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Risk Management Review

Communication Failure Causes Delay in Treatment and Suboptimal Outcome

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Introduction

Many previous issues of *Risk Management Review* have looked at cases in which the care rendered was suboptimal, resulting in a poor outcome and a malpractice lawsuit that was difficult to defend. This case is different; the MedPro-insured doctor's care was appropriate in every respect. Nevertheless, he was sued because of circumstances beyond his control. Yet, this case illustrates how quality care (which the defense could prove) resulted in a favorable resolution of the legal case.

Facts

The patient was a 28-year-old female with many previous medical problems, including depression, anxiety, attention-deficit/hyperactivity disorder, obesity, peptic ulcer disease, chronic back pain, anemia, and a history of smoking one pack of cigarettes per day. She also had undergone gastric bypass surgery approximately 10 years prior to the events of this case.

The patient presented to the emergency department (ED) at Hospital 1 early in February with persistent vomiting after taking acetaminophen with codeine; she also had abdominal and back pain. At the time, she was 28 weeks pregnant. She was sent to labor and delivery (L&D) for monitoring and ultimately was cleared to go home.

The patient returned to the ED at 6 a.m. the following morning with continual vomiting (which was now bloody) and back pain. A nurse practitioner (NP) in the ED, who was working under the supervision of Dr. A (the ED physician), saw the patient. She was given morphine for the pain and ondansetron for the vomiting. The NP also requested that obstetrics/gynecology (OB/GYN) and gastroenterology services see the patient.

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Dr. C, a MedPro-insured gastroenterologist, was contacted shortly after 8 a.m. and advised that the patient was stable. Dr. C sent his physician assistant (PA) to assess the patient. The PA saw the patient at 10:20 a.m. After discussing the case with Dr. C, the PA advised the patient that an esophagogastroduodenoscopy (EGD) would be necessary. Informed consent for the procedure was obtained at that time. At 11:20 a.m., the patient vomited 50 cc of blood; Dr. C ordered two standby units of packed red blood cells in the event that the patient would need them.

After thoroughly reviewing the patient's medical history, Dr. C saw the patient in the short procedure unit at 12:45 p.m. Immediately before the procedure, the patient complained of burning pain in the epigastric region, but she was otherwise comfortable. Dr. C felt that imaging was unnecessary at that time, especially in light of her pregnancy. Dr. V, an OB/GYN physician, also had evaluated the patient, and he and Dr. C were in agreement regarding the proposed procedure.

Dr. C performed the EGD at 1:10 p.m., and a lesion resulting from an arteriovenous malformation was identified at the anastomosis of the stomach pouch and jejunum. (Importantly, the jejunum was not dilated, which would have suggested a bowel obstruction.) The lesion was successfully treated with argon plasma, and the procedure was completed. After the procedure, Dr. C spoke with the patient and determined that the tenderness had not progressed, and she was not in pain. The patient was transferred to L&D at 2:40 p.m.

Almost immediately after Dr. C left the hospital following the procedure, the patient began deteriorating rapidly; however, L&D staff did not notify him. At 3:35 p.m., the patient was in extreme pain and had resumed vomiting, which continued for several hours. At 7:00 p.m., staff noted that morphine had not relieved her pain. Finally, at 10 p.m., Dr. C received notification of the patient's condition.

When he was contacted, Dr. C was advised that the patient had uncontrolled pain, bloody vomit, and tachycardia. He ordered staff to immediately transfer the patient to the intensive care unit (ICU). Before leaving for the hospital, Dr. C activated his endoscopy staff and instructed them to meet him in the ICU to perform an endoscopy procedure.

When Dr. C arrived at the hospital, he assessed the patient and could see that she was in extreme distress; he canceled the endoscopy, ordered a STAT computed tomography (CT) scan of the abdomen, and requested the presence of the general surgeon on call. When

the CT showed free air in the abdomen, the patient was taken for an immediate exploratory laparotomy. Dr. V also was present for the laparotomy, and he and the surgeon agreed that an immediate caesarean section delivery would be performed, followed by bowel resection. After Dr. V successful delivered the baby, the surgeon removed 73 cm of necrotic bowel, debrided the area, and closed the surgical site. The baby was taken to the neonatal intensive care unit (NICU) in fair condition.

The patient's postoperative recovery was very difficult. In the first week, she had two more surgeries (to resection the bowel and further debride the site) and underwent a thoracentesis to deal with pneumonia. She remained intubated for the remainder of the month (about 3 weeks) and had a feeding tube placed. On March 1, she was transferred to Hospital 2 for continued monitoring and treatment (including being weaned off the ventilator). In March and April, she had eight additional debridement surgeries, and she was transferred to a rehabilitation center early in May.

The baby initially needed respiratory support and a feeding tube while in the NICU, but she recovered well by the time of her discharge. She appears to have some mild developmental delays; however, it is uncertain whether these delays are a result of the events surrounding her birth or other factors.

Ultimately, a malpractice lawsuit was initiated against Dr. A and her NP, Dr. C and his PA, Dr. V, and Hospital 1 (which employed Dr. V). During discovery, the case against Dr. A and her NP was discontinued. The case against Dr. C was resolved with a payment in the low range (defense costs were in the midrange), and the hospital resolved its liability for Dr. V and its nurses with a payment in the high range.

Discussion

In cases with multiple defendants, a unified defense is almost always beneficial. However, the parties in this case did not cooperate well, making a unified defense impossible. A significant amount of "finger-pointing" behavior also occurred, which only made the defense of the case more difficult.

The emergency medicine providers (Dr. A and her NP) had a relatively short encounter with the patient on the morning of Day 2, and nothing indicated that their care was below standard. Not surprisingly, after their depositions (in which they did well), they were dismissed from the case.

As a part of Dr. C's defense, the case was reviewed by standard-of-care experts in gastroenterology, OB/GYN, and pediatrics (for damages only). The experts noted that the critical period clearly occurred between 3 p.m. and 10 p.m. on Day 2, when the patient's condition deteriorated while she was in L&D. What happened during these 7 hours is not entirely clear because of poor documentation. However, it is likely that aggressive treatment by Dr. C during this time could have slowed or stopped the patient's deterioration.

A dispute occurred as to whether Dr. C was contacted prior to 10 p.m. Dr. V asserted that he contacted Dr. C by telephone on the afternoon of Day 2, and Dr. C failed to come in and attend to the patient. Dr. C vehemently denied that he was ever contacted before 10 p.m., and a thorough investigation of phone records did not support the assertion that any such call occurred. Rather, it appeared that Dr. V was attempting to "deflect" some responsibility for the handling of this case.

What is known is that during the 7-hour period, the patient was treated in L&D by nurses who, presumably, were not used to treating conditions similar to the patient's. If they did not promptly notify Dr. V of the patient's deteriorating condition, their performance was below the standard of care. On the other hand, if they did notify Dr. V, and he either was unresponsive or his treatment was inadequate, the nurses should have activated their chain-of-command protocol. Either way, it was difficult to defend the nursing care in this case. For his part, Dr. V was basically foreclosed from asserting that the nurses had not notified him of the patient's worsening condition, given his assertion that he notified Dr. C during the time the patient was in crisis.

The gastroenterology expert fully supported Dr. C's care of this patient, citing that Dr. C:

- Had carefully reviewed the patient's history prior to performing the EGD
- Secured appropriate written consent to treatment prior to the procedure
- Performed the procedure skillfully, which produced a good initial result
- Reacted immediately and appropriately when he was notified of the patient's worsening condition at 10 p.m.
- Appropriately followed the patient throughout the remainder of her time at Hospital 1
- Thoroughly documented the patient's care

It's likely that Dr. C also would have been dismissed from the case if it were not for Dr. V's

assertion that he notified Dr. C of the patient's condition in the afternoon (when aggressive care might have slowed or stopped the patient's deterioration).

When Dr. C and his PA were deposed, they did exceptionally well. They had carefully reviewed all of the necessary documentation, and they followed the preparatory guidance from their defense counsel. Doing so greatly contributed to the opportunity to settle the case with a payment in the low range.

Dr. C made the final decision to settle the case. Although defense counsel was confident they could successfully defend Dr. C in court, the doctor opted to avoid the stress, time commitment, and expense of a malpractice trial — particularly since the case could be settled for a relatively nominal amount. For him, it was the best possible resolution.

Summary Suggestions

The following suggestions may be helpful when multiple providers are involved in treating acutely ill, hospitalized patients:

- Except in emergent situations, perform a complete review of each patient's medical history prior to commencing treatment.
- Implement strategies to ensure excellent, timely communication between providers at all levels. Doing so is vital to prevent misunderstandings and potential errors, especially when providers are simultaneously treating multiple organ systems.
- Encourage training in communication and teamwork (e.g., TeamSTEPPS®), which can be valuable in ensuring that an organized, complementary approach to patient care is occurring across the provider spectrum.
- Develop thorough chain-of-command protocols that staff can activate when patients have rapid deterioration. All individuals providing direct patient care should understand these protocols, including when and how to active them.
- Ensure thorough and consistent documentation of patient care. Comprehensive documentation is valuable to provide other practitioners with accurate information regarding current treatment as well as a clear picture of previously occurring events. Thorough documentation also facilitates review of the case at a later time for purposes of billing, quality assurance, or legal review.

Conclusion

On occasion, healthcare providers may be called upon to defend care that was appropriate and within the standard of care. When they can establish the facts of the case with adequate and proper evidence (particularly good documentation), providers can expect the provision of quality care to produce a positive legal outcome.