Orthopedist Breaches the Physician-Patient Relationship by Failure to Communicate Urgent Pre-op Chest X-Ray Findings

By Michael J. Bono, MD, FACEP

The Case

A woman in her 60’s went to an orthopedic surgeon with complaints of the right hip, right leg, and back pain for a month. The patient’s history included: a 1-2 pack a day smoker; social; drinking, and Hepatitis C. The orthopedic surgeon diagnosed osteoarthritis of the right hip and pelvis, advising the patient she would eventually have to have a total right hip replacement.

Initially the patient underwent conservative pain management therapy without pain relief. Several months after her initial consult with the orthopedic surgeon, the patient was scheduled for a total right hip replacement. The surgeon obtained informed consent and ordered a pre-operative chest x-ray and EKG. The patient’s primary care physician faxed a medical clearance form to the PCP, where she declared the patient medically cleared with no further work-up. The PCP had not seen the chest x-ray report, the EKG, or realized the patient gave the radiology department technician a history of shortness of breath and hypertension, at the time his chest-x-ray was performed.

In her report the radiologist wrote, “bibasilar pulmonary nodules are present, rule out metastatic disease…chest CT recommended for further evaluation.” The report was faxed to the orthopedic surgeon’s medical assistant (MA) per the radiology department’s policy. The surgeon never reviewed the report, nor did his medical assistant make him aware of the abnormal findings. After the surgery, the patient complained to the hospitalist of chest pain, which was
worse with deep breaths. The hospitalist ordered a CT scan to rule out post-op pulmonary embolism (PE). The radiologist’s impression was “a tumoral pattern in the chest and upper abdomen with pulmonary hepatic retroperitoneal spread. No pulmonary arterial contrast filling defect to suggest PE; bilateral dependent pleural effusions with neighboring atelectic change, and background chronic liver disease”. Upon further work-up, the patient was diagnosed with end stage hepatocellular carcinoma and metastatic disease. Two months after her hip surgery, the patient died as a result of this disease.

Allegations

The plaintiff alleged both the orthopedic surgeon and his medical assistant breached the standard of care by failing to fully inform her of the radiology imaging results, and the radiologist’s recommendations, which would have allowed her to have made a decision about proceeding with the hip surgery.

Disposition

This case was eventually settled.

Patient Safety Discussion

The damages were limited in this case. In terms of the orthopedic surgeon’s role the delay in diagnosis of metastatic disease was only by a couple of weeks.

It appears the patient had an aggressive, advanced, cancer, and that the short delay in diagnosis did not make a difference in this patient’s outcome. However, case reviewers believed there was merit in the plaintiff’s allegations about the patient’s ability to have made an informed decision about whether or not to proceed with the hip replacement in light of her inoperable, metastatic cancer.

Radiology Communication

The radiologist and the hospital radiology department did adhere to American College of Radiology communication guidelines in ensuring that the radiology report was faxed to the surgeon’s MA. The radiology clerk stated he made a phone call to the practice prior to faxing the report to ensure the correct ordering physician, the correct fax number, and the name of the ordering physician’s MA. In addition, the clerk stated that per radiology department protocol, he spoke with the MA, advising the report was abnormal.

The radiologist and radiology department were not held liable in this case.

Medical Office Communication Systems

The surgeon admitted his MA did not notify him of the abnormal radiology report. Clearly the communication system involving the tracking, receipt, and review of reports and lab results, in particular pre-operative reports, was lacking in his office. Flawed medical office communication systems, such as illustrated in this case, are one of the root causes of medical malpractice cases[1]. Failed communications are the root cause of many malpractice cases we defend at MagMutual. The failure to report abnormal test results can lead to serious consequences for the patient, and that point is not arguable.

Physician Sign-off on Reports

Physicians have responsibility to ensure appropriate follow-up of test results for tests they ordered. Physicians also have the responsibility to take appropriate action, and follow-up with the patient with appropriate urgency. Evidence that the ordering physician has reviewed lab, imaging, diagnostic report results, or consultative reports, can be demonstrated by a signature on such reports. The ordering physician is expected to review and sign all of these reports prior to filing them in patients’ medical records. With the volume of reports medical offices and physicians receive daily; it is imperative that effective record keeping systems procedures be employed. We recommend physicians follow five routine procedures to keep patients informed about test results:
Ensure test results are routed to the responsible physician
Have the responsible physician sign off on the results
Promptly inform patients of all results, normal and abnormal
Document the patient was informed
Advise patients to call the office if they do not receive their test results within a certain time period.

In Summary

A reliable system of reconciling test results and coordinating care with other health care providers involved in the patient's care is a fundamental physician responsibility. When these processes fail, the risk of an adverse outcome is significantly increased. Even a simple process failure can have a significant impact.

MagMutual Patient Safety Consultants invite our policyholders’ questions. If you wish to discuss information presented in this Claim Lesson, or have other questions please call us at 1-800-282-4882.

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The case report presented is a composite drawn from MagMutual’s case files. Any similarity to a specific case is both coincidental and unintended.

References:


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