An Analysis of Interventional Pain Management Closed Claims

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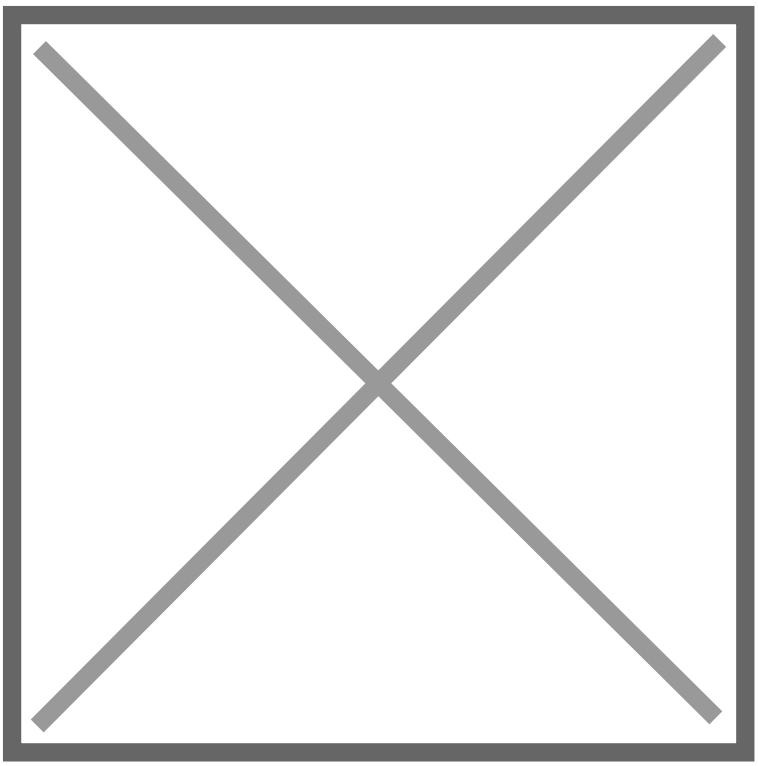
A review of SVMIC Interventional Pain Management claims with a paid loss from 2007 – 2016, reveals that medical judgment was challenged in 79% of the cases. Allegations included utilizing improper technique, failing to properly diagnose and treat a complication, failing to order proper diagnostic tests and failing to obtain a consult.

One case involved a delay in recognizing a post-procedure complication in a 52-year-old female patient who underwent a C5-6 transforaminal epidural steroid (Depo Medrol) injection under fluoroscopy. Within minutes, the patient developed a rapid onset headache, diffuse numbness, slurred speech and nausea. The anesthesiologist suspected excessive sedation as the cause of the symptoms. He evaluated the patient's neuro status by checking hand squeezes and having the patient push her foot against his hand. He determined the response was normal but failed to document this in the record. The patient was observed for 2 hours before being admitted with continued neurologic symptoms. The hospitalist who admitted the patient noted the neurologic deficits and ordered a stat CT and neurology consult. The CT showed a large right side cerebellar hematoma with cerebral edema. The patient arrested after the CT and died the next day. The autopsy revealed a pierced dura and spinal cord injury with death due to a cerebellar herniation. The subsequent lawsuit alleged inappropriate surgical technique and challenged the use of Depo Medrol as its use was under debate in the medical community. A more significant allegation was the failure of the anesthesiologist to recognize and properly treat the symptoms of stroke. Experts criticized the defendant physician for his insufficient and undocumented neurologic exam and his failure to order a neurology consult or obtain a CT.

In addition to medical judgment issues, the graph below reveals that poor documentation, medication errors and ineffective communication were significant issues.



DOCUMENTATION ISSUES: Maintaining a well-documented medical record is a vital component of proper healthcare delivery. Additionally, it can be one of the most important defense tools in the event of a malpractice case. Documentation issues were a factor in 67% of claims paid in Interventional Pain Management; of those, nearly ¾ involved inadequate documentation, which hindered the defensibility of the care provided. Typically, the problem was a failure to document the following: a complete patient and/or family history; the specific elements of a physical exam; the rationale for the diagnosis and treatment plan; the details of patient education; and the specific content of information exchanged in telephone encounters.

A case illustrating several documentation failures involved a 47-year-old male patient who continued to experience chronic pain following cervical-spine surgery. He underwent an epidural steroid injection at C7-T1 under fluoroscopy. He complained of pain following the procedure but was able to move all extremities. As his wife was transporting him home, he lost feeling in his legs. When his wife called the office to report the loss of feeling, a medical assistant, without the benefit of a Clinical Advice Protocol and without consulting the physician, advised that the patient was experiencing a normal reaction to the injection. Later that afternoon, the patient began experiencing leg spasms and had no feeling from

the nipple line down. The on-call physician instructed the wife to take the patient immediately to the emergency room. At the hospital, he was diagnosed with an epidural hematoma and underwent an immediate decompressive laminectomy. The patient suffered significant neurologic deficits including impaired bladder function, pain, and the inability to walk normally. The following documentation shortcomings gave the impression of sloppy, inattentive care and made it difficult to defend against the plaintiff's allegations of negligence:

- the consent form signed by the patient was generic and did not include any risks specific to an epidural steroid block, and there was no office note detailing that specific risks, benefits or alternatives had been discussed;
- there was no documentation of the post-procedure discussions advising the patient regarding symptoms to report or when to seek immediate follow-up care; and
- neither the first phone call to the office, nor after hours exchange with the on-call physician advising the patient's wife to take him immediately to the emergency department, were documented.

Untimely notes were also a problem in a number of the cases reviewed. In addition to the classic case of a physician creating what appeared as a defensive note days after the procedure and complication occurred, there was one case where the discharge summary was dictated well in advance of the procedure and complication. In that case, the patient experienced a spinal cord infarct resulting in paraplegia, impotence and incontinence following an epidural steroid injection. The fact that the discharge summary was dictated in advance of the complications and had not been updated to reflect the emergency event and complications subjected the entire record to suspicion and criticism as to its veracity. Contemporaneous documentation can greatly assist in the defense of a malpractice case because it inspires trust that the record is an accurate and objective account of what occurred in the course of treatment.

COMMUNICATION ISSUES: Effective communication is essential in establishing trust, building good patient rapport, and in achieving treatment adherence. In the claims reviewed, 45% contained evidence of communication breakdowns, 80% of which involved physician-to-patient communication. The recurrent theme throughout these cases was a failure to provide patients with clear and complete information on their medical situation as well as the risks, benefits, alternatives and expected outcomes associated with the recommended treatment plan.

MEDICATION ISSUES: Medication errors were present in 27% of the cases reviewed and involved administration issues, contraindicated medications, wrong doses and wrong drugs. One case involved a 68-year-old female patient with chronic pain syndrome who underwent reprogramming of her intrathecal pain pump in the office. The anesthesiologist used a hand-held device to change the patient's Fentanyl "demand dosage" from 30 to 35 micrograms. Unfortunately, he inadvertently entered 350 micrograms. The next day the patient's husband called to report that his wife arrested at home and was in the ICU. At that point, the physician printed off the Medtronic form reflecting the reprogramming from

the day before and discovered the error. The patient subsequently suffered anoxic encephalopathy and expired.

LESSONS LEARNED:

- Keep current with the standard of care. When utilizing a controversial technique or medication, note your rationale for doing so in the record.
- In the event of an unexpected or adverse outcome, consider the worst-case scenario in your differential diagnosis.
- Perform a thorough neurological evaluation of the patient and clearly document the findings in the medical record.
- Consult with, or refer the patient to, a neurologist if unsure about the source of the patient's neurological complaints or symptoms.
- Develop and utilize a Triage Protocol to assist telephone response personnel in directing calls to the appropriate staff.
- Develop and utilize Clinical Advice Protocols to assist clinical staff who give patient advice and to clarify when to refer calls to the provider.
- Document timely and completely – including a thorough history, details of the physical examination, diagnosis and treatment rationale (if not self-evident), patient instructions/education and details of telephone calls. Such documentation enhances patient care and bolsters your credibility if called upon to defend such care.
- Review all documentation carefully before signing to ensure it is an accurate representation of the examination or procedure.
- Clearly communicate with patients and ensure an understanding of information relayed when providing medical advice over the telephone. At a minimum, document the following types of phone calls: when reporting test results to patients; when the patient is advised to return to the office or go to the emergency department; and when the patient requests medical advice or prescription refills.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, expected outcome, and alternatives. Doing so not only discharges your legal and ethical obligation to provide patients with sufficient information with which to make an educated election about the course of their medical care, but may also help create realistic expectations on the patient's part as to the outcome of treatment. Be careful not to educate above their comprehension level. Be sure to document the details of all discussions with patients in your office record or on a procedure specific form.
- Provide clear, detailed, understandable and specific written post-procedure instructions to patients – including what signs and symptoms to watch for, the significance of keeping follow-up appointments and what symptoms warrant an immediate visit to the emergency department.
- With regard to pain pumps, print off information on the dose entered at the last visit and the new dose entered after reprogramming the setting and review it with the patient.
- Have someone verify the dose calculation and vial of medication to be injected along with the printout after a pump refill has been completed.

- To help prevent medication errors in general: Update the medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits, and alternatives to prescribed medications; closely monitor high risk medications; train staff who are allowed to administer medications to adhere to the “Five Rights”(right patient, right drug, right dose, right route, right time) and to utilize appropriate injection techniques.
- Follow the CDC recommendations for multi-dose vials and safe practices for medical injections available at this CDC link.
