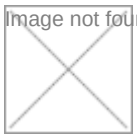
An Analysis of Urology Closed Claims

By Shelly Weatherly, JD

By Shelly Weatherly, JD, *Vice President, Risk Education and Evaluation Services, SVMIC*

A review of SVMIC Urology claims from 2009 – 2015, where there was a paid loss on behalf of an insured, reveals that failure to timely diagnose and improper performance of a procedure were the most common noted misadventures. Most often, the diagnostic errors were not the result of lack of knowledge, skill or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of inadequate documentation, communication breakdowns and poorly designed or ineffective systems.



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 53% of claims paid in Urology. Of those, 75% involved inadequate documentation, which can have a negative impact on the defensibility of the care provided to a patient. The cases reviewed involved:

- Failure to document abdominal exam findings in a patient experiencing post-op complications related to a perforated ureter
- No documented rationale for using an unconventional surgical approach
- No documentation supporting proper identification of landmarks prior to stapling followed by inadvertent transection of the inferior vena cava
- Failure to document telephone exchanges with the emergency physician and other hospital personnel
- Lack of documentation of specific risks and benefits of the procedure in a case complicated by a bladder perforation

EHR documentation issues were also present in the reviewed cases. In one case, the physician, over the course of several office visits, incorrectly carried over erroneous documentation suggesting a positive study for an enlarging renal mass, which was the basis for a radical nephrectomy. The post-op pathology report revealed no such cancer. During the deposition, the physician admitted to the documentation errors that were the result of the “copy and paste” function of the EHR system. While the physician’s failure to review the study prior to taking the patient into surgery was difficult to defend, the documentation errors called the entire record, as well as the physician’s credibility, into question.

COMMUNICATION ISSUES: Effective communication is essential in establishing trust

and building good patient rapport, which in turn plays a role in a patient's perception of the quality of care. Communication breakdowns occurred in 47% of the reviewed claims, and the majority of these involved physician-to-patient situations. Examples include:

- Failure to communicate the detrimental effects of smoking to patients undergoing surgery for tumor removal and who subsequently experienced post-op infection and delayed healing
- Failure to clearly communicate the need for follow-up, which resulted in a delay of stent removal and associated infection
- Failure to discuss the risks of infection and bleeding to patients who subsequently developed these known complications following urologic surgery

SYSTEMS ISSUES: Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanism alone. Systems failures were an issue in 42% of the analyzed claims. Failure to track and act on test results and missed appointments were a common theme.

In one case, a patient presented to the ED with flank pain, nausea and vomiting. The CT scan was originally read as normal by the emergency physician who referred the patient to a urologist for admission. Thereafter, a radiologist over read the CT scan and found a 2x3 cm kidney lesion, which he reported to the emergency physician. The admitting urologist was unaware of this information. He noted in his admission history & physical that the CT scan revealed "no obstruction or stone" and listed the diagnosis as "patient passing a kidney stone". The patient was discharged, never having received information about the abnormal CT scan. Two years later, he underwent a radical nephrectomy for renal cancer.

Another example involved a patient who underwent a cystourethroscopy for complaints of hematuria. Urine cytology was collected which revealed malignant cells. However, the report was not transmitted to the office, nor did the lab call the office to report the critical finding. There was no internal tracking in place to alert the physician of the missing test result. A return visit in six months was scheduled, but the patient failed to keep his appointment. Again, the office had no system to follow-up on missed appointments. Nearly a year later, the patient self-referred to another urologist who diagnosed bladder cancer with brain metastasis.

Also observed in the cases reviewed were wrong site procedures. One case involved a urologist removing the wrong kidney. Instead of reviewing the CT films prior to the nephrectomy, the surgeon relied on the radiology report that incorrectly cited the lesion on the right kidney instead of the left. Another case involved a wrong side ureteroscopy with stent placement. A review of the events revealed that there was no time out, the site had not been marked, and the wrong CT scan was on the screen.

LESSONS LEARNED:

- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief complaint or purpose for the

visit; 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 instructions and information given to the patient regarding such treatment plan.

- Document all telephone communication with patients and with other providers, including evening and weekend phone calls.
- If using an EHR, review and correct all documentation that may have auto-populated or been carried over from a previous visit to ensure it is an accurate reflection of the current office visit assessment.
- 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 the details of all discussions with patients are documented in office records rather than relying on hospital consent forms, which are not procedure-specific and may not capture all details of a conversation.
- Communicate and document follow up instructions, warnings and relevant discharge information to patients. Be sure to convey such information in terms clearly understandable to non-medically trained individuals.
- In order to ensure proper follow-up for patients who require a return office visit, schedule such patients before they leave the office or the hospital and provide a reminder card with date and time.
- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it's important enough to track and personally review.
- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up.
- Implement a tracking system for patients who miss or cancel scheduled appointments so that appropriate efforts are made to contact the patient and re-schedule the appointment in situations where the patient may suffer if treatment is delayed or where the treatment or medication must be monitored closely.
- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected timeframe.
- If using a tasking system for interoffice communication, be sure to have a surrogate reviewer assigned to open task boxes and review messages for anyone not in the office.
- Educate staff to communicate "critical values" verbally rather than relying on tasking.
- Personally review all diagnostic images as well as radiology reports.
- Review results for all tests ordered preoperatively to ensure that any abnormalities receive proper follow-up.
- Use the Joint Commission's protocol designed to prevent wrong patient/site/procedure surgeries by verifying patient identification, marking the surgical site appropriately with the patient/representative prior to surgery, and perform a timeout to review relevant aspects of the procedure with the surgical team and complete the verification process.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.