

Case Scenarios

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*Disclosure, Communication,
Patient Safety*

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Failure to Follow-up on Radiologic Reports / How to be Respectful

Case Scenario:

Miss Jones is a 48-year-old community leader who is very involved in the hospital where you, her primary care physician, practices. She has come in today for ongoing feelings of abdominal pain and occasional cramping. She reminds you that she had seen you 3 times within the last year complaining of RLQ discomfort. At that time, you had asked her to make an appointment with her gynecologist and to obtain x-rays prior to that appointment. She did obtain x-rays, but never went to see her gynecologist.

You order an MRI, which shows metastatic disease involving multiple sites in the abdomen. As you review in more detail the patient's medical record, you see an x-ray report from the prior year that notes an incidental finding of a 2 cm opacity in the right lobe of the liver. This could represent a benign hepatic cyst but additional radiology studies were recommended at the time to rule out malignancy. It does not appear that this was ever done.

What do you tell the patient? What do you do next?

Here's how it plays out with an ineffective disclosure:

Ineffective disclosure

"I have bad news for you. It looks like this cancer was apparent on an x-ray you had last year and your gynecologist did not follow up on it. I never saw the report so any issues you have should be for your gynecologist. I have her number right here if you want to call her since it is her fault."

Effective disclosure

"Miss Jones, I want to review with you your current condition and what we know about your prognosis, as well as discuss with you some information that has recently come to light. In looking back through your record, you had an x-ray last year that showed an incidental finding with a recommendation for follow up with additional studies to rule out any type of cancer. I am not aware that you had additional studies. Do you recall any? In that regard, I am going to look into this further so that I can provide you with information about the circumstances. However, the important thing now is that we have you on course for appropriate care at this time. I am very sorry and I can assure you that we are looking into what may have occurred. We will share more information with you as we obtain it. In the meantime, should you have questions, please do not hesitate to contact me. I am giving you my card and writing my cell phone number on the back. You can call me at any time. Do you have any questions now that I could answer for you?"

Weight Loss Surgery / How to Use Informed Consent

Case Scenario:

Elaine, a 42-year-old woman, weighing 350 pounds, presented for a laparoscopic gastric bypass. With a BMI of 53 and a number of qualifying co-morbidities such as diabetes, hypertension, and chronic low back pain, Elaine was identified as a candidate for the surgery. She was evaluated by a multidisciplinary team. She attended group and individualized educational sessions, she participated in support groups, and began a rigorous regimen of nutrition and activity. After an adequate informed consent was obtained, the patient had a gastric bypass done at a local community hospital that had a proven track record in bariatric surgery. Initially, Elaine did very well postoperatively. Six months after surgery, she had lost 75 pounds. However, shortly thereafter she reported diarrhea, abdominal pain, persistent vomiting and nausea. The patient was very upset over these symptoms and the disruption in her life. The surgeon did not actively pursue the cause of the symptoms. The patient was then admitted to the hospital. He ordered various tests, which would not be reported for several days. In the meantime, he discharged the patient from the hospital, since she was begging to be allowed to go home. The surgeon did not receive the test results within the next few days since they were incorrectly sent directly to the hospital rather than to his practice. Instead he received them 2 weeks later. The results indicated a thiamine deficiency (which could lead to Wernicke's encephalopathy). He finds out she has since been re-hospitalized with inability to walk. He knows that since the patient did not get treatment sooner for the thiamine deficiency she could develop Wernicke's encephalopathy. The surgeon visits the patient at the hospital.

Ineffective disclosure

"I told you that you needed to take your vitamins. Obviously you were not doing so. What you are experiencing was clearly a risk of the procedure that we discussed in detail many times and I can show you. Here it is!"

Effective disclosure

"I was very saddened to hear that you have been hospitalized. As soon as I heard, I spoke with your doctors that are treating you now and have provided them with some information about your past testing results from your last hospitalization. It included the results of your thiamine testing which was abnormal. I apologize for not getting this information to you sooner; although, I just received it yesterday. I tried calling you to let you know of the results and to discuss next steps, and that is when I learned that you were in the hospital. As it looks like now, there was a mix up by the laboratory in mailing of the results to the hospital instead of my office. However, I normally track such things and am very sorry that these test results were not something that I looked into sooner.

You will recall that thiamine deficiency is one of those complications or risks of the procedure that we discussed prior to your surgery. We particularly discussed this during the informed consent process when we discussed the risks of the procedure. Do you remember that? What I commit to you is that I will verify the circumstances of the laboratory testing and implement any needed strategies to prevent a future similar circumstance. In the meantime, I want to make sure you are getting the care you need. Do you have any questions?"

Intrauterine Fetal Demise / No Fault but Significant Injuries

Case Scenario:

Ellen and her husband, Jim, had wanted a child for nearly 20 years. They had undergone years of infertility treatment and at 41-years-old, Ellen was finally pregnant for the first time. However, tragically, eleven days after an amniocentesis study, the fetal heart beat could not be found. An ultrasound study confirmed the absence of fetal heart activity. Jim was working out of town so Ellen was alone at this prenatal visit. As the scenario was unfolding, Ellen was seemingly “dumbstruck.”

Ineffective disclosure

“Death to the fetus is one of those risks of amniocentesis. You can’t have it both ways, you know. Finding out the information from amniocentesis requires taking some risk, and unfortunately you got burned. Don’t worry. There’s still time to get you another try at a successful pregnancy.”

OR

“I am so very sorry that you lost the baby. I worried that the Maternal Fetal Medicine group was trying to pack in too many amniocentesis patients each day. I sure hope that didn’t contribute to this tragedy.”

Effective disclosure

“Mrs. Smith. I am so sorry to be the one to tell you this, but there is no heartbeat and it is apparent that your baby is not alive. At this time, it is unclear how this happened, but we will be able to provide you with more information as we investigate this further, which will include examining your baby and the placenta. The amniocentesis report may also shed some light on the cause. I promise to keep you up to date on the investigation. For now, we need to make some treatment choices to deal with this immediate situation. I know you said your husband is out of town. Is there someone that we can contact for you to be here for you now as we work through this?”

Medical Error Aggravated by Insensitivity

Case Scenario:

A 35-year-old man with type II diabetes presented to his physician's office to discuss his diabetes management. The patient admitted not taking his medications, adhering to the prescribed diet or monitoring his blood sugars. In the office, his blood sugar was 335 mg/dL, so the physician ordered 6 units of regular insulin. The medical assistant prepared the medication and gave it to the physician who injected the insulin. Immediately after the injection, the physician discovered that a tuberculin syringe was used instead of an insulin syringe. As a result of the error, the patient inadvertently received 60 units of insulin rather than 6 units.

Ineffective Disclosure

The physician then left the patient's room and shouted down the hall at the medical assistant, saying "Why do I always have to be responsible for you people who don't care or don't pay attention. What were you thinking when you gave me that syringe...this could kill him---I am so sick of these people who don't bother to take care of themselves!"

Effective Disclosure

The physician should sit down with the patient and explain what happened, empathize, apologize, and explain how they will prevent future, similar events. He must do so without placing blame, which can be difficult in such situations.