Back to the Basics: The Importance of Good Communication and Documentation in a Complex Case

By Stephanie Walkley, JD, BSN

Tony Green[1], a 29-year-old construction worker, presented to the emergency department of a small, regional hospital complaining of lower and upper back pain over two days after lifting some flooring at a worksite. He described the pain as worsening with movement and radiating through to his chest. He was able to move all of his extremities, had full range of motion, and walked with a normal gait. The emergency room provider diagnosed Mr. Green with muscle strain and discharged him home with prescriptions for a muscle relaxer and pain medication.

Two days later Mr. Green woke up with severe pain in his neck, back, and chest. He also had weakness in his right leg. Within a few hours of waking, he could not move his right leg so he called 911. EMS transported Mr. Green to the hospital emergency department where he had been seen only a couple of days earlier. On arrival, he had profound weakness in both of his legs and was unable to stand. The nurse triage record indicates Mr. Green was able to wiggle his toes but could not otherwise move his lower extremities. The emergency room provider admitted Mr. Green and ordered a neurology consult.

Dr. Mark Hanson, neurologist, arrived to see Mr. Green approximately five hours later. By the time Dr. Hanson arrived and examined Mr. Green, Mr. Green could no longer move his toes and could not feel touch on either extremity. He denied any bladder or bowel problems. He could feel touch at the T12 level and above. Dr. Hanson ordered a STAT MRI of the lumbar and lower thoracic spine.

Within the hour, a MRI of the thoracic and lumbar spine was completed. Dr. Seth Grant, radiologist, read the MRI off site in the middle of the night. He completed a preliminary report, which indicated lumbar degeneration with a minimal annular bulge at L5-S1 and a normal thoracic spine.

Relying on the preliminary report, which ruled out compression of the spinal cord, Dr. Hanson made no attempt to transfer Mr. Green to a facility with neurosurgical coverage. Given the MRI results, Dr. Hanson's differential diagnosis now included cancer, intrinsic lesion within the cord not seen on MRI, and transverse myelitis. Dr. Hanson ordered a battery of tests, including lumbar puncture and MRI of the cervical spine, to determine what non-compressive problem could be causing Mr. Green's symptoms.

The following day, Mr. Green began having urinary problems and could not void. Dr. Hanson continued with his differential diagnosis of a non-compressive condition. Dr. Grant came to the hospital and reviewed all of the films from the night before. When he looked at Mr. Green's MRI, he noticed issues that he did not appreciate on his initial read. Dr. Grant saw a possible acute epidural hematoma from T7 through T11, causing moderate mass effect on the spinal cord. He recommended further evaluation.

Dr. Grant dictated a final report but made no attempt to call Dr. Hanson or Mr. Green's nurse to alert them of his findings. Instead Dr. Grant dictated his final report and relied on the hospital's notification system to fax the final report to Dr. Hanson's office and the nurses' station. The final report was not transcribed and faxed until the next day. The final report was also uploaded to the hospital's EMR system. However, Dr. Hanson did not learn of Dr. Grant's findings from the final report for another day. In total, more than 60 hours had passed since the MRI before Dr. Hanson knew of the correct results.

When Dr. Hanson learned of the findings from the MRI final report, he immediately tried to find a facility and neurosurgeon willing to accept the patient for transfer. After a couple of failed attempts, Dr. Hanson found a facility and neurosurgeon in a major metropolitan area approximately 50 miles away to assume care of the patient. Arranging the logistics of the transfer took time. The patient had been in the hospital more than 72 hours before he was finally transferred to his new facility. Once the transfer occurred, Dr. Hanson made no effort to find out about the patient's prognosis or outcome.

We now know that Mr. Green did indeed suffer from a hematoma at multiple thoracic levels. After arriving at the accepting facility, he underwent an emergent thoracic laminectomy for decompression. Despite the neurosurgical care and treatment, Mr. Green did not recover sensation or function below the waist. He now requires the use of a wheelchair and is incontinent of bladder and bowel.

Mr. Green filed suit against Dr. Hanson, Dr. Grant, and the hospital. The hospital settled for an undisclosed amount shortly after the suit was filed. After the hospital was dismissed, Dr. Hanson and Dr. Grant remained in the lawsuit.

The primary criticisms in the lawsuit related to Dr. Grant. He clearly missed the compression on the initial read of the MRI. Although no one knows if the ultimate outcome could have been different, Dr. Grant had the opportunity to mitigate his mistake. When he did his final read the day after the MRI, he should have done more than rely on the hospital's automated reporting system.

Once he noticed the compression lesion on the MRI, Dr. Grant should have been more proactive in making sure the ordering physician, Dr. Hanson, knew about it. Time is of the essence with this type of finding, and Dr. Grant's approach to his reporting and communication duties was indefensible. [2] Dr. Grant negotiated a settlement with Mr. Green not long after the hospital finalized its settlement.

Dr. Hanson remained in the lawsuit as the sole defendant. He felt very strongly that he should defend the lawsuit and not entertain any settlement negotiations. He relied on Dr. Grant's interpretation and preliminary report. Likewise, he relied on Dr. Grant and the hospital to apprise him of any changes in interpretation or emergent findings.

Defense counsel for Dr. Hanson had the case reviewed and located two neurologists who supported his care. However, of note, Dr. Hanson's defense was not without its problems. His history and physical lacked detail, particularly with regards to the neurological exam. Dr. Hanson did not dictate the history and physical, or the discharge summary, until six months after his treatment of Mr. Green. Furthermore, some of the information in Dr. Hanson's history and physical was inconsistent with his progress notes from Mr. Green's hospitalization.

The case proceeded to a jury trial. Ultimately, the jury returned a verdict in favor of Mr. Green. Mr. Green's experts successfully persuaded the jury that Dr. Hanson had a duty to look at the films himself and call the radiologist. The jurors also took issue with the fact that there was such a significant time lapse with Dr. Hanson's dictation as well as the discrepancies in his charting. The jury felt the charting issues hurt Dr. Hanson's credibility and bolstered the allegations that he was less than diligent with his care.

There are many lessons to be learned from this unfortunate case. The primary takeaway can be condensed into two words—communicate and document. Patient safety and outcomes often depend upon good communication and documentation. Not every negative outcome can be prevented or avoided, but a negative outcome should not be a result of poor communication or documentation.

Although Dr. Grant initially misread the MRI, he caught his mistake. Rather than picking up the phone to alert Dr. Hanson or Mr. Green's nurse of the emergent finding, he relied on the hospital's routine reporting system. There should have been immediate action by Dr. Grant to ensure the ordering physician, Dr. Hanson, knew about his final read. The lack of communication resulted in a tragic outcome.

Finally, the importance of complete, accurate, and contemporaneous documentation

cannot be overstated. In order for the healthcare team to provide good care, everyone on the team should be writing, typing, or dictating their notes in a timely fashion. The information should be clear and concise. As illustrated above, poor documentation can impair the defense of a claim. Although the primary purpose of documentation is to facilitate good communication among providers and continuity of care, when there are poor outcomes, documentation often becomes the main focus of litigation. Be sure that your records accurately reflect the care and treatment.

[1]The names of the patient and physicians have been changed.

[2] While clinical practice guidelines do not set the legal standard of care and each case is fact-dependent, the American College of Radiology Guidelines may be found at here.