Lessons learned from failing to follow up

Good intentions don't compensate for faulty systems of tracking patients' needs

Stephen S. Entman, MD
Professor of Obstetrics and Gynecology, Vanderbilt University School of Medicine, Nashville, Tenn

The author reports no financial relationships relevant to this article.

Physicians are multitaskers. Every day, we balance the demands of patient care, the burden of regulatory mandates, and the needs of our families—and try to get adequate rest and recreation in the process!

As pressures upon us increase, we have begun to build teams and systems that ensure the kind of care our patients demand. We may not be able to deliver personal continuity to every patient, but a team can approximate that continuity—after it meets several key challenges. Foremost: developing systems of communication that are consistent, reliable, accurate, and accessible to any member of the team.

There is another locus in the continuum of care that is often neglected: post-event follow-up for medical, psychosocial, or legal purposes. The following case illustrates this point.

CASE A lawsuit is filed despite comprehensive care

C.S., a 34-year-old G4P3, at 35 weeks' gestation with suspected premature rupture of membranes, was referred to the tertiary-care center where I practice. She had reported a gush of fluid, and the referring physician had observed nitrazine-positive fluid at the introitus.

On initial speculum examination at the tertiary-care center, no fluid was observed coming from the cervix, and vaginal secretions were nitrazine-negative. The cervix was long, posterior, and patulous. Ultrasonographic examination of the uterus demonstrated a normal fetus of appropriate size for the reported gestational age and a maximum pocket of amniotic fluid greater than 10 cm in depth. The fetus was active, and the nonstress test was reactive. The patient's urine was alkaline; a specimen sent for culture was found to be negative.

Despite the reassuring clinical assessment, this mature multipara's description of events was credible. She was offered the option of overnight observation or amniocentesis with instillation of indigo carmine. Because her husband and 3 children would have had to stay in their car overnight if she remained in the hospital, the patient chose instillation.

Amniocentesis was performed under sonographic guidance, with a return of clear fluid. The fluid was sent to the lab for fetal lung maturity testing, which was negative. Ten cubic centimeters of indigo carmine dye were instilled, and a tampon was inserted. After 2 hours of ambulation, there was no dye on the tampon, and another nonstress test was reactive. The patient was discharged.

The next day, the patient reported to her family physician complaining of severe uterine pain, fever, and a loss of fetal movement. When fetal heart activity could not be detected by Doppler ultrasound, she

FAST *TRACK*

In a team setting, communication systems must be consistent, reliable, accurate, and accessible to any member

was again referred to the tertiary-care center. There she was noted to be in extreme pain, with a temperature of 104°F, and bulging forewaters. There was copious fluid and no fetal heart motion on ultrasonography.

Amniotomy elicited a gush of clear, blue, odorless fluid. The cervix dilated completely, and the fetal head was expelled to the chin. Examination revealed a nuchal and shoulder cord tightly wrapped and tethering descent. The vaginal wall was retracted, and the cord was visualized and divided. A stillborn male was immediately expelled, and the placenta followed rapidly. Bleeding remained within normal limits.

Although there was no explanation for the fever, the patient was treated with antibiotics during her postpartum hospital stay. She recovered quickly. Cultures from mother, baby, and placenta detected no organisms. The patient was discharged on day 4.

Ten months later, the patient filed a lawsuit alleging a failure to diagnose amnionitis at the time of the first visit.

What prompted the lawsuit?

Clearly, this patient had a tragic loss. Just as clearly, there were multiple incongruities between her clinical presentation and the outcome. The patient and the care team were both aware of these truths.

Research has demonstrated that physicians who interact in a positive manner with their patients are less likely to be sued than those who fail to communicate warmth and caring. Patients of physicians who have a history of multiple lawsuits may consider them knowledgeable and competent—but they also are likely to describe them as unavailable, abrupt, and disinterested. Patients often characterize their experiences with such physicians as negative even when the clinical outcome is good. This negativity often prevails even when the office staff is skilled in communication, education, and support.[1,2]

The team performed well

In the case of C.S., the physicians, by nature and by intent, were attentive to the human needs of this grieving family. Here is what we did well:

- The same residents provided care through both labor and delivery and during postpartum care
- The attending physician (me) was present through all clinical milestones
- All members of the team openly expressed their sorrow to the family
- I visited with the patient daily—providing honest answers to the family's questions and acknowledging gaps in the medical team's understanding of what had happened
- A follow-up plan was established to provide autopsy results to the family

At discharge, the family expressed appreciation for the team's efforts and caring.

So what went wrong? Why did the family—and the members of the care team—have to suffer the ordeal of litigation?

Critical lapse uncovered

Note the last bulleted item, above. This was the critical lapse: I did not call the family to relay the results of the autopsy. Why not? I knew better, after all, and prided myself on my commitment to all dimensions of the care I provided. As with most lapses in medical care, failure was multifactorial—part system design, part human failing.

At the tertiary-care institution in question, maternal transport high-risk pregnancies are managed with a group of attending obstetricians on a week-by-week rotational schedule. This provides continuity of care through the calendar week but, by its very nature, relieves the attending of the previous week from clinical responsibilities. By happenstance, the monthly rotation of residents coincided with this patient's hospitalization. Thus, no member of her care team had continuing direct responsibility for the OB service.

To complicate matters, I left town after the delivery for a conference, with vacation tacked on afterwards. When I returned to the office 10 days later, my head was refreshed but my memory had been purged, and I failed to follow through on my promise to contact the family.

CONTINUED

***FAST** TRACK*

Establish a plan to ensure continuity of care even when key team members are unavailable

Averting disaster: *4 ways* to ensure adequate follow-up

1. Build a solid foundation. We all know communication is important, but many of us fail to take the extra steps necessary to standardize communication so that the entire care team is apprised of the goals for a given patient—as well as exactly how much progress has been made toward those goals. Various systems have been designed to accomplish this aim, many of them derived from the aviation industry. A small investment in time can reap big rewards. A few examples:

- **"Time-out"**—A pause before an invasive procedure to confirm that you have the correct patient and will be performing the appropriate procedure.
- **"Snapshot"**—An overview of cases within a defined time period, including identification of the team's priorities. For example: "This morning we have 3 patients scheduled for surgery, beginning with Mrs. 'A,' whose hysterectomy for a large myomatous uterus will likely be time-consuming."
- **"Turn-over"**—A synopsis of cases at the time they are handed over to another team member or a different team. The information provided should include outstanding tasks and tests.
- **"De-brief"**—Time set aside after a case to discuss what happened, what could have been handled differently, and what the next steps are. These sessions provide immediate feedback to the team and influence the care of future patients.

2. Don't leave warmth and caring to your staff. The evidence is in: Physicians who interact in a positive manner with their patients are less likely to be sued than those who fail to communicate warmth and concern. Given the competing demands on our time, it is all too easy to rush through patient visits or other aspects of care without attending to the human component. Take a few minutes to greet each patient by name, inquire about her family and any concerns she may have about her condition, and listen attentively to her response. Then document any important details that arise during this discussion, so the rest of your team knows about them, too.

3. Offer and follow through on an evidence-based explanation of events. At times of tragedy, pay attention to the needs of grieving patients—and their families. This begins with an acknowledgment of the shock and sorrow they are experiencing and includes reassurance that the reasons for the adverse event will be explored and reported. This should not be an empty promise. It is important that the physician offers as full an explanation of an event as possible—as soon as all the facts are in—and that this explanation is voluntary, not something the patient has to ask for repeatedly.

4. Implement an effective tracking system. The case of C.S. (page 29) illustrates the need for a more comprehensive tracking system. In that case, my failure to relay the need for autopsy results to other team members, and my subsequent absence from the scene, allowed a critical detail to slip through the cracks.

Because patient files tend to be forgotten once they are stored away, a tickle file or similar system is a simple way to keep track of tests and communications that have not yet been performed.

***FAST** TRACK*

Physicians who interact in a positive manner with their patients are less likely to be sued than those who fail to communicate warmth and concern

About 3 months after the delivery, I overheard a secretary trying to calm a frustrated patient on the telephone. When I heard the secretary say, "I'm sorry, ma'am, but we just don't have the autopsy results, maybe you should call pathology," I realized which patient it was and took over the conversation. Abjectly apologetic, I promised to get the information for her within hours. The patient

CONTINUED

was reserved but accepted my offer.

The autopsy revealed a polymorphonuclear leukocyte infiltration throughout the body, but no organisms could be identified by culture or on histologic examination. The final pathologist's report provided no definitive explanation of the sequence of events that led to fetal death. When I explained this to the patient during a telephone call, her demeanor turned icy and she hung up. Several months later, the lawsuit was served.

To trial

The jury deliberated for 18 minutes after a 5-day trial, and returned a verdict for the defense. As one of the physician-defendants was leaving the courtroom, he overheard the patient's husband comforting her about the verdict. Her response resonated: "That's OK. All I wanted was to know the real reason Bobby died."

This was a painful way to relearn an important lesson. Although OB patients and their families file suit for any number of reasons, 20% state that one driving force is the need for information, and 24% believe a cover-up occurred.[3]

Further, although a defense verdict was returned, legal fees and lost time amounted to roughly $250,000 in costs—a substantial loss that a timely telephone call could have prevented.

***FAST** TRACK*

20% of OB patients who file suit do so primarily to obtain information, and 24% because they feel a cover-up has occurred

Loss of trust can be exponential

All the warmth the care team shared with this patient and her family during her hospitalization became irrelevant after the lapse in follow-up. The team let this patient down by failing to implement a system to track her human needs as well as her acute clinical issues. One individual's limitations of memory led to several years of anguish for a grieving family.

We have learned the importance of keeping track of Pap smear results, quad screens, mammograms, and other tests that have direct, acute impact on patient care, but many offices lack a system for tracking the fulfillment of other needs.

Such a system need not be complex. In this case, a tickler file would have sufficed—ie, a calendar or accordion file that contains individual reminders of tasks that need to be performed and the date they are required, such as the need to obtain results or to touch base about personal issues. (The reminder should also include patient contact information, to eliminate the need to look it up again.) If the results are delayed, the reminder can be refiled or reposted for the following week.

"Out of sight, out of mind"

Some of us have a photo of each patient taped to the inside front cover of her chart—along with her nickname, children's names, life-cycle events, and key personal information. These pieces are a prompt that allows us to humanize the relationship during office visits. That approach works well for the patient, and for us: We use the chart to make notes about the need for clinical and, perhaps, personal follow-up. But there is one fatal flaw: The chart has no value once it is put back in the file rack, where we won't see it when we need to act.

As we confront the complexity and demands of practice in the 21st century, we cannot rely on our intrinsic good character, good will, and good intentions. And we certainly cannot depend on our memory or trust that the documents that will direct us to our next step will land on our desk when we need them. We owe it to ourselves, our partners, and, most important, our patients to take the time to develop systems for the "miscellaneous" tasks that remind us when it is time to do the right thing. ■

References

1. Hickson GB, Clayton EW, Entman SS, et al. Obstetricians' prior malpractice experience and patients' satisfaction with care. JAMA. 1994;272:1583–1587.
2. Entman SS, Glass CA, Hickson GB, et al. The relationship between malpractice claims history and subsequent obstetrical care. JAMA. 1994;272:1588–1591.
3. Hickson GB, Clayton EW, Githens PB, et al. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA. 1992;267:1359–1363.