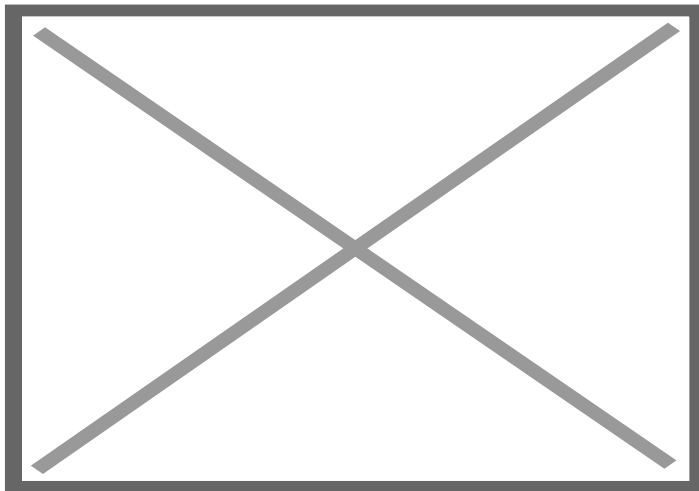


An Analysis of Oncology Closed Claims

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Unexpected adverse outcomes can lead to allegations of medical malpractice; however, in the oncology specialty, many of the adverse outcomes are not unexpected. Nevertheless, the stressors of a lawsuit are devastating. Being aware of potential vulnerabilities can help reduce exposure. This article focuses on lessons learned from a review of closed claims with a loss paid on behalf of the SVMIC-insured oncologist.

A review of paid oncology claims from 2001-2016 revealed that, excluding errors in medical judgment, there were 3 basic areas that contributed to the determined indefensibility of the claims, as illustrated in the graph below.



MEDICATION/INFUSION ISSUES:

Across all specialties, SVMIC continues to see medication issues as a leading source of claims and this holds true for this particular specialty as well. Unique to oncology are the complex chemotherapy regimens where a miscalculation or medication error can be

serious, as seen in the following two examples:

The first involved an infusion pump error in which the 5-FU ordered to be given over 46 hours was infused over an hour causing a loss of hearing, vision impairment, numbness in extremities, severe stomatitis and pain in a 69-year-old woman. The infusion company programmed the infusion pump erroneously, and the nurse failed to look at the pump screen to verify the correct dosage and rate before starting the pump. The plaintiff was successful in her allegations that the physician failed to provide proper oversight and training for his staff.

The second example involved a chemotherapy nurse who accidentally picked up the wrong syringe from under the protective hood and administered Vinblastine instead of 5-FU. The patient immediately developed light-headedness with tingling in the extremities and suffered long-term peripheral neuropathy. It was later discovered that another nurse had prepared the Vinblastine and set the unlabeled syringe down next to the 5-FU syringe.

DOCUMENTATION ISSUES:

Documentation issues were a factor in 36% of paid claims, with inadequate documentation as the key contributor to the indefensibility of the case. Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. It is impossible to document every event that occurs in the physician/patient interaction, but a few additional facts documented in the medical record can make cases appear quite differently to an outside observer. When a claimant presents a medical malpractice claim, the medical judgment of the provider is evaluated based upon the reasonableness of the decisions he/she made. It is critical that the important facts be documented; failure to include the rationale for medical decision making can hamper the defense. Inadequate documentation was a factor in the following two examples:

A 60-year-old patient with a known history of ovarian cancer was started on a chemotherapy protocol for suspected metastatic ovarian cancer. The diagnosis was made based on a CT scan that showed liver lesions with a CEA and CA 125 that were within the normal range. Following two rounds of chemotherapy, the patient self-referred to another oncologist who ruled out all signs of metastatic disease and maintained that the patient had been misdiagnosed. The patient filed a lawsuit alleging emotional injury due to the misdiagnosis as well as unnecessary treatments. In the lawsuit, the patient argued that further confirmatory tests (MRI, liver biopsy) were needed to confirm the presence of recurrence. Unfortunately, there was no documentation in the medical record to support the rationale for proceeding with treatment without confirmatory testing.

An oncologist treating a 56-year-old with hairy cell leukemia and known sulfa allergy allegedly failed to convey the risks/benefits/alternatives of using sulfamethaxazole as a critical support drug while the patient underwent a Leustatin® infusion. The patient suffered a severe allergic reaction and Stevens- Johnson syndrome ensued, followed by death. The

oncologist did not think the patient had a true allergy but rather a sulfa intolerance issue, and, in his mind, the potential benefits of preventing pneumonia while the patient was immunosuppressed outweighed the risks of administration. In his deposition, the oncologist testified that this discussion took place with the patient and her husband, but he failed to document it. That testimony allowed the plaintiff's attorney to postulate that, had the patient been aware of the risk, she would have likely declined the medication. Without the documentation, it became the husband's word against the physician's making the case less defensible.

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 received and helps ensure compliance. Communication breakdowns occurred in 27% of the reviewed claims. The case below exemplifies a breakdown in communication further complicated by documentation issues.

A 61-year-old with lung cancer was admitted with fever, cough and weakness after a round of chemotherapy. The on-call physician rounded Saturday morning and made a brief note that the patient was complaining of a little shortness of breath but not in any distress. That evening and the following Sunday morning, the hospital nurses called regarding continued and increasing shortness of breath. The physician's triage nurse handled these calls. The patient coded the next day and died. An autopsy showed a pericardial effusion and cardiac tamponade. The lawsuit alleged that the oncologist missed an opportunity to save the life of the patient through earlier intervention and diagnosis of the pericardial effusion. The absence of a thoughtful physical exam during the Saturday morning rounds when the patient first complained of shortness of breath and the apparent lack of clear communication between the parties involved regarding the well-being of the patient painted the picture of a complacent physician who relied too heavily on his nurse. A complicating factor for the defense was that the oncologist dictated the discharge summary a week later and then subsequently dictated a more complete version (that appeared self-serving). The delayed dictation and attempt to embellish on the prior note were factors in the indefensibility of this case.

LESSONS LEARNED:

Chemotherapy administration:

- Stay abreast of the [American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards](#).
- Be aware of the best practices and safety self-assessment for chemotherapy (oral and parenteral), available at [Institute for Safe Medication Practices](#).
- Develop policies and procedures to ensure safe medication practices; reduce distractions in areas where chemotherapy is being prescribed and staff are preparing medications for administration:

- Consistently apply the “five rights”: right patient, right drug, right dose, right route, right time
- Maintain two-person verification of chemotherapy preparation and label chemotherapy agents immediately upon preparation
- To prevent administering a contraindicated medication, take a complete medication history, update it at each visit and prominently note allergies in the chart
- Have a comprehensive educational program for new staff administering chemotherapy, including a competency assessment at specified intervals and maintain documentation of such
- Maintain CPR certification for all clinical staff
- Have a written medical emergency plan and practice mock emergency drills

Documentation:

- Document the rationale for a treatment decision that may not be clear in the chart.
- Before beginning treatment, document your discussions with the patient about risk and benefits. Documentation should include:
 - the diagnosis and goals of therapy,
 - planned duration of the chemotherapy, drugs and schedule,
 - specific short- and long-term risks vs benefits,
 - address risk of no treatment, mention alternatives,
 - risks or symptoms that require notification and
 - emergency contact information, plan for monitoring and follow-up
- Include a family member in the consent discussion.
- Never alter a medical record. It will not only destroy your chances of prevailing in a lawsuit, but your professional liability coverage for the incident may be at risk.
- Do not be tempted to bolster your notes in an attempt to improve defensibility. Never amend the record without consulting first with SVMIC, especially if there has been an adverse outcome or you have received notice of a claim or lawsuit.
- Document any medical complications or unusual occurrences in an objective fashion and without reference to an incident report.
- Include specific clinical parameters in your orders that instruct when the physician should be notified.

Communication:

- Listen to patients who try to tell you when something does not feel right.
- Communicate relevant patient information in a timely and clear manner to the covering physician, especially information on patients with anticipated problems.
- Provide written and verbal instructions to the patient, including when to call the office and when to go to the ED and document this communication with the patient.
- Provide oversight to your phone call nurses and ensure they are well-trained on written advice parameters and can demonstrate competence.

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