Prioritize Diligent Medicine Over Events

By Jamie Wyatt, JD

Four out of five physicians say they are currently experiencing symptoms of burn out. [1] One of the biggest challenges for any working professional is finding a work-life balance. Given the current health care climate, providers are dealing with increased stressors ranging from the global pandemic, a decrease in compensation due to suspension of surgeries and elective procedures, rising costs of doing business, and loss of control over the practice of medicine due to heavy regulation. These are just some of the factors affecting overall professional contentment. The need to recharge is ever more present, but how is this accomplished while ensuring you, as a medical provider, meet your ethical obligations to refrain from abandoning your patients or a perceived abandonment outcome?

This edition of Closed Claim Review provides a good lesson on what **not** to do in handling patient calls. The patient is George Callaher[2], a 40-year-old male, who suffered with chronic back pain for years. He was referred to Dr. Strobl for consideration of a dorsal

column stimulator after he successfully completed a trial by his pain management physician. All conservative measures were taken but seemed to fail, and Mr. Callaher was deemed an appropriate candidate for the surgery. He consented to the procedure and underwent placement of a dorsal column stimulator, which was done successfully by Dr. Strobl without any complications. On the initial postoperative visit, Mr. Callaher was recovering well from the surgery. His incisions were healing well with no tenderness to palpation, no erythema, edema, open areas, nor any drainage at the incision site. It appeared his thoracic and right flank incisions were healing without issue.

Three weeks post-operatively, Mr. Callaher woke up in severe pain and presented to the emergency room with complaints of pain at his incision site along with abdominal pain. He noted his pain scale was a ten out of ten and also reported a low-grade fever. The emergency physician ordered labs and a CT scan. The labs revealed that Mr. Callaher had a slightly elevated white blood count. The emergency room physician considered infection in her differential diagnosis, examined the incision site, and noted some redness. The results of the CT scan did not provide any evidence of cellulitis or abscess. Mr. Callaher waited a total of seven hours in the emergency room. He would later learn that the emergency room staff, and the physician, made two attempts to contact Dr. Strobl's office and left messages stating that the patient was being treated in the emergency room for complaints of severe pain at the wound site. The emergency physician communicated to Dr. Strobl's office the need for the patient to be seen by Dr. Strobl. When this message was discussed with Mr. Callaher, he notified hospital staff that he had attempted to reach Dr. Strobl's office earlier that morning but had not received a return call from the physician or his staff before he felt that he needed to go to the emergency room. The emergency room physician told the patient to contact Dr. Strobl's office if he continued to have any issues and/or did not hear from Dr. Strobl's office. He was then discharged with a clinical impression of low back pain with no infection.

The following morning, Mr. Callaher's wife contacted Dr. Strobl's office to advise staff that her husband needed an appointment as he had continued pain and was vomiting. She only spoke with the front office staff and was told that he couldn't be seen that day because the office was closing early due to a practice function. She was given an appointment for two days later. Later the same day, distraught by her husband's ongoing condition and pain, the wife called the office again and finally spoke with Dr. Strobl himself. He recommended that she take Mr. Callaher to the emergency room if they couldn't wait until the appointment provided. Dr. Strobl further advised Mrs. Callaher to have the hospital staff call him if Mr. Callaher decided he needed to go there. Dr. Strobl left for the day and was out of the office for an additional day. Mr. Callaher failed to present on the day of his scheduled appointment, and no follow-up action was taken by the office staff regarding the missed appointment. Dr. Strobl would soon find out why his patient was a no show.

Unbeknownst to Dr. Strobl, Mr. Callaher presented to the emergency room hours after his wife was told he could not be seen by Dr. Strobl's office. He complained of back and flank pain giving a history of a dorsal column stimulator placement with two days of increased

pain, he had fever, was nauseous and vomiting and was evaluated by the emergency room physician. Over a two-day period and through the course of treatment, Mr. Callaher was diagnosed with a surgical wound infection and MRSA. He was also diagnosed with aspiration pneumonia, acute respiratory failure with hypoxemia, and severe sepsis. Dr. Strobl was unaware of the patient's admission to the hospital. No one contacted Dr. Strobl from the hospital despite multiple providers treating Mr. Callaher, nor did Dr. Strobl's staff contact the emergency room that was recommended to his spouse. Dr. Strobl only became aware of the admission later when his PA rounded on another patient in the hospital and learned that Mr. Callaher was there. By the time he saw Mr. Callaher, the patient had developed sepsis and was too unstable to undergo removal of the dorsal spinal column device. Ultimately, Mr. Callaher expired. The autopsy concluded that the cause of death was sepsis with the source of infection determined to be cellulitis of the lower back around the spinal cord stimulator.

Following the patient's death, his wife filed a wrongful death lawsuit. The suit was filed against our insured, Dr. Strobl, multiple providers who provided hospital care, and the hospital. Among the allegations against Dr. Strobl was abandonment. The allegations included a failure to see the patient at the hospital on the date he sent Mr. Callaher there with signs and symptoms of infection, a failure to recognize and appreciate the seriousness of Mr. Callaher's medical condition, a failure to communicate with the emergency room, the failure to make sure someone was caring for his patient, and abandonment resulting in Mr. Callaher's death.

The discovery process began with Dr. Strobl represented by a very competent defense attorney. Numerous providers were defendants to the lawsuit, which in this case added an element of difficulty in defending the claim; not only was the plaintiff's attorney alleging negligence, but other medical providers were asserting claims of negligence against each other as well given their roles in Mr. Callaher's treatment. In a case such as this, discovery depositions were very important in determining the interactions of the parties and led to some difficulty in mitigating liability as it became clear that phone calls were not answered and follow up did not occur. Physicians, staff at the hospital, plaintiff's spouse, and family friends all testified that contact was made with Dr. Strobl's office, but there was either no response or Mr. Callaher's concerns fell on deaf ears. Dr. Strobl testified that he was made aware of Mr. Callaher's initial treatment at the emergency room, but he was told that Mr. Callaher had a normal CT and that labs were not elevated so his issue appeared to be unrelated to the dorsal column stimulator. Dr. Strobl was not given any chance to handle the patient's issues in the second admission because as the saying goes, "you don't know what you don't know." The lawsuit ultimately resulted in a settlement due to the issues of lack of communication and perceived abandonment.

This case had many challenges. In a situation such as this, the medical care provided could meet or exceed the standard of care, and yet the appearance of abandonment or failure to appreciate a patient's concerns can lead to a settlement as the best resolution. Post-operative complications are always a possibility following surgery. Having a plan or protocols in place for staff to alert a physician of such complaints, missed appointments, or

a situation where complications lead to a patient's hospitalization is a must in preventing an event such as occurred in this case. In answering the earlier question of preventing a claim of abandonment, it is necessary to put protocols in place to address appropriate vacation coverage as well as staffing guidelines to tackle any problems faced when a physician is out of the office. This case illustrates the need to have advice and triage protocols for office staff as well as office procedures for when a physician is out of the office that outline the steps to take when a surgical patient calls requiring assistance. Unfortunately, we continue to see lawsuits filed by patients asserting claims of medical negligence for alleged acts of abandonment for failing to follow-up on care or delaying/failing to treat a medical condition resulting in injury.

To reiterate, the key lesson here is the need to establish guidelines to prepare for vacation, leave, and the inevitable patient calls. In developing protocols, steps should include educating and training the triage staff on how to handle calls such as documenting who, what, when, and why. If it's documented, it happened. This goes a long way in assisting in the defense of any medical malpractice claim. It's also important to ensure the provider is made aware of changes in the schedule daily. This can determine how to handle any necessary follow-up. Also, place follow-up flags on patient records as necessary. Review the chart to determine if a patient had a recent procedure to determine if complaints warrant immediate assistance. If a patient doesn't keep an appointment, contact should be made to inquire why and whether rescheduling needs to occur. Also, designate someone in the office to respond to calls if the physician is out and be sure to designate back up personnel. If possible, schedule back up physicians if the provider is out of the office. It is vital to have an outbound message for after-hours calls that provides on-call physician information, instructs a patient to go to the emergency room, or, if incident is not an emergency, to leave a detailed message. Lastly, in addressing patient messages, advise staff that calls must be returned the same day. Following such guidelines will allow for an appropriate and effective response that will help ensure patient needs are met and will likewise minimize the risk of liability from a medical malpractice claim.

[1] Medical Economics Journal, Medical Economics September 2021, Volume 98, Issue 9.

[2] Names and identifying details have been changed for confidentiality.
