Volume 8, Number 15, 1st Quarter 2002

Healthcare RISK MANAGER

MAG MUTUAL INSURANCE COMPANY
® A Member of the MAG Mutual Group®

Karol DeVito, R.N. and Carol A. Austin - *Editors*

# Effective Consultations Depend on the Quality of Physician-to-Physician Communication

Doing a thorough job of arranging consultations is time consuming for you and your staff.[1] Yet, patients need a smooth, well-coordinated plan of care between all treating physicians. Patient care hinges on how well information is conveyed from one clinician to another. Communication breakdown between treating physicians can lead to delays in diagnosis and liability on the part of both referring and consulting physicians.[2] Physicians on both sides of the consultation process should strive to clearly communicate all pertinent information needed to provide patient care. In addition, clarity in who will take primary responsibility, or how care will be shared, is key to improving quality of care and reducing liability.

## The Role of the Referring Physician

Studies on the consultation and referral process have found that the success of feedback from consultants to referring physicians was directly related to *the quality of communication sent from the referring physician to the consultant*.[3] The following risk management recommendations can aid in improving this communication process.

- Request the consult in a timely manner
- Document all communications
- Be specific about what you expect of the consultant: any tests to be done, surgery required and feedback expected
- Communicate in writing: the specific reason for the consultation, a description of prior evaluation, including tests and procedures, who will take primary responsibility for further management of the problem, and who will have primary responsibility for overall care
- If the consult is urgent, initiate consultation by telephone and follow up in writing
- Provide the consultant with your office notes, hospital summaries, lab and x-ray data prior to the consultation
- Ask the consultant to educate you on technical issues
- Track and follow up your referrals
- Educate your patient regarding the reason for the consultation, who will schedule the appointment, the urgency of completing the consultation, who will follow up and when to return to your office
- Implement the consultant's recommendations in a timely manner or document your rationale for electing not to
- Keep patients in the loop. Provide feedback on the consultant's recommendations

## The Role of the Consulting Physician

Consultants need effective systems for communicating their findings and recommendations back to the referring and primary care physicians. TIMELY COMMUNICATION OF ABNORMAL FINDINGS IS PARTICULARLY CRITICAL. Review of the medical record should provide a picture of the patient's course of care. Don't assume what the referring physician has done. Make sure that tests have been done, medications ordered and patient instructions provided. The following risk management suggestions can help provide an effective consultation and report[4].

- Conduct the consultation in a timely manner
- Determine the precise reason for the consultation and include this in your written report
- Ensure that the referring physician is notified of the visit and provide a written report
- Communicate in writing: specific findings (including any test results), recommendations, further visits or follow-up needed, a summary of the instructions given to the patient and whether the patient's care will need to be co-managed by both physicians or if the consultant will no

- continued on page 2

INSIDE:

*Effective Consultations, continued from page 1*

longer be following the patient
- Recommendations should be as specific as possible e.g., "digoxin 0.25 mg IV now, again in six hours, and then once a day," rather than, "digitalize the patient"
- Educate the referring physician on technical issues
- Coordinate any additional referrals needed with the referring physician and/or primary care physician
- In a hospital setting, notify the patient's primary care physician of the patient's admission. Critical or stat recommendations should be listed first and clearly labeled as urgent. Clearly determine who will assume the overall care of the patient and document this in the medical record. Provide the primary care physician with discharge plans so that follow-up care can be arranged, and clearly communicate and document if you will no longer be following the patient
- Direct the patient back to the referring physician when the consultation process is completed

1 Epstein R. M. Communication between primary care physicians and consultants. *Arch Fam Med* 1995;4:403-9.
2 Franks P. Nutting PA. Clancy CM. Health care reform, primary care and the need for research. *JAMA*. 1993;270:1449-1453.
3 Bourguet C. Gilchrist V. McCord G. The consultation and referral process: a report from NEON (Northeastern Ohio Network Research Group). J Fam Pract. 1998;8(1):66-70.
4 Krammerer and Gross' *Medical Consultation* 1998:Chapter 1. Williams & Wilkins Third Edition.

## Inadequate Communication By Multiple Providers Leads to Patient Injury and Claim

**Case Report:**

A 35-year-old male presented to his Primary Care Physician (PCP) with complaints of upper musculoskeletal pain. Chest and thoracic films were ordered to rule out a paraspinal mass. The radiologist interpreted the films as an osteoporotic compression fracture at T6. Two weeks later, the patient was referred to an orthopedic surgeon for "complaints of upper back pain, compression fracture/will bring films".

The patient presented to the orthopedic surgeon minus his films and was evaluated for "complaints of mild upper back pain." He was diagnosed with a rhomboid strain. One week later, he went to the ER due to intensified pain and "numbness from nipples to toes." Work-up was reported to be negative and the patient was discharged. Two days later, he lost all bowel and bladder function and fell twice at home. He was taken to the ER where an emergent MRI revealed a large epidural mass causing spinal cord compression. Suit was brought against all of the physicians involved for alleged delay in diagnosis and treatment of a paraspinal mass resulting in paraplegia. Plaintiff's experts alleged a series of miscommunications between physicians lead to the delay.

Allegations against the radiologist included a failure to call the PCP to recommend either an MRI or CT due to the unusual nature of a compression fracture in a 35-year-old with no history of trauma. The PCP was cited for failure to obtain the radiology report in a timely manner and failure to ensure that the orthopedic surgeon was fully aware of the reason for the consultation. Allegations against the orthopedic surgeon included a failure to obtain radiology films and failure to assimilate all information provided in the referral. The ER physician was cited for a failure to adequately evaluate the patient's symptoms and failure to communicate the final radiology report to the patient. Any failure to communicate and lack of coordination among multiple providers involved in the diagnosis and treatment of a patient increases the possibility of patient injury. This case was settled for $1.1 million dollars.

# Vaginal Birth After Cesarean Section (VBAC): New Study Results

Cragin's dictum "once a Cesarean, always a Cesarean" dates back to 1916 when he suggested that uterine rupture following vaginal delivery after previous Cesarean birth was so catastrophic an event that a repeat Cesarean should be done prior to the onset of labor[1]. This practice prevailed until 1981, when the National Institutes of Health (NIH), noting a rising Cesarean rate (23 percent), formed the Consensus Development Task Force on Cesarean Childbirth. The task force concluded that VBAC was an appropriate option[2]. Following the wave of enthusiasm for VBAC, some third-party payers and managed care organizations mandated that all women who have had previous Cesarean deliveries should undergo a trial of labor. However, it is becoming increasingly recognized that there are potential risks to VBAC and that some repeat Cesareans are clinically indicated[3,4]. A new study published in The *New England Journal of Medicine's* (NEJM) July 5, 2001 issue reports significant new findings relating to VBAC. We recommend that all physicians caring for pregnant women review the article. It can be found in NEJM volume 345, no. 1, pages 3 and 54. It may also be accessed online at **www.nejm.com**.

*- continued on page 3*

*continued from page 2*

**New England Journal of Medicine Significant Findings:**

- The risk of uterine rupture in patients who had repeated Cesarean section without labor was 1.6 per 1000 (0.16%)
- The risk of uterine rupture in the setting of a spontaneous onset of labor following one previous Cesarean section was 5.2 per 1000 (0.52%). This translates into a relative risk ratio versus repeat Cesarean section without labor of 3.3 times greater risk of rupture
- The risk of uterine rupture in the setting of induction of labor without the use of prostaglandins following one previous Cesarean section was 7.7 per 1000 (0.77%). This translates into a relative risk ratio versus repeat Cesarean section without labor of 4.9 times greater risk of rupture
- The risk of uterine rupture in the setting of induction of labor using prostaglandins following one previous Cesarean section was 24.5 per 1000 (2.45%). This translates into a relative risk ratio versus repeat Cesarean section without labor of 15.6 times greater risk of rupture

In addition, the postpartum complications of second deliveries among women with a prior Cesarean delivery were significantly higher when uterine rupture had occurred.

| | No Uterine Rupture | Uterine Rupture |
|---|---|---|
| Bladder injury | 1.20% | 7.70% |
| Death of infant | 0.50% | 5.50% |
| Hysterectomy | 0.10% | 4.40% |
| Major puerperal infection | 1.20% | 8.80% |
| Maternal hospital stay >5 days | 4.20% | 26.40% |
| Paralytic ileus | 0.40% | 3.30% |
| Severe puerperal infection | 4.80% | 11.00% |
| Surgical complication | 0.70% | 35.20% |

Most studies of VBAC have been conducted in university- or tertiary-level centers under ideal conditions with staff coverage and in-house anesthesia[5]. However, the majority of obstetric patients in this country are delivered where manpower may be limited. There have been too few studies with sufficient numbers of patients to determine the results of VBAC in rural hospitals. **Nevertheless, it is incumbent upon the physician to provide a safe setting if VBAC is to be undertaken.**

The American College of Obstetricians and Gynecologists (ACOG) July 1999 *Practice Bulletin* offers the following clinical guidelines for identifying candidates and conditions most predictive of a safe and successful trial of labor, as well as potential contraindications.

**Candidates for VBAC include:**

- One or two prior low transverse incision Cesarean sections
- Clinically adequate pelvis
- No other uterine scar or previous rupture
- Physicians **immediately** available throughout active labor capable of monitoring labor and performing an emergency Cesarean section
- Availability of anesthesia and personnel for emergency Cesarean delivery

**Contraindications to VBAC are:**

- Prior classical, T-shaped or transfundal uterine surgery
- Clinically contracted pelvis
- Medical or obstetric complication that precludes vaginal delivery
- Inability to perform emergency Cesarean section because of unavailable surgeon, anesthesia, sufficient staff or facility

There has been a tendency to expand the list of obstetric circumstances under which VBAC may be appropriate. However, further study is needed before VBAC is routinely adopted in these circumstances[6].

**Relative contraindications include:**

- Multiple previous Cesarean deliveries
- Unknown uterine incision or scar
- Breech presentation
- Twin gestation
- Post-term pregnancy
- Suspected macrosomia

*- continued on page 4*

*Vaginal Birth After Cesarean Section, continued from page 3*

1 Cragin EB. Conservatism in obstetrics. *NY Med J.* 1916;104:1-3.
2 The National Institutes of Health, The Cesarean Birth Task Force. National Institutes of Health consensus development statement on Cesarean childbirth. *Obstet Gynecol*. 1981:57:537-45.
3 Scheller JM. Nelson KB. Does Cesarean delivery prevent cerebral palsy or other neurologic problems of childhood? *Obstet Gynecol*. 1994;83:623.
4 Lagrew DC. Morgan MA. Decreasing the Cesarean section rate in a private hospital: success without mandated clinical changes. *Am J Obstet Gynecol*. 1996;174:184.
5 Scott JR. Mandatory trial of labor after Cesarean delivery: an alternative viewpoint. *Obstet Gynecol*. 1991;77:811.
6 American College of Obstetricians and Gynecologists Practice Bulletin, no. 5, July 1999. Vaginal birth after previous Cesarean delivery.

## Failed Trial of Labor Leads to Cesarean and Brain-Damaged Infant

**Case Report:**

A 25-year-old female presented to the hospital at term for delivery of her second child. Her first child had been delivered by Cesarean section. The physician recommended a planned Cesarean, but the mother expressed her desire to have the second child vaginally. Labor was induced with Pitocin, but after 12 hours, the patient was dilated only three to five cm. The physician then left the hospital. At 1:00 a.m., the patient was noted to be fully dilated. The Pitocin was stopped and the patient began to push for an hour. The fetal heart monitor then showed distress and bradycardia. The physician was notified and arrived 10 minutes later. The patient was taken to the OR for an emergency Cesarean section. On making the incision, the physician discovered that the uterus had ruptured at the previous Cesarean site and that the baby's head had emerged through the rupture into the peritoneal cavity. The anesthesiologist did not arrive until after the baby was born, and most of the procedure was performed under local anesthetic. The child suffers from cerebral palsy and a permanent vegetative state.

In addition to compensation for the child, the mother sought damages for emotional injury as well as pain and suffering based on the absence of general anesthesia. The mother further claimed that the physician was negligent in failing to advise her that she was not a proper candidate for vaginal delivery. There was no informed consent signed regarding the risks of VBAC, nor any documentation in the chart advising the mother of the risks of VBAC. She also alleged that the physician improperly monitored her progress and that after the fetal monitor signal was lost, an internal fetal scalp electrode should have been employed. The claim was settled for $1.75 million.

Common sense and clinical judgment are important factors in deciding whether trial of labor or repeat Cesarean is best in each specific case. **We offer the following risk management suggestions.**

- Follow the ACOG practice guidelines in patient selection for VBAC
- Inform the patient of the risks of a trial of labor. Thorough and factual educational counseling beginning early in the pregnancy should be documented in the prenatal record. The same information should be reviewed again later in the pregnancy, followed by a **detailed, informed VBAC consent document** prior to the trial of labor
- Labor and delivery of VBAC patients is safest in facilities where anesthesia, obstetric and blood bank personnel are **immediately** available at all times
- Adequate personnel should be present who are familiar with the potential complications of VBAC to watch closely for fetal distress and inadequate progress of labor
- Active, contemporaneous charting along with close monitoring of labor progression can be of great value in defending your care



MAG Mutual Insurance Co.
P.O. Box 52979
Atlanta, GA 30355-0979



PLEASE ROUTE THIS TO PHYSICIANS, OFFICE MANAGERS AND KEY PERSONNEL