate line. If I put it proximal to that, you're not going to feel that. If I put it too low, you're going to feel that. But we don't do that, we do it with you awake.

So, this 34-year-old patient recently had a new baby three weeks before, went into his doctor for rubber band ligation and did fine. Five days later, went back because of increasing rectal pain, subjective fevers and bright red rectal bleeding. When he left the procedure, the five days before had no pain at all, which is what you're supposed to. You should not have pain after the band, otherwise it may be in the wrong place. Five days in, symptoms. He had some nausea and vomiting the night before, subjective fevers, and went to go back to see his doctor.

His doctor doesn't do any vital signs. His doctor does not examine him and says, "It's probably a result of the band. Take a... I'm going to put you on some Motrin. I'm going to put you on some muscle relaxers. You're going to be fine." Two days later, this is three days later. It goes from Friday to Monday and gets worse. More nausea, vomiting, fevers of 103°, shaking chills documented by the wife, nausea, vomiting, and now he can't urinate. He calls the doctor Monday morning. This is now eight days after a routine outpatient elective rubber band ligation. He calls in the morning. The wife says, "He's sick and needs to be seen." They get him worked in a 4:00 in the afternoon. He looks sick. The doctor doesn't examine him again and sends him over to the emergency room as, "Possible spasm of the hemorrhoid, please see him."

He walks into the emergency room with a fever of 102.9°, blood pressure of 90 over 80. They do some lab work. He's got a white count of 34,000. He's got a lactic acid of 2.1. They do a CT scan. The diagnosis is hemorrhoidal band procedure, spasm of the anus, possible infection. The ER doctor does not roll him over and examine him. And I mean, this is, yeah, so one of these Swiss cheese things. Seriously, this is the third provider.... Third... second person who's seen him. The third time nobody's looked at his bottom. It's all documented. "Rectal exam not performed, secondary to pain." Okay, that's not standard of care.



He gets a CT scan to rule out infection. The CT scan shows significant inflammation of the rectum, edema all the way up the pelvis and sidewall, and "no drainable infection, no drainable abscess." The call goes out to the colorectal surgeon at bed at 11:00 at night and was told all the labs that I said: fever, white count, lactic acidosis, severe rectal pain, 10/10. This is what the CT scan says. He says, "Okay, I'll admit him" over the telephone. "We'll put him on some antibiotics. I'll see him in the morning."

During the night, he spikes a fever at 103°, worsening rectal pain, 6:00 AM the morning labs (show) his lactic acid is now up to five. His white count is up to 59,000. By the time the colorectal surgeon sees him at 9:00, he then rolls him over to look. Necrotic, foul smelling drainage. Takes him to the operating room and debrides the necrotic tissue. He goes to the recovery room, cardiac arrest and dies on the way to the intensive care unit.

Let's go back to the Swiss cheese model. A 34-year-old, otherwise healthy for an elective outpatient procedure. Lots of problems with standard of care. You shouldn't have any pain at all five days after a hemorrhoidal band. It was an obvious infection that was starting the five days before. Had the GI doctor looked at him and done an exam, it would've sparked something. He would have been treated quicker, number one. Number two, the night before had the ER doctor examined him, more likely than not based on a reasonable degree of medical certainty and probability, would've seen something and called the surgeon in earlier. The CT scan, soft tissue infections don't necessarily have anything to drain. So, I don't care that the CT scan said nothing to drain. He needed surgery. This was a survivable event had many steps along the way someone just took care of him. A very disheartening case.

**Pat:** Did they start antibiotics at any point during this?

**Stephen:** They did start antibiotics. By that time, it was about 11:00 at night. He had already been in the ER for about six hours. You know the initial lactic acid was two. They hydrate him and the lactic acid came down to one. Antibiotics were ordered. It took three hours to get there. There was a lot of different things that happened. It was group think of, "It looks like he's getting better. We got his blood pressure from 90 to now it's okay."

But you know, he's a 34-year-old healthy person. I only expect your blood pressure to drop until you're over the cliff. So, you know it's not like you're elderly, diabetic, or heart disease or on beta blockers. He had nothing. You shouldn't have a 34-year-old somebody with a simple outpatient procedure with a blood pressure of 90 and a white count of 34,000 and the lactic acid of two to start with. That's not the norm.

So, lots of problems in that case. This was a disaster and now unfortunately a dead patient. It is a known complication of hemorrhoidal banding of overwhelming sepsis from an infection. But if it's caught early, it's treatable. You go to the operating room. And I've had patients like this. They come in three days in pain and you can't pee, you go right to the operating room. I don't even want to examine you. I'll examine you when you are asleep because I already know what the problem is. The diagnosis was not in question. Your butt is killing you and you have enough objective data. At that point, I know what you need. The CT scan wasn't even helpful. The CT scan is going to show you exactly, I would expect, nothing to drain. I don't expect an abscess cavity. I expect soft tissue infection. The only way I'm treating that is in the operating room. That's not something we treat only with antibiotics, especially in this area.

**Pat:** There's been so much emphasis recently on making sure that there are sepsis screening tools in place, that people recognize the symptoms, that they recognize the urgency of treating.

**Stephen:** And that did not come through in this case because there was a significant delay in getting everything in this case. But again, you know I will go back to when you talked about the Swiss cheese. That patient should not have been there eight days after the band. He should've been there three days before and then you're not septic. And then I debride you, and I put you on antibiotics, and I watch you for a day, and you go back home to your baby the next day or two days later. So, you know by the time you're in the emergency room all the issues that happen there, that didn't even need to happen. And this is the kind of case, obviously, from a medical legal standpoint everybody got sued. Obviously, the GI doctor, the hospital, the surgeon who never came to see the patient, and everybody's pointing the finger.

So, from a legal nurse perspective, if you're on the plaintiff side on this case when they're starting to point the finger at everybody else, right? I mean, the colorectal surgeon says, "Well, he didn't give him the antibiotics quick enough." The hospital says, "Well, the GI doctor should have treated him three days before," right, so that's an issue. So, it's...

**Pat:** Everybody's pointing their fingers.

**Stephen:** And small little things lead to a disaster. And not all the cases I review are that clear cut. But in that case, one bad decision five days after a routine elective outpatient procedure that should've been perfect, something wasn't right. And the failure to recognize the significant potential complication for elective hemorrhoidal treatment led to the death of that poor patient

**Pat:** And there's huge damages in this case. How did it get resolved?

**Stephen:** It is still undergoing, and I don't know yet.

**Pat:** The damages, just think of the age of the patient. The family that he's left behind, the lost income potential, all the pain and suffering that he experienced in the process of that eight-day period.

**Stephen:** Right, a lot of potentials on that case. There's a life planner involved. You know all the type of things that are important to try to prevent that. But I mean, if you're from a provider standpoint, if you're doing a procedure, you need to know what the potential complications are and how to fix them. I tell the residents and medical students this all the time. As a surgeon, I'm going to have complications and that's fine. It's not the complication normally that you... There's a medical and legal action because most things are known complications. I'm going to have wound infections. I'm going to have urinary tract infections. If for every 100 colorectal anastomosis I do, I'm going to get a five- to 10-percent leak rate. That's fine. It's the failure to recognize, which then causes a bigger downstream effect. If you have the right signs and symptoms of a complication, recognize it, work it up, and fix it. And that's the key.

**Pat:** What happens when physicians or nurses or other health care providers don't recognize? I mean, what goes into our brain where we see a complication and we don't put it together, we don't analyze it

correctly? We don't use critical thinking skills. What's your insight for us on that?

**Stephen:** Yeah, so many times when I'm looking at different cases, I sometimes have that question too. I say, "Listen there was enough signs and symptoms. Fever and white count and not progressing normally after a bowel resection." But, why would you not think to do something? And most of the times when you read their depositions, it's "I never have that complication. I didn't think I would have that complication." It's really group think, and I use that a lot when I'm asked about these things. Because you have...again, when a patient's not doing well in the hospital, most of us load the boat, right?

I want the cardiologist. I want the pulmonary doctor. I want the renal because all the organs start to go. And everybody looks at it just to their little issue. So, the renal doctor even though you have a healthy patient and now they're in kidney failure. You say, "Well it could be pre-renal and maybe it's related to the antibiotics." No, it's from sepsis because you have a leaking anastomosis.

And the cardiologist does the echo and says, "The heart seems to be okay and maybe it's just a low potassium." No, it's from the sepsis. So, we all get caught up in this group think and want to believe we never have complications. I mean, surgeons who say they never have complications either are lying or they're not doing surgery. There's no two ways about it. It's okay to have the complication but *recognize* it. You know that's part of the informed consent.

So, one of the things that I'll bring up about informed consent... And I have the same conversation with every patient and sometimes they don't want to hear it. But I can't possibly tell you every potential complication from everything that I do, right? There's always something weird; patients don't read the textbooks. So, I talked to them about six different things that generally gives them an idea of what's going on. I can have bleeding. I can have an infection. I can have anesthesia complications and that covers a lot. The other three things I say is that I can make you worse, number four. Number five, I can injure another organ, or number six, you can die.

Now when I'm telling that to my hemorrhoid patients, they don't really like that. But it generally covers any potential, because I have

reviewed cases or the complication. I've never even heard of the complication and how could that possibly happen? But those things certainly can happen. You know obviously documentation of why you're doing the surgery.

That's another thing that I like to preach to the residents. It's okay to have complications, but when you have a complication the first question anybody is going to ask you is, and this sounds very simplistic, "Did the patient need an operation?" Yeah, "Did the patient need an operation?"

So that's important because you know patients will put their trust in their physician and sometimes the way medicine is now, I get reimbursed for the more procedures I do. It's kind of a weird system, but that's the way it is. And it's not necessarily below standard of care to offer somebody surgery because that will fix the problem. But medical therapy may also as well.

So, I've had plenty of patients who want surgery who haven't tried medical therapy. Well, they probably... they might not need surgery. So, does the patient need an operation? When I'm looking at a case, "Did they need surgery?" I mean, if they have perforation, diverticulitis, colon cancer, yes, they need surgery. But what else was tried? Was the patient offered something else if indicated? And, again, looking at the consent form, was the alternatives described and did the patient make an informed consent?

**Pat:** So many factors to think about, isn't it?

**Stephen:** Yes.

**Pat:** Our time has gone by very quickly and I know that the people who are listening to this program would be appreciative of knowing how they can contact you if they are looking for an expert witness who covers the area that you do. Could you provide that contact information for our listeners?

**Stephen:** Yes. Stephen Cohen. It's Stephen with a "PH", very easy. I do have a LinkedIn site, so (you can reach me) through LinkedIn. I've had some legal nurse consultants contact me through my LinkedIn. I think I'm the only Stephen Cohen. That's hard to believe, but I think I am. And you know, again, my email, stephencohen615@gmail. Six, one, five is

my birthday. So, if you want to remember that, it's halfway through the year. I get presents every six months. So, stephencohen615@gmail. You can get me through LinkedIn. I'm happy to give you my opinion.

I will tell you about 30-percent of the time when I'm asked from either plaintiff or defense, because I do about half of each, about 30-percent of the time I make that attorney not happy with me. Because I either tell them they don't have a case, or I can't support them because I really felt that what... You know if I'm asked from a defense attorney and I can't support what the doctor did or the provider did that, I certainly won't make that person happy. But when you're telling the truth, it's easy.

I'm happy to review and happy to give my opinion based on colorectal issues. There's a lot of issues. You know the guidelines for colorectal cancer has changed in the last year. We're doing it a little bit earlier now. So, there's a lot of important factors that come into play when you're looking at a medical malpractice case.

**Pat:** Thank you and I appreciate you sharing your experience with our listeners. You've got a wealth of experience and I'm sure, as happened to me when I was doing expert work for 25 years, the lessons that you learn as an expert, you carry over into your practice as well.

**Stephen:** Absolutely. Many truths on that. I look at everything a little bit different. I document a little bit different. Talk to the patients a little bit different. It's great and hopefully I can pass some of that knowledge to the some of the young doctors who are coming out today because they need it.

**Pat:** Absolutely. Thank you for being our guest and thank you to our listeners for watching this program and listening to this program. Be sure to tell other legal nurse consultants about Legal Nurse Podcast and to come back next week when we have a new show.

**Stephen:** Thank you.

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