

# PPIC® Closed Claim Case Review

## Discontinuity and Errors

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### Abstract

Data suggests that over 1.5 million preventable adverse events, or injuries, occur due to medications in the United States annually (Aspden, 2006). Medical errors can occur because of many other reasons. This case involves a continuity of information error, in that relevant information concerning the abnormal lab results was not adequately communicated from the doctor to the patient or from the lab to the patient.

### Overview

In the summer of 2001, a 46-year-old husband and father of three children, whose active lifestyle included running marathons, saw his PCP for a routine check-up. His Prostate-Specific Antigen result was 5.12 (normal = 0.00 – 2.5). On his lab result, the number was circled and “chart” written beside it. A year later, during another routine check-up, the physician performed another PSA, with a result of 7.94. The physician did not document any discussion of the previous year’s results with the patient at that time.

A letter was sent to the claimant that stated his PSA had risen since the prior year — that in 2001 it had been 5.12 and was now about 8. It goes on to state, “This is usually not a cause for concern, but I would recommend that you see a urologist to see if any further testing is necessary regarding this. I hope this information is helpful to you.” A handwritten note on the letter states that it was mailed to the patient.

The claimant was seen in the office four months later for an ankle injury without any mention of the lab result or questions about whether the claimant had followed up on the recommendation. Just a few days later, the patient came back complaining that he had noticed blood in his semen several times. He was then told that he had been sent a letter regarding the elevated PSA in the past, but the patient stated he had never received it. His prostate felt normal. The doctor suspected prostatitis and placed him on antibiotics for 14 days with a recheck of PSA, and if the result was still high the claimant would need to see a urologist.

The patient’s PSA recheck revealed an elevation to 10.5. He was seen by the urologist for consult. He essentially had no symptoms related to his urinary system other than bloody semen. The urology exam showed that he appeared well, his testicles were normal, and his prostate was firm. The urologist did not find any palpable evidence of cancer, but he ordered an ultrasound and fine needle biopsy of the prostate. Adenocarcinoma was found. The patient sought a second opinion, and the diagnosis was confirmed. He was scheduled for a radical prostatectomy. There was also seminal vesicle involvement, which increased the claimant’s risk for reoccurrence. The patient underwent chemo and hormonal therapy. At one point he was documented as cancer free.

In fall 2005, the patient’s PSA began to rise again. Initially it was 0.19, then 0.25. The claimant restarted hormonal therapy. The following summer, scans to check for metastasis found multiple skeletal lesions. He began chemo and radiation but eventually suffered multiple complications including dehydration, colitis, diarrhea, and weakness. He soon developed lesions in his lungs and brain, followed by aspergillosis and pneumocystis carinii pneumonia. The claimant chose comfort care measures and died with his family at his bedside in January 2007.

### Expert Opinion

Plaintiff experts opined that if treatment had occurred within two months of the July 2001 5.1 PSA, the patient would have been cured, and that the two-year delay in diagnosis was a significant cause of his death. They also opined there was no involvement of the seminal vesicles when the case was first diagnosable. The patient should have been notified in the summer of 2001. Antibiotics should have then been prescribed to treat prostatitis or rule it out by September or October 2001 when diagnosis of prostate cancer should have been considered and treatment should have commenced leading to an 88% chance of survival rather than the 10% that the patient later faced.

Defense experts were split. Three of the five reviewers stated that they could not support the insured as the standard of care had not been met. The remaining two stated that the claimant’s PSA was over eight times the median value for men his age by July 2001. A high PSA is a strong predictor of advanced cancer in men in their 40s. The two felt that he had advanced prostate cancer in 2001, which meant his cancer had been present for many years prior. The advanced stage also indicated that the patient’s prostate cancer had been multiplying on a molecular level for several years and had migrated outside of the prostate by 2001. These experts felt that men with advanced prostate cancer have a very poor prognosis, and even if aggressive treatment had started in 2001, this patient’s disease would not have been cured.

## Discussion

An error is “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.” Discontinuities epitomize both the system’s complexity and the role of people in creating safety through smoothing over transitions, handling disruptions, and double-checking handovers. Other categories can be delayed; return of results not seen and/or followed up on; communication lapses; overlapping amended reports requiring action from radiology or cardiology; and misplaced assumptions that a test is normal by not checking a final result. Avoiding the discontinuity of communication that this case exemplifies necessitates a candid review of one’s own policies, practices, and experiences. It requires a multifaceted review of systems.

## Risk Prevention Strategies

Issues to ponder when developing a process or identifying weak spots for standardization and systematic improvement might include:

- What are our policies for handling test result follow-up? How do we handle amended reports?
- No matter the policies, what are our actual practices? How well do the policies work? Are they adhered to?
- What exceptions occur that lead to occasional deviations from the standards practiced? Do different practices occur at different times of the day, shift, and department?
- What back-up mechanism are in place to deal with challenges? What happens when computers fail, staff calls in or quits, or other problem issues arise?
- How do communication hand-offs occur and do they work? Do patients and physicians get printed copies of test results? What about amended and delayed results?
- How are results, both normal and abnormal, explained to patients?
- What computer programs exist to communicate results to primary physicians? Are there ways the results can be sent electronically to patients?
- What is the procedure for critical results obtained? How do we minimize the number of tests done and the appropriateness of tests?
- Who is responsible for overseeing the follow-up of test results?

## Summary

The insured admitted in his deposition that he had a duty to notify the patient of the 2001 elevated PSA of 5.12. The insured also intended to match the lab slip to the chart and arrange a referral to an urologist. He agreed the standard of care required notification, and the standard of care was violated.

The office nurse acknowledged that the insured wrote the word “chart” on the lab sheet and that this meant he wanted the chart, and it was her responsibility to ensure that he received the chart. The insured admitted that he had never received the chart. The nurse acknowledged that if the insured did not receive the chart, the system failed and that this was below the standard of care. Because the insured violated the standard of care and his amended answer was filed, along with the nurse admitting the standard was not met, this case was settled. The collective settlement of all defendants reached well into seven figures.

## References

Aspden, P. (2006). Committee on identifying and preventing medication errors. In: Preventing Medication Errors. Institute of Medicine. Washington, DC: National Academies Press.

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