Lessons from Settled Malpractice Cases Involving Failed Physician-Nurse Communication

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Inadequate communication and documentation are often at the heart of events that prompt a medical malpractice lawsuit. When the miscommunication is between a physician and a nurse, it can give rise to conflicts of interest significant enough to alter the defense of the case. When the evidence to be presented at trial will make the presentation of a unified defense difficult (if not impossible), cases that would otherwise be defensible have to be settled, usually with both the physician and the nurse contributing to the settlement amount. The following examples are based on CRICO malpractice cases that were settled with payment.

Case 1: Who Knew What When?

An internal medicine physician treats patients who are in a rehabilitation/nursing facility. When the patient is transferred from the local hospital, the transfer papers include a discharge summary written by a physician, and nursing notes. The rehabilitation facility physician does not read the nursing notes; she only reads the discharge summary. No mention is made of any skin breakdown in the discharge summary; an ulcer is mentioned in the nursing notes. Because the patient is uncomfortable and in a brace, the rehabilitation facility physician does not turn the patient over to check her back and buttock area. On the initial physical evaluation form filled out by the rehabilitation facility physician, she checks off the box regarding full physical examination, including *having* examined the patient's skin.

The nurse assigned to this patient reads the nursing notes and knows this patient is developing a decubitus ulcer (which she has little experience treating). There is no communication between the physician and the nurse regarding the ulcer. The rehabilitation facility physician's office is called for medication (for the ulcer) and the nurse writes in the chart that the physician authorized the medication by verbal order. The nurse also records in the chart that the family, the dietician, and the physician are aware of the ulcer and its treatment. The wound continues to worsen. The rehabilitation facility physician learns the patient has an infection; the source is unknown to her. Because the infection is not responding to broad range antibiotics, the patient is hospitalized, and subsequently dies from septicemia.

Lessons

Do not create a record of events that did not take place; if part of an examination is incomplete, document what was not done and why. Defense counsel cannot defend a false medical record. This negative inference will taint the jury's overall impression of the defendant physician no matter how earnestly he or she tries to explain the circumstances.

Physicians are obliged to read nursing notes and talk with the nursing staff. At trial, the evidence would be that the physician sees a patient maybe once a day, but nurses are covering a patient 24 hours a day. Who better to ask and learn from than the 24-hour-a-day caregivers? Defense counsel does not want a jury to believe that the physician cannot be "bothered" to speak with and learn from the nursing staff.

Physicians should review office practices regarding dispensing of medications by verbal order without the physician's knowledge, no matter how "routine" the medications are that have been requested. A verbal order means the physician has authorized the medication request and he or she will be charged with that responsibility and knowledge. At trial, the nurse would have to testify that she had notified the physician—the proof being the verbal order for the prescription medications. In this case, the physician denies having been informed of the patient's condition despite the order. It is the jury that, ultimately, determines credibility; if this case went to trial, one, or both, of the defendants would lose.

Case 2: Counting on Each Other

Following surgery, the surgeon packs a neck wound and does not tell the nurse how many pieces of gauze were used. (The surgery was done emergently and late at night. The proper packing material was not available and gauze, if used, should have been counted and the count recorded.) The surgeon writes an order for dressing changes. The patient is seen post-operatively by other members of the physician's practice group, not the operating surgeon. The nursing staff unpacks and repacks the wound as ordered, without knowledge of how many pieces of gauze were initially used in the operating room to pack the wound. No count is kept by the nursing staff of the number of gauze pieces removed nor of the number used to repack the wound.

Weeks following surgery, the patient's complaints of pain are attributed to the chronicity of the patient's underlying medical condition and a slow recovery from surgery. The patient and the family become dissatisfied with the surgeon and seek a second opinion. The wound is re-explored and a piece of gauze is removed. It cannot be determined whether the gauze that was removed had been placed by the surgeon and not removed by the nursing staff, or whether the retained gauze had been placed and left by the nursing staff during subsequent dressing changes. The physician says wound dressing changes are a nursing responsibility; the nursing staff says their dressing changes were appropriate and the surgeon placed the gauze deep in the wound where it could not be visualized. Further,

they assert they did not know the number of pieces of gauze the surgeon originally used to pack the wound, as the surgeon did not record a count in the record.

Lesson

The bottom line is that a patient will be compensated for a retained foreign body and a jury could find all defendants liable because of finger pointing and the mutual lack of documentation and failure to communicate.

Case 3:

The patient (diabetic with no history of chest pain) is admitted for cataract extraction. The day after admission, the patient complains of chest pain. An EKG is read as showing no ischemic changes and no changes from a baseline EKG performed one year prior. The nurse writes in the chart that cardiac enzymes are to be drawn to rule out a myocardial infarction. There is no corresponding physician order, verbal or written, for cardiac enzymes and none is drawn. The patient continues to complain of chest pain and is given nitroglycerin. There is no documentation in the record of a physician having ordered nitroglycerin and no documentation of nitroglycerin in the medication administration record. There is no documentation in the record of the physician's evaluation of this patient for chest pain. The patient undergoes surgery and is discharged the next day. Four days later, the patient arrests at home and sustains anoxic encephalopathy.

The physician is charged with failure to order appropriate diagnostic testing and failure to examine the patient, as there is no documentation of such an examination. If the case went to trial, the nurse would testify that the physician gave either a verbal or telephone order for the administration of nitroglycerin after evaluating the patient. Without an order, the nurse is being charged with practicing beyond the scope of her license. The physician would testify that there was no notification from the nursing staff of the patient having any continuing cardiac complaints.

Lessons

In Case 1, it was recommended that a physician not document that an examination was performed when one never took place. In this case scenario, it is recommended that a physician document an examination, if one is performed, and the results of that examination. Remember: not written, not done. At trial, it is unlikely that a jury is going to believe a physician who tries to testify about a memory of an examination and the findings of the evaluation years after the event.

In this case, the physician claims the nursing staff did not inform her of the patient's ongoing cardiac complaints. The nurse would testify that the physician was informed of the patient's complaints, examined the patient, and gave an order for nitroglycerin. The case could be defensible had there been appropriate communication and documentation by both defendants; however with having neither, the case settles with contribution from both the physician and the nurse. ■