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Risk Management Review

PATIENT SAFETY & RISK SOLUTIONS

Failure to Rescue Decompensating Patient Due to Nonresponsive On-Call Physician Has Tragic Consequences

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

Introduction

Even routine care can sometimes "go sideways" in a short time. Because of this, standards of care and regulations require healthcare providers and hospitals to have contingency plans in place to manage rare but inevitable crises. This interesting case from the Northwest illustrates how a tragedy can occur when contingency plans fail.

Facts

The patient was a 64-year-old female who was in overall excellent health; she presented to an ear, nose, and throat (ENT) practice because she noticed a lump in her right neck. Dr. S examined the patient and determined that her right tonsil was enlarged. A biopsy of the tonsil showed squamous cell papilloma but no dysplasia or carcinoma. Dr. S concluded that no treatment was needed at that time because the tonsil was not interfering with breathing or swallowing.

Approximately 2.5 years later, the patient returned to the practice for removal of ear wax. On her intake form, she noted that the lump in her neck was larger. Dr. S saw the patient again and observed that the right tonsil was now significantly enlarged (4/4), and the left tonsil was slightly enlarged (1/4). Dr. S recommended a right tonsillectomy, to which the patient agreed.

Ten days later, Dr. S's partner, Dr. K, performed a direct laryngoscopy and right-sided tonsillectomy, which resulted in some modest bleeding that was controlled without cautery.

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After the 15-minute procedure, the patient was sent to the postanesthesia care unit (PACU) in stable condition. When she was discharged from the PACU, she complained of pain and some nausea. She had a pulse of 91, blood pressure (BP) of 133/70, and a pain rating of 5/10.

The patient did well that evening, but the following evening she began to have increasing pain in her neck and stomach, and she vomited "large amounts of blood." The patient's daughter took her to the emergency department (ED) at approximately 9 p.m. Her initial vital signs were a pulse of 116, BP of 132/91, and O_2 saturation of 100% on room air.

The third partner in the ENT group, Dr. J, was on call and was summoned to the ED. She arrived promptly and evaluated the patient. In the ED, Dr. J removed a clot from the patient's tonsillar fossa, and brought the bleeding under control using suction, silver nitrate cautery, and Arista powder. After Dr. J determined that the patient was stable (with a hemoglobin of 12.3), she was admitted for observation. Dr. J then went home around 12:30 a.m.

About an hour after Dr. J arrived home and went to bed, the patient complained again of throat pain and began vomiting significant amounts of blood. Hospital staff called Dr. J on her cellphone; however, she had given a lecture earlier in the evening and still had her phone on vibrate. Dr. J did not hear the page from her phone (which was on her nightstand).

The patient progressed into cardiac arrest. As clinical staff members began resuscitation, Dr. J was again called without response. The patient spontaneously regained a pulse and was moved to the intensive care unit (ICU). At that point, no further attempt was made to reach Dr. J or either of her partners (or any other physician).

Approximately an hour later, the patient began to bleed again and soon progressed into cardiac arrest a second time. Dr. J was called twice more without response; she finally became aware of the situation when hospital staff called her home phone. She came to the hospital immediately; however, at that point, the patient responded only to painful stimuli.

The patient was declared brain dead later in the morning. At autopsy, the cause of death was determined to be a combination of severe blood loss and airway compromise due to the bleeding.

A professional liability lawsuit was brought against the three ENT physicians, their professional corporation, and the hospital. The case against the doctors and their professional corporation was settled with a payment in the high range and defense costs in the midrange. The case against the hospital also was settled, but the amount of the payment was undisclosed (although it was likely substantial).

Discussion

When this case was evaluated from the standpoint of legal defensibility, one obvious problem immediately presented itself: A person does not expect to have a relatively minor procedure and die from its sequelae the following day. That premise, in combination with several other issues (some of which were clinically significant), made this case difficult to defend.

The first issue in this case was Dr. J failing to turn her cellphone (her primary means of being contacted) from vibrate to ring after she finished her lecture. Such oversights are not uncommon in everyday life, and it is reasonably predictable that they will occur at some point.To address such oversights, the concept of Failure Modes and Effects Analysis (FMEA) — which was pioneered in the airline industry — poses the question "What is the result *when*, not *if*, this happens?" This is an important distinction that easily translates into the provision of healthcare. One of the primary ways the airline industry has dealt with the inevitability of human error is to build in redundant systems.

In this case, two logical redundancies could have been applied to deal with the failure (for whatever reason) of Dr. J's cellphone: (1) a secondary phone number for Dr. J, and (2) a secondary physician to contact in her place. Unfortunately, both of those options were available to hospital staff, but neither was used in a timely fashion.

The defense experts who reviewed this case determined that the actual clinical care that the ENT physicians provided was acceptable. They had a sound clinical indication for the procedure, the initial procedure was performed correctly and without any complications, and the follow-up care in the ED was appropriate. (**Note:** The plaintiff's expert opined that the follow-up care should have been performed in the operating room; however, but this criticism was weak because Dr. J was able to completely stabilize the patient before she left.)

The sentinel event in this case occurred when the patient began to bleed after being admitted for observation. When she complained of throat pain and began vomiting significant amounts of blood, the clinical staff should have aggressively pursued treatment; however, the records indicate that this did not occur. The patient progressed to the point of cardiac arrest without sufficient attention, while staff apparently waited for direction from Dr. J.

The patient was then moved to the ICU, but no effort was made to get her immediate attention by an ENT surgeon. The patient continued to decompensate without significant intervention, to the point of complete circulatory collapse. Dr. J eventually was contacted via her home phone (apparently the fifth attempt to contact her), but it was too late to be of benefit to the patient.

Hospitals maintain chain-of-command protocols to provide nursing staff with a way to access supervisory assistance (all the way up to the CEO) when physicians are unresponsive to requests to come to the hospital or otherwise provide direction related to patient care. In this case, when the patient was decompensating and Dr. J could not be reached, the staff should have used the chain-of-command protocol; failure to do so raised concerns about appropriate and acceptable nursing practice.

The Emergency Medical Treatment and Active Labor Act (EMTALA—Anti-Dumping Act) also could have been an issue in this case. EMTALA requires hospitals to maintain an on-call list for available medical specialists so that patients who need emergency care (e.g., a patient in the ED or — as in this case — a patient admitted for observation only) can receive it from the appropriate specialist in a timely manner. In this case, the hospital had contact information for backup ENT specialists, but the nursing staff did not use it. Although the law is somewhat unsettled on this point, the nursing staff's failure to contact the backup specialists might have been an EMTALA violation.

A final deficiency occurred in this case that should be mentioned. A review of the ENT practice's health record for this patient showed several errors, such as wrong dates, wrong sides (right vs. left), and inconsistent entries. These errors did not directly affect clinical care. However, if this case had progressed to trial, the patient's health record would have been admitted into evidence. If

that had occurred, the documentation errors might have made the ENT practice appear inept to a jury. The inaccuracies in the health record were an additional factor inclining the defense toward settlement without a trial.

Summary Suggestions

The following suggestions might be helpful to healthcare providers and staff members treating patients in the ED and during the post-surgical period:

- On-call physicians should maintain adequate means to be reached if needed. This can be accomplished by having multiple phone numbers or a secondary coverage arrangement if they cannot be reached promptly.
- Hospitals must maintain accurate, up-to-date, on-call lists for all appropriate medical specialties. On-call lists are a requirement under EMTALA, and they are vital from a patient safety and liability standpoint.
- Hospital nursing staff should contact the on-call or attending physician when a patient first begins to decompensate. If the on-call or attending physician does not promptly provide appropriate direction or cannot be reached, the nursing staff should activate its chain-of-command protocol.
- Patient health records must be maintained in a manner that is timely, accurate, and internally consistent to ensure patient safety, to memorialize the provision of care, and to record information that might be critical in defending a malpractice claim.

Conclusion

Unfortunately, even with the most routine treatment, complications will arise. Most can be handled without difficulty when they are recognized promptly and treated appropriately, including the involvement of appropriate specialists at the proper time. Careful planning for these eventualities will help healthcare organizations and providers implement well-designed protocols that maximize efficient use of resources and support quality patient care.

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