The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation
A 69-year-old man came to his family physician complaining of right-sided abdominal pain. The family physician suspected cholelithiasis (gallstones) and referred the patient to a general surgeon.

Physician action
The general surgeon confirmed the diagnosis, and scheduled the patient for a laparoscopic procedure. The surgery was completed on a Friday morning. In his operative report, the surgeon stated that the gallbladder was very contracted with densely packed gallstones with a narrow duct. He elected not to proceed with cholangiogram at that time even though liver functions were abnormal.

The patient was kept in the hospital overnight for observation and discharged Saturday at noon. The surgeon testified that he spoke with the family physician while the patient was in the hospital and told the family physician to contact a gastroenterologist to set up a post-surgical endoscopic retrograde cholangiopancreatography (ERCP). This conversation was not documented in the medical record. The patient was discharged with instructions to see the surgeon on Wednesday and to follow up with the family physician in two to three days to repeat liver function tests.

At 8:51 p.m. on Sunday, the surgeon was paged and told to call the patient’s wife. During the phone conversation, the surgeon asked her to put the patient on the phone, but she refused to do so. She told him the patient was having hiccups and experiencing pain that was regionalized at the suture site. The surgeon instructed her to have her husband hold a pillow against his chest when he coughed to reduce the pain. He could also take Lortab for the pain. The surgeon advised her if she was in any way concerned, to take the patient to the emergency department (ED). He told her to come to his office Monday instead of Wednesday and to see the family physician Monday morning to have lab work done and arrange to see a gastroenterologist. He testified that she did not seem to understand what he was saying and he had to repeat himself several times.

The patient and his wife went to the family physician’s office on Tuesday not on Monday as instructed. The physician noted the patient was complaining of “post-op problems with vomiting.” He recorded a benign abdominal exam and ordered antiemetic medication and follow-up lab work. The lab results were called to the family physician’s office that afternoon and a copy was faxed to the surgeon’s office at 2 p.m. The results revealed the patient had a WBC of 25,000 and elevated liver enzymes.

The surgeon testified that he saw the lab results when he arrived at his office at noon on Wednesday. He expected the patient and his wife to be in his office that afternoon and that he would discuss plans to have an ERCP scheduled. Shortly after the surgeon arrived at his office, the family physician called to tell him that the patient had suffered a cardiac arrest and was at a local hospital. The surgeon went to the hospital and when he arrived the patient had already been pronounced dead. The patient had vomited and aspirated and could not be resuscitated.

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Allegations

A lawsuit was filed against the general surgeon. The plaintiffs alleged that the surgeon did not appreciate the patient’s postoperative condition and failed to respond in a timely manner. The plaintiffs argued that it was appropriate to wait to do an ERCP after the surgery, but that it should have been done no later than 48 hours after the surgery.

Legal implications

Negligence, when used with respect to the conduct of a physician, means failure to use ordinary care — that is, failure to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances.

The surgeon admitted that it was a difficult surgery, and that he could not complete an intraoperative cholangiogram. He then discharged the patient and planned to follow his condition with liver function tests. The patient contacted the surgeon on numerous occasions after the surgery with complaints suggestive of a blocked common bile duct and possible retained stones. Experts suggested that the surgeon should have sent the patient to the ED on Sunday or Monday or insisted that his lab work be performed on Monday accompanied by a visit to the surgeon’s office. The patient should not have been evaluated by the family physician. If the surgeon had evaluated the patient sooner, an ERCP would have been scheduled, revealing the blockage in the common bile duct. This may have prevented the complications that lead to the patient’s death.

Disposition

This case was settled on behalf of the surgeon before trial.

Risk management considerations

It is prudent practice for any surgeon to closely follow a patient’s postoperative course, especially with a difficult cholecystectomy where an intraoperative cholangiogram could not be performed. It is ill advised for a surgeon to suggest that a family physician evaluate a postoperative patient.

If a discharged patient calls with complaints consistent with a blocked common bile duct, the surgeon is expected to respond in a timely manner with appropriate instructions. If a face-to-face evaluation is not possible, a referral to the emergency department should be made. With the defendant’s testimony that the spouse did not seem to understand his instructions, one might surmise that a directive to report to the ED was clearly in the patient’s best interest. Poor communication often becomes the basis for unexpected outcomes and subsequent claims against physicians.

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Reducing errors in health care: where are we now?

By Barbara Rose
Senior Risk Management Representative

“To err is human” but what a price we pay in the delivery of health care. In 400 BC Hippocrates wrote “Medicine is of all the arts the most noble; but, not withstanding, owing to the ignorance of those who practice it, and of those who, inconsistently, form a judgment of them, it is at present far behind all the other arts. Their makeup appears to me to arise principally from this, that in the cities there is no punishment connected with the practice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it. Such persons are like the figures which are introduced in tragedies, for as they have the shape, dress, and personal appearance of an actor, but are not actors, so also physicians are many in title but very few in reality.” 1

Where are we now in reducing medical errors since the Institute of Medicine (IOM) report was released in November 1999? A lot has been written, including denials of the report’s accuracy and opinions that the number of deaths from medical errors is actually much higher when errors in outpatient care are considered.

In the news

August 2005: President Bush signed the “Patient Safety and Quality Improvement Act of 2005.” This legislation allows health care providers to report medical errors to new “patient safety organizations” without fear that the information would be used to file a malpractice claim or used in a claim already filed. The function of the Patient Safety Organizations (PSOs) is to collect and analyze the data reported to them and develop and disseminate recommendations, protocols, and information for the purpose of improving patient safety.

Dennis S. O’Leary, MD, president of JCAHO, said “This bill is a breakthrough in the blame and punishment culture that has literally held a death grip on health care. When caregivers feel safe to report errors, patients will be safer because we can learn from these events and put proven solutions into place.” JCAHO describes this law as promoting a culture of safety across health care settings by establishing federal protections that encourage thorough and candid examinations of the causes of errors and resulting in the development of effective solutions to prevent their recurrence. 2

September 28, 2005: Senators Hillary Clinton (D-NY) and Barack Obama (D-IL) introduced the National Medical Error Disclosure and Compensation Act, S. 1784. This bill would establish a federal Office of Patient Safety, create a national patient safety database, develop a voluntary program for submitting data to the database and for establishing prompt error resolution procedures within participating entities, and provide grants to entities participating in the program. The bill was referred to the Committee on Health, Education, Labor and Pensions that is unlikely to take action on it at this time.

Patient safety in 2006

We have passed a sixth anniversary of the release of the IOM report declaring “medical error a public health epidemic.” 3 The report revealed how patient safety can be viewed as a basic measure of health care quality. However, incidents of wrong site surgery, medication errors, and nosocomial infections — as a few examples — continue to occur in alarming numbers. “Shoddy quality control plagues American medicine, killing at least a 100,000 people every year and running up an estimated $500 billion a year in avoidable medical costs, or 30% of all health care spending.” 4

Numerous studies published in journals have brought attention to the problems caused by medical errors and demonstrate that patient safety is a significant health care issue. The following are some studies published since the IOM report in 1999.

• A HealthGrades study of July 2004 found that on average 195,000 deaths a year are attributable to medical errors, nearly double the number estimated by IOM, with an associated cost of $6 billion per year. 5

• A National Committee for Quality Assurance (NCQA) report found that health care quality gaps result in 39,000-83,000 preventable deaths each year; between $2.8 and $4.2 billion in avoidable medical costs; and up to 83.1 million sick days and $13 billion in lost productivity. 6

• A 2003 study concluded that one-quarter of all U.S. patients with health problems have experienced a medical or drug error — and half said the error caused serious health consequences. 7

Other than propagating more studies, has anything positive been elicited by these reports? There is some good news. JCAHO implemented national patient safety goals as part of its standards. Some pioneering physicians and hospital chains are also taking action. In his article “Fixing Hospitals,” Robert Langreth described the efforts of several hospitals and health care systems including Intermountain in Salt Lake, Ascension Health in St. Louis and OSF Healthcare System in Illinois. 4

Closer to home, a recent article in the Austin American-Statesman described the efforts at Brackenridge Hospital as part of the Institute for Healthcare Improvement (IHI) “100K Lives Campaign” aimed at saving 100,000 patient lives by June 2006. This campaign aims to enlist U.S. hospitals in a commitment to implement changes in care that have been proven to prevent avoidable deaths, starting with these six changes:

• deploy rapid response teams at the first sign of patient decline;

• deliver reliable, evidence-based care for acute myocardial infarction to prevent deaths from heart attack;

• prevent adverse drug events by implementing medication reconciliation;

• prevent central line infections by implementing a series of interdependent, scientifically grounded steps called the “Central Line Bundle”;

• prevent surgical site infections by reliably delivering the correct perioperative care;

• prevent ventilator-associated pneumonia by implementing a series of interdependent, scientifically grounded steps called the “Ventilator Bundle.”

Detailed information on each of these six changes is available at www.ihi.org/IHI/Programs/Campaign/Campaign.htm.

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According to the IHI, 3,000 of America’s approximately 5,800 hospitals have joined the IHI initiative. In Texas, 141 of the state’s 350 acute-care hospitals are participating. 8–9

As a strategic partner in the IHI campaign, the AMA “supports and encourages physician leadership and involvement through its own patient safety program, Making Strides in Safety.” 10 Recently the AMA developed an online toolkit to guide physicians in the integration of safety interventions at their hospitals. Visit www.ama-assn.org/go/makingstrides to learn more about the program or download the toolkit.

As stated by Lucian Leape, MD in testimony before the U.S. Senate on January 25, 2000: “No physician or nurse wants to hurt patients, and doctors, nurses, and other health workers are highly trained to be careful and take precautions to prevent mistakes. They are held and hold themselves to high standards. Paradoxically, it is precisely this exclusive focus on the individual’s responsibility not to make mistakes, reinforced by punishment that makes health care so unsafe. Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes. Errors can be prevented by designing systems that make it hard for people to do something wrong and easy to do it right.” 11

Those who defend physicians, health care facilities and ancillary personnel know the common theme in medical mistakes — lack of communication among members of the patient care team. Whether a trauma center, a small community hospital, ambulatory surgery or imaging center, a nursing home, or a physician office, communication holds the key to reducing errors and improving patient safety. Those who provide care cannot ignore the facts. Every physician needs to become involved and serve as an advocate for patient safety.

Sources

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