

Patient Does Not Receive Timely Treatment Following Critical Injury, Resulting in Permanent Impairment

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Introduction

Fortunately, the overwhelming majority of medical care provided is not time sensitive. However, in some cases, “time is tissue.” In this interesting case from the Southeast, the criticality of the patient’s injury was not appreciated, and the resulting delay in treatment had catastrophic results.

Facts

The patient was a 33-year-old male who was involved in an altercation outside of a bar while highly intoxicated and under the influence of methamphetamines. He was punched in the face, fell to the pavement, and struck his head. He suffered a stellate fracture to the right temporoparietal lobe, extending to the floor of the middle fossa, resulting in a 5 cm (in diameter) subdural hematoma (2.5 cm deep) and a 7 mm midline shift,

causing effacement of the ventricles and sulci in the left hemisphere. His initial Glasgow Coma Scale (GCS) evaluation in the emergency department (ED) was 14. However, because of his combativeness (apparently from being intoxicated), he required sedation in the ED.

Dr. J (a MedPro-insured neurosurgeon) was paged regarding the patient at 10:17 p.m. By 10:32 p.m., the patient’s GCS had dropped to 7. In a note dictated at 10:43 p.m. (apparently from home), Dr. J indicated that the patient had a 1.5 cm deep hematoma with no midline shift. He ordered the patient’s transfer to the intensive care unit (ICU) for observation and an additional CT to be performed at 3:00 a.m. Although Dr. J’s documentation indicates that he viewed the initial CT and discussed the case with the ED physician, his note is inconsistent with the CT results, and

neither physician documented any details about the discussion. The ED physician ordered the patient's transfer to the ICU, with hourly neurologic checks.

Upon the patient's arrival at the ICU, the staff did not perform a neurologic evaluation; the first assessment in the ICU was conducted at 2:00 a.m. At that time, the GCS score was 3. Dr. J was immediately called and advised of the GCS score, and he said that he would be in "now"; however, he did not arrive at the hospital until 3:15 a.m. He provided no explanation for the 75-minute delay.

After a craniotomy was performed, the patient remained in the tertiary care hospital for approximately 3 weeks. Intracranial pressures remained within normal limits postsurgery, and the patient was gradually weaned off ventilator assistance. He had no further complications and was transferred to a skilled nursing care facility.

The patient's long-term sequelae include incontinence of bladder and bowel, vision problems, walking assistance needed with a walker, and memory and behavior deficits. These conditions appeared permanent through the resolution of the case.

A medical malpractice lawsuit was commenced against Dr. J and the tertiary care facility. With Dr. J's consent, the suit against him was resolved with a payment in the high range; defense expenses were also in the high range. A payment (amount unknown) was made on behalf of the facility.

Discussion

From a risk management perspective, many lapses occurred in this case, resulting in a suboptimal outcome for the patient and liability exposure for Dr. J and the facility. Two major issues involved documentation and communication. To begin, Dr. J's note from 10:43 p.m. states that the depth of the patient's subdural hematoma was 1.5 cm, with no midline shift. Yet, the initial CT results show that both of these statements are inaccurate.

An expert for Dr. J's defense questioned whether the physician had even seen the original CT results at the time of the dictation. Although the expert noted that some neurosurgeons like to take a "wait and see" approach to small subdural hematomas, the patient's hematoma did not fit in the "small" category.

The concerns about whether Dr. J had seen the CT results also raised questions about his communication with the ED nurses. No documentation exists to verify what the ED nurses told Dr. J when he called the hospital after being paged at 10:17 p.m. Thus, it is unclear whether Dr. J relied on incorrect information when he dictated his note at 10:43 p.m.

Additionally, in the intervening time between the initial page to Dr. J and his note at 10:43 p.m., the patient's GCS score decreased to 7. The ED nursing documentation does not indicate whether Dr. J was made aware of the drop in score from 14 to 7; however, the defense expert noted that if Dr. J was advised of the change, he should have immediately reported to the hospital. Further complicating matters, neither Dr. J nor the ED physician (who was not sued) documented the details about their phone conversation that occurred before the patient's transfer to the ICU.

The nursing care in the ICU also presented defense problems in this case because of the delay in performing a neurologic evaluation. The patient was on the unit for more than an hour before the staff conducted an initial assessment; by that time his GCS score had dropped to 3. Although Dr. J was immediately

notified about the score, the delay in assessment was difficult to defend.

Also difficult to defend was the amount of time it took Dr. J to arrive at the hospital after the ICU staff advised him of the patient's low GCS score. The defense expert noted that 30 minutes was a reasonable response window; however, in the absence of an adequate explanation, 75 minutes (the actual time it took Dr. J to arrive) was not acceptable.

A final factor in Dr. J's decision to settle the malpractice suit was the opinion of the defense's neurosurgery expert, who felt that the patient likely would have made a full recovery if he had been operated on promptly after arrival in the ED.

Unfortunately, Dr. J's troubles were not necessarily over when the lawsuit was settled. Under the Emergency Medical Treatment and Active Labor Act (EMTALA—Anti-Dumping Act), physicians who are on call to the ED and who are “summoned” because their services are needed can face significant penalties if they do not report within a “reasonable” time. The penalties can include monetary fines and exclusion from federally funded programs. Each EMTALA case is evaluated individually, considering the totality of the circumstances.

Whether the ED staff summoned Dr. J is unknown because of poor documentation. However, documentation shows that the ICU staff summoned him at 2:00 a.m., and he did not arrive for 75 minutes. Without an adequate explanation for his delay (e.g., weather, traffic, performing another surgery, etc.), Dr. J might face sanctions from the Centers for Medicare & Medicaid Services.

Summary Suggestions

Facilities should have comprehensive protocols in place pertaining to the assessment of neurologic patients in the ED and ICU, including emergency action steps in the event of an inadequate response to a deteriorating patient. These protocols should include notification of a supervisor so that the situation can be dealt with in a timely manner by the appropriate chain of command.

The following suggestions might be helpful to healthcare providers who are required to provide urgent or emergent care to patients:

- When contacted about an urgent or emergent patient, carefully question whether the patient's condition is static or changing. Thoroughly document this conversation.

- When documenting a diagnosis, explain what data sources are being relied on in reaching that particular diagnosis.
- When clinically significant conversations occur between physicians, both parties should carefully document what was discussed.
- When on call to the ED, physicians should take the necessary steps to ensure they arrive in a "reasonable" time. If a delay occurs for a valid reason, the physician should document the cause of the delay.

Conclusion

Advances in medical imaging and digital communication have allowed more accurate diagnoses to be made in much less time, resulting in better utilization of available resources and improved patient outcomes.

However, concomitant with that capability is the responsibility to respond in a timely and appropriate manner to urgent conditions. The failure to do so may likely result in a suboptimal patient outcome and accompanying professional liability exposure.

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