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Risk Management Review

Patient Disregards Physician's Recommendations for Immediate Treatment; Complications Result, Leading to Malpractice Lawsuit

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Introduction

Doctors have dealt with patient nonadherence to care and treatment for many decades. All too often, when patients disregard their doctor's advice and it doesn't go well, they try to blame the doctor. This challenge is frequently complicated when the doctor is part of a large, often multispecialty network rather than a solo or small group practice (where he/she might more easily develop personal relationships with patients). This case from the Northwest illustrates how easily a case can "go sideways."

Facts

The patient was a 52-year-old male who had seen Dr. T, a MedPro-insured internist, on an as-needed basis through the large multispecialty clinic with which Dr. T was associated. Dr. T had treated him 8 years earlier following a motor vehicle accident resulting in injury to his cervical spine. The patient had fully recovered from that injury.

On November 2, the patient became sick at home. He was vomiting and had a headache, general body aches, and nausea. He had no prodromal illness and believed he had the flu.

On November 3, he presented to Dr. R (another MedPro-insured internist) at the clinic's urgent care facility complaining of fever, nausea, vomiting, headache, and abdominal pain. His temperature was 103.3 degrees. Appropriate lab tests were ordered, but the results were not available that day. A chest X-ray also showed possible pneumonia. The doctor prescribed levofloxacin and instructed the patient to contact the clinic if his symptoms worsened.

Two days later, the lab results were available and indicated elevated liver enzymes; the patient was called and asked to return to the

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office, which he did that day. Dr. R saw the patient again and informed the patient that elevated liver enzymes and bilirubin appeared on his test results. A CT of the abdomen and pelvis was performed, which showed a cyst on the kidney and possibly the liver. An ultrasound of the right upper abdominal quadrant also was performed; it was positive for gallstones. Repeat liver enzymes showed some improvement and lipase was within normal limits.

Dr. R explained to the patient that he had gallstones and would need to be monitored to see if his liver enzymes continued to normalize. Dr. R also explained to the patient that he would need surgery because a serious complication could result from this condition in the absence of surgical treatment.

On November 7, the patient and his wife saw Dr. R for follow-up care. His bilirubin, alkaline phosphatase, and lipase were all within normal limits; the alanine aminotransferase and aspartate aminotransferase were elevated but were lowering. The patient explained that he was aware that Dr. R preferred for him to see a surgeon regarding his gallbladder, but that he was feeling fine, so he and his wife were going on a long-planned vacation the following day. Dr. R was hesitant to approve the patient's plans, but he ultimately acquiesced. He explained that he would have the surgery department contact the patient to arrange an appointment for after their return. Dr. R's documentation of this conversation was as follows: "Discussed surgery if desired and if symptoms return again."

Unfortunately, there was no indication in the health record that Dr. R requested follow-up by the surgery department, and the patient contended that no call took place. Because he felt good, the patient did not re-contact the practice.

On December 16, the patient presented to the emergency department (ED) with a sudden onset of crampy abdominal pain "after eating cereal." He was nauseated and had vomited three times. Lab tests showed elevated liver and pancreatic enzymes.

The patient was admitted to the hospital with a diagnosis of pancreatitis. Dr. T and a member of the clinic's surgery department saw the patient every day during this hospitalization. The plan at that time was watchful waiting to allow the pancreas to improve/heal and then proceed to surgery if needed.

On December 20, the patient had continued pain in the abdomen with the introduction of clear liquids. The surgeon noted that a CT showed that the pancreatic head remained

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inflamed. The plan of care included continued rest of the abdomen.

On December 21, because of continued pain and the inability to tolerate liquids, a nasogastric (NG) tube was placed for decompression. The patient removed the tube himself, complaining that it made him feel worse and made him gag. The tube was then reinserted and the patient obtained relief from his discomfort.

On December 24, the NG tube was clamped and the patient appeared to be improving. He ate ice chips without difficulty. His pain was controlled, and the plan was to discharge him the following day. On December 25, the patient pulled out his NG tube on his own. He was up and laughing with his family. The surgeon approved discharge home on clear liquids. However, the patient interpreted "clear liquids" to include pudding, broth, sports drinks, other liquids, and crackers.

On December 28, the patient returned to the ED, and he was diagnosed with abdominal pain and ileus. He was treated with ondansetron and hydromorphone. His amylase was 76, lipase was 427, and his white blood cell count was 14 K/uL, with 83 percent neutrophils. The on-call physician approved discharge, recommending that the patient see Dr. T in 3 days and return to the ED if he developed chills, nausea, vomiting, or fever. The patient misunderstood the instructions to see Dr. T in 3 days; he contended that he was told "to call" Dr. T in 3 days.

On January 4, the patient followed up with Dr. T for a repeat CT of the abdomen that showed persistent changes in the pancreas and gallbladder. Pancreatic necrosis could not be excluded. Dr. T recalls deliberating as to whether outpatient management was possible or if admission that day was necessary. He decided to schedule the patient to see the surgeon and permit him to convalesce at home.

On January 6, the patient had a sudden onset of projectile vomiting and was admitted to the hospital with acute and chronic pancreatitis. A CT showed worsening of the pancreatitis, with possible abscess/necrotizing infection. Dr. T admitted the patient to the intensive care unit and consulted the surgery, infectious disease, and critical care departments.

On January 8, surgery was performed for a pancreatic abscess with necrosis. The gallbladder was removed, and a jejunostomy tube was placed. The wound was left open, requiring packing and drain attention. The patient and his wife contend that when the

surgeon saw them that morning she stated, “If the pancreas is necrotic today, it was on Friday and surgery was needed.”

From January 8 to February 28, the patient convalesced in the hospital, being treated for a duodenal obstruction resulting from postoperative narrowing. In addition, on February 11, the patient was diagnosed with a thrombus of the left femoral vein and posterior tibial veins. On February 28, he was transferred to a transitional care hospital. He ultimately required additional treatment at a tertiary care center for a ductal fistula that had formed between the pancreas and biliary duct remnant. He had fully recovered by August of that year and had no residual permanent injury.

Later that year, a medical malpractice lawsuit was initiated against the group practice, Dr. R, and Dr. T. After extensive discovery, the case was taken to trial, resulting in a verdict in favor of both doctors and the group practice. Defense costs were in the very high range.

Discussion

An examination of this case shows that basically all of the providers’ failures were related to communication in one form or another. Unfortunately, such failures are not uncommon in daily practice, and they can have significant effects on patient care and the defensibility of malpractice cases.

It is easy to see how Dr. R’s documentation of the conversation about surgery on November 7 could be misinterpreted. The documentation of “Discussed surgery if desired and if symptoms return again” becomes problematic in more than one way. A note this short and obtuse would not be very helpful to Dr. R if he were subsequently trying to recall what he was thinking when he wrote it. Additionally, another provider would have difficulty understanding exactly what Dr. R meant.

A purpose of documentation that is less commonly recognized is its use to re-create the treatment circumstances at a later time, either as part of a peer review process, board of medicine inquiry, or in a subsequent legal process. Unclear and incomplete documentation is of little value when trying to reconstruct the case later (sometimes much later).

It is clear that Dr. R’s intended referral to the surgery department did not happen. This can occur for many reasons, such as Dr. R being interrupted just as he was preparing to enter the referral (it was an electronic order entering system), incorrectly entering the information (such as the wrong date), or simply forgetting to do it.

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A simple solution (which works equally well with tracking test results) is to enlist the patient as a "fail-safe" technique. When a doctor indicates that he/she is going to order a test, consult, etc., he/she should tell the patient: "You should hear from surgery in the next 7 days. If you don't, please let me know so that I can follow up." This statement does two things. First, the typical patient is less likely to forget about it when he/she is expecting a call within a certain timeframe. Second, it puts some responsibility on the patient, which can be beneficial in circumstances such as this one in which disputed communication occurred.

On December 28, when the patient was discharged from the ED, it was anticipated that he would come in to the practice in 3 days, an instruction he misunderstood. Although the discharge summary was not available for review, if it did not specifically say that he was to come to the practice on December 31, it should not be surprising that he might misunderstand, especially when he had previously misunderstood the meaning of "clear liquids."

Discharge instructions are very valuable to facilitate patient adherence as well as document what the patient was told; however, they must be clear, concise, and easy to understand to ensure patient comprehension. It is noteworthy that the patient did not call the clinic either.

Finally, there is the issue of the surgeon's alleged remark stating, "If the pancreas is necrotic today, it was on Friday and needed surgery." Although it was disputed that the surgeon actually said this, if she did, it was obviously inappropriate and should not have been said. These kinds of remarks can rarely be used as evidence of malpractice, but they can serve as an impetus for less-than-completely-happy patients to contact an attorney.

Summary Suggestions

The following suggestions may be valuable to physicians treating patients who are demonstrating less than full adherence to treatment recommendations:

- Ensure that your verbal communication with the patient is clear and understandable. Include the diagnosis and the treatment plan, and explain the consequences of not following the treatment plan. Using a technique such as "teach-back" can help facilitate patient comprehension and identify potential issues or areas of misunderstanding.
- Similarly, ensure that documentation of clinically significant conversations with

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patients are clear and understandable. Should patients call back to verify information, it will be necessary to accurately determine what the patients were originally told.

- Implement a reliable and consistent process to track and monitor the status of diagnostic tests, referrals, and those patients requiring follow-up. Enlist the patient as a “double-check” on expected activity, such as referral calls or test results.

- Provide a visit summary and discharge instructions. Ensure that discharge instructions are clear, understandable to the patient, and in the patient’s primary language. Summaries and instructions are of no value if the patient cannot easily understand them.

- Be cautious whenever commenting on another provider’s care. You may not have a complete understanding of what was said or the exact circumstances, which can result in commentary that is inaccurate and potentially damaging.

Conclusion

Unfortunately, there will always be patients who don’t adhere to recommendations and treatment plans for many reasons, including miscommunication, fear, stubbornness, or just “not getting it.”

Every clinically significant conversation should be conducted with this fact in mind. You cannot change your patient; you can only arm your patient with accurate information in a way that maximizes his/her chances of understanding. Be sure to always thoroughly document your conversations with patients.

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