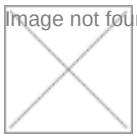
An Analysis of Pulmonology Closed Claims

By Shelly Weatherly, JD

A review of closed paid pulmonology claims over a seven-year period revealed the primary allegation asserted was failure to diagnose and treat. Most typically, such diagnostic errors were not the result of lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of communication breakdowns, poor documentation, and medication errors.



COMMUNICATION ISSUES: Clear and complete communication between providers and nurses is necessary to provide optimal patient care. Electing to treat a hospitalized patient over the phone was a recurrent criticism faced by physicians when a complication occurred. In nearly every case, the physician came under heavy scrutiny for failing to personally evaluate the patient, or for failing to obtain sufficient information to enable proper treatment over the phone.

A case that illustrates the failure to properly make clear the circumstances upon which communication should take place involved a 33-year-old patient who presented to the emergency room with shortness of breath, dysphagia and facial swelling. A CT revealed superior vena cava syndrome. She was admitted to the hospital by a pulmonologist and then underwent a successful percutaneous transluminal angioplasty, which was performed by an interventional radiologist. However, upon removal of the sheath, the patient's blood pressure dropped from 161/90 to 81/50, she began seizing and then became unresponsive. After being resuscitated, the pulmonologist ordered her transferred to the ICU where she remained hypotensive. He did not personally evaluate the patient, and did not clearly communicate with the nursing staff regarding the patient's situation. Through the night the patient deteriorated, no urine output was noted, and the patient became drowsy and confused. It was not until the patient had pulseless electrical activity, no verbal response and a BP in the 60's, that the nursing staff contacted the physician. The lawsuit alleged that the physician and nurses failed to appreciate the significance of the severely low blood pressure and seizures; and further that they failed to collaborate regarding the patient who was clearly unstable after her procedure.

DOCUMENTATION ISSUES: The importance of maintaining a well-documented medical record, from both a patient care and a risk management standpoint, cannot be overstated.

As the graph above illustrates, documentation issues were a factor in 27% of claims paid in Pulmonology. Most often, there was a failure to document completely the patient and/or family history, details of the physical exam, rationale for the diagnosis and treatment plan, patient education, and conversations with the patient and family regarding treatment recommendations.

MEDICATION ISSUES: Failure to monitor was the primary issue in cases involving allegations of medication error. Coumadin was the drug most commonly involved. One case involved a 51-year-old female who was admitted for treatment of a pulmonary embolus with a Heparin drip and Coumadin. Four days following admission, she was transferred to the ICU after a MRI revealed a retroperitoneal hematoma in the right lower quadrant of the pelvis. The pulmonologist who took over the care did not personally evaluate the patient, but instructed the nurses to continue the anticoagulants due to concerns about the pulmonary embolus. The patient died shortly thereafter from hypovolemic shock. The pulmonologist faced expert criticism for keeping the patient on the Coumadin without making any effort to disprove active bleeding by doing a contrast CT or following with serial hematocrits. His failure to personally assess the patient, or to document his rationale for his treatment plan, further compounded the problem.

LESSONS LEARNED:

- Communicate relevant patient information in a timely and clear manner to all individuals on the health care team.
- When other providers are involved in the care of a patient, make sure there is a clear understanding as to everyone's role and responsibility.
- Clearly communicate with other providers those circumstances upon which you expect contact regarding a patient's situation/status.
- Recognize the limitations of assessing a patient over the phone.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, alternatives, and expected outcome. Be careful not to educate above a patient's comprehension level. Be sure to document the details of all discussions with patients and families in the hospital record.
- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief problem; all relevant positive and negative clinical findings; your diagnosis or medical impression; the decision-making process for the clearly defined treatment plan; and all relevant information given to the patient and family regarding such treatment plan.
- If your treatment plan deviates from any local community standard or nationally recognized guidelines for your specialty, document your rationale for doing so.
- Clearly document all telephone conversations regarding patient care, including the name, date and time of the call as well as the essence of the exchange.
- To help prevent medication errors: Obtain a medication history; review the history whenever new medications are ordered; discuss risks, side effects, benefits of, and alternatives to, prescribed medications; and closely monitor high risk medications.

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