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Risk Management Review

PATIENT SAFETY & RISK SOLUTIONS

Poor Continuity of Care and Inadequate Documentation Combine With a Rare Condition to Produce a Suboptimal Outcome

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

As medical practices become larger and often involve providers at various levels, it can be challenging to maintain appropriate continuity of care. Nevertheless, when this continuity does not occur, the likelihood of a missed or delayed diagnosis increases.

In this interesting case from the Midwest, poor continuity of care combined with suboptimal documentation caused a delay in the diagnosis of a rare, but detectable condition.

Facts

The patient was a 5-year-old male with no remarkable medical history. In October of Year 1, the patient's mother (a registered nurse) presented him to the pediatric practice because of an enlarged lymph node on the right side of his neck. Although his temperature was normal in the office, his mother indicated that he had had a cough and cold symptoms with a 102 degree temperature. Nurse Practitioner (NP) #1 examined him and ran a strep test that was negative. She diagnosed him with a slightly enlarged right lymph node and felt that no medicinal treatment was indicated at that time.

Five days later, he returned with a rash and sore throat. NP #2 and Dr. P examined the patient. On this visit, he was diagnosed with strep pharyngitis. NP #2 did not note any enlargement of any lymph nodes and stated that she would have documented so if any had been present. She did note an erythematous tympanic membrane (without rupture) on the right. She also noted a "lacy rash" on the

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chest. Cefdinir was prescribed for the patient, and the mother was advised to contact the office if her son did not improve.

In February of Year 2, NP #3 and Dr. S examined the patient. The patient's chief complaint was swollen lymph nodes that had persisted since the previous October. Dental caries were noted, as were "several shotty cervical nodes which were mobile" (NP #3 contends that the cervical lymph nodes were so small that they could not be observed; they could only be detected by palpation). Large (approximately 1.5 cm) tonsillar nodes bilaterally also were noted, which were also mobile.

Several lab tests (including complete blood count, C-reactive protein, and erythrocyte sedimentation rate) were ordered; however, all test results were normal except for slight anemia. Given no history of unusual fatigue, no family history of cancer, and no fever or infection, the diagnosis was enlarged lymph nodes and dental caries. It was suggested that the patient see a dentist for treatment of the caries.

In October of Year 2, NP #4 conducted the patient's annual physical. In this examination (which NP #4 described as "very systematic and regimented"), no lymph node or other concerns were communicated to the NP (and apparently not noted in his review of the patient health record). NP #4 did not note any dental caries, tonsillar hypertrophy, or exudates, and no nodular abnormalities were noted in the thyroid or cervical region. The assessment was summarized as a normal routine child health examination.

In subsequent litigation, the parents produced photographs of the patient taken 3 days before the above described physical showing elevated cervical lymph nodes bilaterally, which can easily be seen with the naked eye (the date of the photographs was verified forensically). No explanation exists for the disparity between the physical examination results and the photographs. The mother contends that the cervical lymph nodes were enlarged for the entire period between October of Year 1 and October of Year 2.

In December of Year 2, the patient presented to the practice with a cough. Dr. J examined the patient at this visit and diagnosed the cough as croup. Dr. J did not note any enlarged lymph nodes; however, a photograph taken 1 week earlier (again, verified) shows an enlarged lymph node on the left side of the

neck. Again, no explanation exists for this disparity. Dr. J prescribed steroids and the croup resolved as expected.

In February of Year 3, the mother took the patient to the emergency department (ED) where she worked because of "abnormal breathing sounds." The ED physician diagnosed a "large mass pressing on the pharynx" and recommended a consult with an ear, nose, and throat (ENT) physician. Shortly thereafter, the ENT physician biopsied a mass on the patient's thyroid gland and ultimately diagnosed metastatic papillary thyroid carcinoma. At the time of litigation, the patient was receiving treatment and was in satisfactory condition.

A medical malpractice lawsuit was instituted against Dr. S, NP #3, and the practice for the delay in diagnosing this condition. With the parties' consent, the case was resolved by a payment in the high range, with defense costs in the very high range.

Discussion

The facts of this case made it difficult to administer from a claims standpoint. The basic cause of action was a delay in diagnosing an extremely rare type of carcinoma (approximately 0.7 cases out of every 1 million cases seen). One defense expert opined that the average pediatrician would encounter this condition once or twice in his/her career. All other things being equal, it would be a strong argument that the failure to promptly identify the condition would be reasonable given its rarity. Unfortunately, all other things were not equal.

No continuity of care existed during the time period in question. During this 14-month period, the patient saw four NPs and three physicians — and never the same clinician twice. Any opportunity to get to know the patient was lost as a result of the apparently random assignment of him to different providers as he returned to the practice multiple times for the same condition. Certainly, plaintiff's counsel would have little difficulty portraying the practice as a "mill."

The plaintiffs placed quite a bit of importance on the visit in February of Year 2. Their contention was that this was the best opportunity to make a timely diagnosis. Although it appears that it was appropriate to order tests (although these test results obviously did not indicate this condition), further testing and/or other follow-up should have occurred

when the test results were negative, given an identifiable condition that had persisted for several months. This follow-up could have been as simple as scheduling the patient after he had seen a dentist to learn what the dentist's findings and recommendations had been, and to determine whether any change in the size, location, or mobility of the swollen lymph or tonsillar nodes had occurred.

The documentation in this case was not helpful in resolving it or even understanding it. Although some practices intentionally operate as this one did (random assignment of patients based on which provider is currently available), in such cases, the documentation of care must be clear, accurate, and very complete, and the provider must thoroughly review it prior to providing subsequent care.

During the visits of October of Year 1 (the second visit), October of Year 2 (the physical), and December of Year 2 (the treatment for croup), no enlarged lymph nodes were noted, although their presence was established by verified photographs. If this case had proceeded to trial, the credibility of the entire patient record would have been undercut by this unexplainable conflict. Additionally, NP #4 stated that no enlarged nodes "had been communicated to him." This assertion leads to the inference that he did not review the patient record prior to performing the physical, since the chief complaint for the February of Year 2 visit was "swollen lymph nodes of several months duration."

Although this was a very rare condition that many competent physicians would not immediately identify, this sequence of events made it difficult to defend this case. Given the age of the patient (and the inherent sympathy for the patient), the seriousness of his illness (including arguable worsening due to the delay in diagnosis), and the chronology of events, the only viable option was to make a large payment to settle this case.

Summary Suggestions

The following suggestions may be helpful in assessing and documenting patient care in the healthcare office:

- Continuity is an important aspect of quality care. Especially in large, multi-provider practices, every effort should be made to provide consistent, attentive care, preferably by the same provider or team.

- The patient health record is an essential tool in providing quality patient care. Providers should carefully and thoroughly document care in the health record, as well as review it before commencing subsequent care.
- Conditions that continue undiagnosed for some time require careful follow-up to their conclusion. This conclusion may be resolution of the condition, acceptance of the condition as chronic, or discontinuation of treatment. However, abandonment of the investigation prior to resolution is not acceptable.
- In larger practices "round-tabling" difficult cases can be very beneficial. This continuous quality improvement process allows "new eyes" to assess a case and identify any potential weaknesses in the practice's treatment processes. It can also be a valuable educational opportunity for newer-to-practice providers to hear these discussions. Before commencing such discussions, providers at the practice should consult with their MedPro patient safety and risk consultant to ensure the confidentiality of these discussions and the available protections from legal discovery.

Conclusion

In the 21st Century, the face of healthcare practice is changing. Factors such as economy of scale, work-life balance, and the "graying" of the physician workforce are resulting in the one- or two-doctor healthcare practice becoming less common.

With the increasing size and complexity of today's healthcare practice, it is much easier for a patient to become lost in the system. To avoid this possibility and its inherent risk to the patient and practice, the healthcare practice needs to have consistent, well-organized processes that everyone understands. A commitment to excellence, combined with effective communication and adherence to these processes, will significantly minimize the risk of a catastrophic error.

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