MIEC

Write On!

MIEC'S DOCUMENTATION NEWSLETTER

OCTOBER 2007 ISSUE 2

Communication errors. Systems failures.

How can physicians prevent them?

INSIDE

Write on!

A publication of the Loss Prevention Department, Medical Insurance Exchange of California, 6250 Claremont Avenue, Oakland, CA 94618.

In a study reported in the Annals of Internal Medicine, Dr. Tejah K. Gandhi and colleagues researched the most common causes of missed or delayed diagnoses as alleged in the 307 closed malpractice claims that the group surveyed. A total of 181 claims (59%) involved diagnostic errors that harmed patients (Table 1). Well over half of the errors resulted in a missed or delayed diagnosis of cancer (e.g., breast and colorectal).

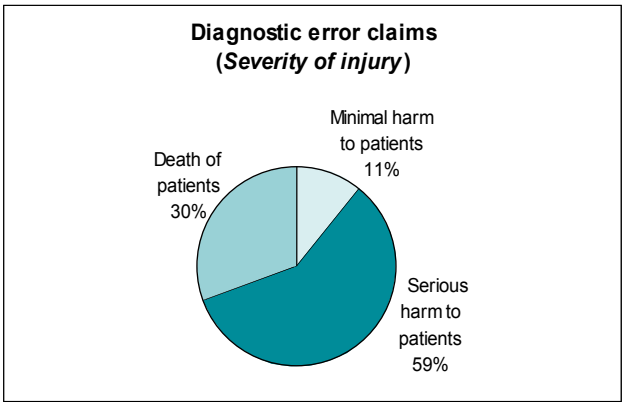

Table 1

Researchers found five common breakdowns in the 181 diagnostic error claims as illustrated in Table 2.

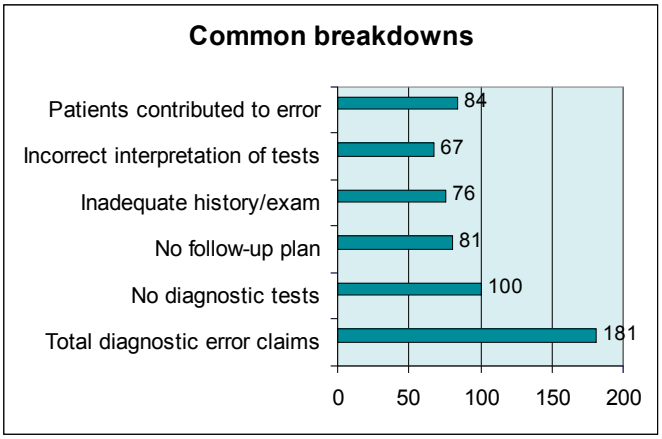

Table 2

In most of the cases, more than one breakdown occurred and more than one provider contributed to the diagnostic error. Dr. Gandhi and his colleagues concluded, "Diagnostic errors that harm patients are typically the result of ***multiple breakdowns*** *and individual and system factors. Awareness of the most common types of breakdowns and factors could help efforts to identify and prioritize strategies to prevent diagnostic errors."* [1]

How much money do policyholders lose…collectively?

Some policyholders ask how much money they "lose" when MIEC pays a large sum to a patient on behalf of a policyholder. It is impossible to quantify all the factors in each case and how they impact each policyholder. However, it **is** possible to draw conclusions from an average of costly cases and to estimate the likely dollar effect on each policyholder.

- Between 1998 and 2007, MIEC closed 11,301 claims
- 9.6% involved indemnity payments
- Average indemnity = $224,167
- 75% of the indemnity payments occurred in just 226 cases (2% of the closed claims)

When the cost (indemnity + expenses) of these few large cases is put on a *per policyholder basis*, it amounts to more than **$5183 every year!** Include expenses paid for claims closed without indemnity payment, the average per policyholder increases to **$6800 per year.**

MUC Executive Vice President Andy Firth reassures and reminds policyholders, "This is how insurance is *supposed* to work—spreading the costs of the system **among** all the policyholders. What we have tried to do for the past 34 years is **reduce the costs of the system** that our policyholders have to bear. On that point, the most frustrating reality of **defending** medical malpractice **claims and lawsuits** is the large proportion of cases (90%) **in which** the doctor did nothing wrong, and the huge cost of resolving them. This is why MIEC works with its physician-owners to reduce the possibility of being sued in the first place."

Errors in diagnosis are not always caused by the failures of a single doctor; they frequently are attributed to several sources and a number of providers. In this edition of Write On*, we will present two MIEC cases that illustrate (to an extreme) how communication breakdowns and systems failures can directly result in medical injury and liability exposure for physicians. The cases illustrate that physicians, their colleagues, and staff must work together to develop meaningful systems for communicating, ordering diagnostic tests, referring patients to specialists, effectively managing information, and follow-up. The names and some details of the cases have been changed to protect the identities of both plaintiffs and defendant physicians.*

The cases we present in the *Write On!* newsletter series represent some of the higher-end cases that could have been prevented—or better defended—if the physician(s) defendant(s) had practiced more protective and defensive documentation habits.

Case #1: Allegation – One year delay in diagnosis and treatment of lung cancer.

The plaintiff was a 45-year-old male whose history was significant for smoking 1½ packs of cigarettes daily and bilateral iliac stenosis. In March 2002, his primary care physician, Dr. A, referred the patient to vascular surgeon Dr. B because of increased symptoms related to the iliac stenosis.

Dr. B scheduled a balloon dilation to be performed the following month at MI Medical Center. He ordered preoperative lab work and a chest x-ray. He did not request a copy of the diagnostic studies to be sent to Dr. A. (**Breakdown #1**)

A few days before the scheduled dilation, MI Medical Center notified Dr. B that they cancelled the procedure because they did not have qualified staff to perform it. Dr. B referred the patient back to his primary care physician to reschedule the procedure but did not notify his staff that the procedure had been canceled.

In the meantime, the patient underwent the pre-op X-ray which was interpreted by radiologist Dr. C as showing an "ill defined density" in the right lung. Dr. C allegedly called the vascular surgeon to report the findings, but did not remember who took the call. No one documented the call on either end of the line. (**Breakdown #2**)

The Radiology Department faxed the chest X-ray report to Dr. B's office. *Per office policy,* the staff (who did not know that the procedure had been canceled) immediately sent the report to the medical center where the balloon dilation was originally scheduled. Dr. B did not review the report. (**Breakdown #3**)

Dr. A referred the patient to interventional radiologist Dr. D who performed the angiogram and stent placement without incident.

One year later. . ., the patient returned to Dr. A for a physical exam. A chest X-ray was taken which revealed a 5 cm lesion; the image was compared to the 2004 film which showed the same lesion, then measuring only 0.5 cm. This was the *first time* Dr. A learned of the 2004 chest X-ray. He referred the patient to a pulmonologist who diagnosed Stage III-IV disease. The patient died ten months later.

The outcome: The patient's family filed suit against all the physicians, the surgical group, and the radiology group. The lawsuit was settled prior to the scheduled trial date. Indemnity monies were paid on behalf of Dr. B, the surgical group, and the radiology group for between $50,000 and $150,000 per entity. Drs. A, C and D were dismissed.

Breakdown/Recommendation: We identified at least three (3) documentation and/or system breakdowns in this case, problems, which if prevented, could have resulted in a timely diagnosis of lung cancer and significantly earlier treatment for the patient, and decreased liability exposure for the physicians and groups.

Breakdown #1: Dr. B's office ordered the chest X-ray but did not request that a copy of the report be sent to Dr. A.

Recommendation #1: When ordering pre-operative diagnostic tests, request that a copy be sent to the patient's PCP and other co-treaters, to ensure that all treating clinicians remain in the communication loop. Radiologists would be well-served to implement a policy that requires staff to ask patients for the names of their PCP and other treating physicians if this information is not already included in the referral.

Of note: The ordering physician is ultimately responsible for follow-up on test results, especially when the results are abnormal. However, in malpractice cases where multiple providers/defendants have knowledge of abnormal results, the culpability of each physician will be considered when determining the cause of the patient/plaintiff's injury. Realistically, if you have significant medical information about a patient, you must act on it even if it involves no more than confirming which co-treater will be responsible for follow-up and treatment.

Breakdown #2: Neither Dr. C nor Dr. B documented the alleged telephone call in which they discussed the findings of the chest X-ray. Therefore, it was the word of one physician against another, making it difficult to determine what or who prevented a timely diagnosis of lung cancer in this case.

Recommendation #2: Document *all* significant phone calls in patients' charts and include the date and time of the communication, the caller's or recipient's name, and contents of the call. "Significant" conversations are those in which new medical information is conveyed, medical decisions are made, or a physician gives medical admonitions, directions or advice. Ensure that your staff members do the same, and that they inform you of all significant information received from a consultant, co-treater, or patient. Radiologists should document when they have communicated urgent results. Some note in their final reports, "Phone report given to Dr. XX on (date). Report faxed to Dr. XX on (date)."

Breakdown #3: Dr. B never saw the chest X-ray report and denied being called about the results. In this case, the problem originated with Dr. B's office policy requiring that preoperative diagnostic test results be forwarded—unreviewed—to the surgery center, on the assumption that the surgeon would see the information immediately prior to a procedure. Dr. B did not inform the staff that the procedure was canceled; the staff duly sent the chest X-ray report to the surgery center; and Dr. B never saw the report because he did not perform the procedure. No policy prevented this contingency, nor did policy ensure that Dr. B inform the staff that a procedure had been canceled. The surgery center had no obligation to return the report for the patient whose surgery was canceled.

RECOMMENDATION #3: Ensure that you see *all* results of tests that you order, even if a procedure is canceled. Initial the reports or write notes on them as evidence of your review; file the information in the chart. Medical clearance should be clearly documented in a patient's chart *prior* to commencement of any procedure. Many surgeons note this significant information in their History and Physical reports.

If results reveal abnormal findings, document your efforts to notify the patient and the PCP. Advise the patient that additional medical care and treatment may be required, and document the discussion. Likewise, call the patient's PCP to make certain he/she is aware of the results. Again, document the discussion, specifically noting any communication about the patient's return to the PCP or referral to another specialist.

Case # 2: Allegation – The defendants negligently cleared a diabetic patient for vitrectomy. As with the previous matter, Case #2 involved a number of communication breakdowns and system failures (resembling an avalanche when viewed from a distance) that led up to the patient's cardiac arrest, coma and ultimate death, and exposed four physicians, two medical groups, and one hospital to significant liability.

The patient was a 34-year-old male with an 11-year history of Type I insulin-dependent poorly-controlled diabetes for which he was treated interchangeably by an internist subspecializing in endocrinology (Dr. E) and his partner (Dr. F). In July, ophthalmologist Dr. G evaluated the patient for diabetic retinopathy diagnosed as severe in both eyes. The ophthalmologist scheduled a vitrectomy for the right eye in late October.

During the first week of October, Dr. F saw the patient for a right leg injury, reported knee pain and increased swelling in his ankles. Dr. F ordered lab work and asked the patient to return in two weeks.

A week later Dr. E saw the patient for pre-op evaluation. The patient had gained 16 pounds in the week since the last visit; however, Dr. E was unaware of the significant weight gain as he did not read his partner's earlier note. Dr. E reviewed the previously ordered lab work, which was significantly abnormal (e.g., elevated BUN and creatinine levels), and instructed the patient to see a nephrologist for possible renal insufficiency; the patient was given a referral form. The progress note read, "Ok for vitrectomy under **local** *[emphasis added]* anesthetic, need nephrology consult." Dr. E did not call the ophthalmologist to discuss the use of a local anesthetic; the patient did not see the nephrologist. (**Breakdowns #4, #5, #6**)

Ten days later the patient returned to Dr. F with continued complaints of swelling in both legs. Dr. F ordered more lab work, referred the patient to a nephrologist, and recommended that the proposed eye surgery be ***rescheduled***; the patient was given a referral form. The chart read, "Refer to Dr. X, nephrology. Reschedule eye surgery." (**Breakdowns #6 and #7**)

The next day Dr. G's staff faxed a pre-op History and Physical form to Dr. E's and F's office; accompanying information stated that a **general** anesthesia was planned and Dr. G was to be notified immediately if there were any contraindications to the scheduled anesthetic. One of the medical assistants wrote Dr. F a note, "Pre-op yesterday with you. Is he cleared for surgery?" to which the physician responded,

"No." There was no evidence in the chart that anyone called Dr. G's office, and/or the patient, to cancel the surgery. (**Breakdown #7**)

The following day Dr. E's staff faxed the pre-op evaluation progress note to Dr. G, but none of Dr. F's notes. Dr. G didn't review the information sent so he didn't know that Dr. E recommended a **local** anesthetic and nephrology consultation pre-operatively.

On the day of surgery, the patient was anxious and **requested a general**. No one in the surgery center knew that 1) a local anesthetic was recommended if and when the surgery took place, 2) the patient had not seen the nephrologist for evaluation, and 3) Dr. F recommended rescheduling the vitrectomy. (**Breakdown #8**)

During the pre-operative phase, the anesthesiologist administered Fentanyl; shortly thereafter he noticed the patient wasn't moving or breathing. The patient sustained cardiac arrest with respiratory failure. He suffered brain damage and required round-the-clock care while he remained in a coma, which was about a year until his death.

The outcome: The patient's family filed suit, which was settled prior to the scheduled trial date. Indemnity monies were paid on behalf of Dr. E and Dr. G (between $50,000 and $100,000 each) and on behalf of the anesthesiologist, ophthalmology group, and surgery center (between $20,000 and $40,000, each). Dr. F was dismissed because his progress note stated that he recommended that the vitrectomy should be rescheduled.

Breakdown/Recommendation: At least five (5) breakdowns in communication or systems occurred in the second case; all were missed *opportunities* for the clinicians and their staff to avoid catastrophic injury.

Breakdown #4: Dr. E did not review Dr. F's previous chart note. According to one MIEC medical consultant, had Dr. E done so, he would have noticed the patient's significant weight gain and been alerted to the fact that he was not a surgical candidate at that time, even if the vitrectomy was performed using a local anesthetic.

Recommendation #4: In a group practice, when patients are treated by more than one physician, it is prudent to review recent progress notes, diagnostic test results, and other significant documentation to ensure knowledge and understanding of the patient's care and treatment as provided and/or recommended by colleagues.

Breakdown #5: Dr. E did not call or otherwise notify Dr. G about the patient's possible renal insufficiency and Dr. E's recommendation to use a local versus a general anesthetic.

Recommendation #5: Communicate significant medical information to co-treaters, especially when a patient could be injured if the co-treater is unaware of the facts/data/information. Clearly document these discussions or other means by which you inform the co-treater in the patient chart.

Breakdown #6: The nephrology referral was clearly documented in the patient's chart; however, Drs. E and F, and their staff, failed to follow-up with the patient and/or consultant to ensure that the patient was seen.

Recommendation #6: Create a system to track recommended diagnostic studies and consultations. Many practices monitor consultations using a tickler system or some other type of reminder. A few days before the patient is to return in follow-up, the staff checks to see if the consultant sent a report. If there is no report, the staff calls the patient or consultant to determine when the patient was seen, and asks the consultant to fax a written report. If your patient has failed to see the specialist, find out why, and when appropriate, remind the patient why you referred him/her for consultation. Document your efforts and the patient's response.

Breakdown #7: Dr. F and his staff failed to contact Dr. G to recommend rescheduling the eye surgery. Dr. F's progress note did not indicate whether the patient was advised that the surgery should be rescheduled because of his possible renal insufficiency.

RECOMMENDATION #7: Significant changes to a patient's proposed medical treatment (e.g., cancellation of a scheduled surgery) should be clearly documented in the medical record. Ideally, Dr. F should have called Dr. G, discussed his concerns, and documented the conversation in the chart. The patient also should have been informed that surgery was contraindicated, and the staff should have been informed of the cancellation.

When a procedure is contraindicated, consider instructing your staff to contact a co-treater's office to cancel the procedure. Some physicians use "Physician Orders" to direct their staff (e.g., "10/19/XX, Call Dr. G and advise we need to reschedule the eye sx. Patient's BUN and creatinine levels are too high. Needs neph consult before sx.")

Clearly document your advice to the patient of the need for follow-up (e.g., "10/19/XX Advised pt his kidney lab work is elevated. He needs to see a neph BEFORE surgery. Advised him to contact Dr. G and cancel sx. Pt understands and will call.") Ask your medical assistant to call the patient or specialist in a few days to ensure the surgery was cancelled.

Breakdown #8: Dr. G did not review the faxed information received from Drs. E and F. As a result, Dr. G did not even know that a local anesthetic was recommended.

RECOMMENDATION #8: Review pre-operative documentation received from co-treaters to ensure you have a clear understanding of the patient's medical history and readiness for surgery. In this case, had Dr. G reviewed the information, he might have been prompted to follow-up with Drs. E and F.

Final thoughts… Reduce your liability exposure by carefully reviewing office policies, communication practices, and follow-up systems. With your staff:

- Copy primary care physicians and co-treaters on ordered diagnostic studies.
- Satisfy yourself that abnormal results are being followed by an appropriate physician.
- Document the details of significant phone calls.
- Review and initial diagnostic test reports before they are filed.
- Review your colleagues' notes, especially if you're in group practice.
- Communicate significant medical information to co-treaters and document that it was done.
- Track recommended diagnostic studies and consultations to ensure their completion.
- Specialists—review pre-operative documentation received from PCPs and/or co-treaters.

[1] "Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims," *Annals of Internal Medicine*, 3 October 2006, Volume 145, Issue 7, pages 488-496

TO REACH MIEC

PHONE:
Oakland Office:
510/428-9411
Honolulu Office:
808/545-7231

Boise Office:
208/344-6378
Outside:
800/227-4527

E-MAIL:
Lossprevention@miec.com
Underwriting@miec.com
Claims@miec.com

FAX:
Loss Prevention:
510/420-7066

Oakland:
510/654-4634

Honolulu:
808/531-5224

Boise:
208/344-7903

MIEC ON THE INTERNET
www.miec.com