Failure to communicate

By Wayne Wenske, Communications Coordinator, and
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PRESENTATION
A 70-year-old woman with a history of hypertension, hyperlipidemia, and atrial fibrillation came
to the emergency department (ED) of a large hospital with a left front scalp laceration. The patient
sustained the injury after falling in her home due to a syncope episode. The on-call emergency
medicine physician noted that the patient’s pulse was irregular, and an EKG showed new onset
atrial fibrillation. CT scans of the patient’s head were ordered.

PHYSICIAN ACTION
A hospital radiologist reviewed the CT scan and
identified a left frontal scalp hematoma and a 4mm right
frontal subdural hematoma with no mass effect. This
information was documented in the body of the radiology
report. However, under “Impression,” the report read:
“Thin right-sided frontal subcutaneous hematoma” with
no mention of subdural blood.

The emergency physician received the report and read
the “Impression” section, which reflected a subcutaneous
hematoma. The patient was admitted to the hospital
with a diagnosis of syncope due to atrial fibrillation. The
admission note indicated that the CT scan showed a
“thin, right-sided frontal subcutaneous hematoma.”

The laceration was closed with primary sutures in
the ED. A carotid ultrasound was performed and found
negative. To treat her atrial fibrillation, the patient was
given enoxaparin sodium and warfarin by a hospital
cardiologist.

The patient continued to do well for the next two days.
The morning of the third day, the patient complained of a
headache, followed by nausea and vomiting. The patient
was given ondansetron. The patient then experienced a
decreased level of consciousness and an increase in blood
pressure. The responding physician ordered a STAT CT
of the head and the patient was transferred to the ICU.

The CT scan showed a substantial increase in size of
the right frontal subdural hematoma with acute and sub-
acute features, measuring 18mm in thickness with a 6mm
midline shift from right to left, and early uncal herniation.

The patient became semi-comatose with unequal and
fixed pupils. The patient aspirated and was intubated.
The anticoagulation medications were discontinued.
Mannitol, vitamin K, and fresh frozen plasma (FFP) were
given to the patient.

A neurosurgeon performed a right frontoparietal
craniotomy for evacuation of the subdural hematoma.
Excessive bleeding from the scalp occurred, and four
more units of FFP were administered. A right frontal
brain contusion was also noted. A subdural drain was
placed. Estimated blood loss was more than 500 ml.

The patient’s neurological status improved. A few
days later she suffered one or more ischemic infarctions,
possibly embolic in nature, that caused her condition
to deteriorate. The patient also

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developed renal insufficiency. She was later moved to a skilled nursing facility. The patient eventually returned home in stable condition, after lengthy stays at the skilled nursing facility and a rehabilitation facility. She continued to experience mild neurocognitive impairment, depression, dizziness, fatigue, weakness, and headaches.

**ALLEGATIONS**

A lawsuit was filed against the radiologist alleging:

- failure to create an accurate radiology report; and
- failure to orally communicate the presence of a subdural hematoma to treating physicians.

It was further alleged that these failures to communicate resulted in inappropriately aggressive anticoagulation therapy, which led to the expansion of the subdural hematoma, subsequent neurological decline, and permanent impairments.

**LEGAL IMPLICATIONS**

Three consultants for TMLT felt the radiologist breached the standard of care by 1) not documenting the subdural hematoma in the “Impression” section of the radiology report, and 2) not orally notifying the ED of this significant finding. A subcutaneous hematoma is non-life-threatening as opposed to a subdural hematoma, which indicates intracranial bleeding that requires close monitoring.

Because the ED physicians were unaware of the subdural hematoma, they administered anticoagulants to treat the patient’s atrial fibrillation. Anticoagulation was contraindicated with subdural hematoma and may have increased the size of the hematoma. However, two of the consultants pointed out that it was not possible to confirm that the anticoagulation caused the enlarging hematoma and subsequent complications. One of the consultants also pointed out that the ischemic infarctions suffered by the patient were more likely related to the patient’s atrial fibrillation as opposed to the subdural hematoma.

The radiologist believed that the hospital’s voice recognition transcription system caused the error in the CT scan radiology report, leading to an incorrect dictation entry in the “Impression” field. The radiologist admitted that he did not catch the error when he proofread the report.

These admissions led the plaintiff’s attorney to claim that the radiologist negligently failed to inform the hospital administration about problems with the voice recognition transcription equipment. In addition, the attorney intended to use American College of Radiology (ACR) guidelines and the hospital’s own written policy on communicating urgent findings to strengthen the allegations.

**DISPOSITION**

The case was settled on behalf of the radiologist.

**RISK MANAGEMENT CONSIDERATIONS**

It is the responsibility of the physician to proofread the report or entry he or she is creating. Although time consuming, it is important to check that the patient information is accurate and conveys the intended message. In this case, placing “subdural hematoma” in the “Impression” section of the radiology report may have saved a succession of assumptions and errors. If the physician is aware of problems with the voice recognition transcription equipment, timely notification to the facility’s administration is vital and proofreading all the more essential.

An ACR guideline states that findings that suggest a need for immediate or urgent intervention include “Findings that the interpreting physician reasonably believes may be seriously adverse to the patient’s health and may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome.” It is impossible to determine how the outcome of this case would have been altered had this guideline been followed.

However, the subsequent physicians had the correct information in the body of the report had they taken the time to read beyond the “Impression” section. It is a good practice to read the full report.

**Source**


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Dos and Don’ts of Renewing Your Texas Medical License

By Franklin Hopkins

Every two years, physicians licensed by the Texas Medical Board (TMB or Board) are required by law to renew their medical license either online or by mail. During registration, physicians must answer questions regarding any status changes since their last renewal. However, certain answers or omissions can trigger an investigation by the Board, and physicians may find themselves explaining their answers before an Informal Settlement Conference.

Two of the six questions in the “Professional History” section of the renewal application are routinely misunderstood and are often the cause of a Board investigation. To illustrate the dos and don’ts of renewing your Texas Medical License, these two questions (Questions 2 and 3) are presented below, along with an examination of where misunderstandings may occur and a hypothetical example of how a physician may consider responding.

QUESTION 2 — INVESTIGATIONS AND DISCIPLINARY ACTIONS
“Since your last registration or submission of your license application, not including investigations and disciplinary actions by the Texas Medical Board, are there pending investigations, pending disciplinary matters, or final disciplinary actions against you by any licensing agency or health-care entity?”

WHERE MISUNDERSTANDINGS MAY OCCUR
To answer this question, the physician must fully understand the definitions of “licensing agency” and “health-care entity.” The meaning of “licensing agency” is pretty clear. If the physician is licensed in another state and that state’s board is investigating the physician, or has pending (or final) disciplinary actions against him or her, the physician must report it.

But the scope of what constitutes “health-care entity” is less clear. Section 151.002 (5) of the Medical Practice Act defines a health care entity to include a hospital, clinic, practice group, medical school, professional medical association, and the like. Such entities’ investigation and disciplinary process is ordinarily known as a “peer review.” Peer review may take many names, such as a credentialing committee or performance review committee. No matter what title the hospital gives its peer review type committee, its investigations and actions are subject to TMB reporting requirements.

The Medical Practice Act also defines “disciplinary action” broadly. Reportable actions may include seemingly routine actions by credentialing committees. For example, a physician voluntarily relinquishing his or her privileges or deciding not to renew privileges while an investigation is pending, constitutes a reportable disciplinary action.¹

Keep in mind, the Board does not automatically accept a hospital’s peer review action. The Board is required by law to independently verify any allegation found by a health care entity.

PHYSICIAN EXAMPLE
In March, Physician A, an orthopedic surgeon, performed spinal stimulation surgery on a patient. Unfortunately, the patient had complications that prompted the hospital to initiate a peer review proceeding. That June, with a peer review pending, Physician A renewed his license and failed to disclose the pending peer review.

WHAT SHOULD PHYSICIAN A HAVE DONE?
It would have been better for Physician A to report the pending peer review. Within the renewal, Physician A would have the opportunity to explain the circumstances of the review. In addition, Physician A may supply letters of support from hospital supervisors and peers and inform the Board if the review allegation is determined to be “unfounded.” Physician A could even submit an independent expert report verifying that there were no violations of the standard of care.

QUESTION 3 — CRIMINAL CONDUCT
“Since your last registration or submission of your license application, have you been arrested, fined, charged with or convicted of a crime, indicted, imprisoned, placed on probation, or received deferred adjudication? (Unless the offense involved alcohol or drugs, you may exclude: 1) traffic tickets; and 2) violations with fines of $250 or less).”

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All examples in this article are hypothetical and not based upon actual physicians or cases. This article is purely informational and not intended to be legal advice and should not be construed as such.
PHYSICIAN EXAMPLE
In January 2014, Physician B was arrested for DUI. The prosecutor did not pursue the case, and the charges were dismissed shortly thereafter. In February 2015, Physician B renewed her license, but did not report her arrest since the DUI was dismissed.

WHAT SHOULD PHYSICIAN B HAVE DONE?
Reporting the arrest from January 2014, along with the subsequent dismissal, would have been appropriate. She may have also supplied the Board with letters of support from supervisors, family, and friends, along with a personal letter explaining what happened.

Physician B would also be wise to obtain an examination by a substance abuse counselor to show the Board that she does not have an alcohol problem.

The best approach to these Board questions is to disclose with explanation. The Board may be more concerned about a failure to report than the subject of the omission. Physicians who are worried about reporting an arrest, consider this: The Board does not initiate an ISC for every physician who is arrested. Failing to report creates an impression that you have something to hide.

Source

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