Communication is in the Eye of the Beholder

By J. Baugh, JD, CPA

Over the years, SVMIC has emphasized the importance of effective communication as it relates to providing medical care. The physician should attempt to effectively communicate with patients as well as with other healthcare providers. Patients sometimes claim after the fact that they didn't really understand the physician's orders, including what the physician recommended the patient should do as a part of the course of treatment. Communication between physicians is also important. SVMIC has had cases in which physicians reported that, if another physician had better communicated to them the condition of the patient, the course of treatment would have been different. The following case is one in which communication with the patient and with other physicians could have been improved.

Jennifer Smith [1]was a 33-year-old female patient who had a medical history which included a diagnosis of hydrocephalus for which a right ventriculoperitoneal shunt was implanted shortly after her birth. Ms. Smith had shunt revisions at 2 years and at 9 years of age. As a toddler, she was also diagnosed with epilepsy.

Ms. Smith began treatment with Dr. Mark Taylor, a neurosurgeon, and Dr. Edith Russell, a neurologist, in 2013 and 2014, respectively. They practiced in the same large multispecialty physician group. In November 2013, Ms. Smith saw Dr. Taylor for implantation of a Vagal Nerve Stimulator (VNS) to control her seizures. The procedure was performed later that month with no complications. Ms. Smith began seeing Dr. Russell in September 2014 for management of the VNS device and medication management.

In November 2014, Dr. Russell prescribed Ms. Smith an antiepileptic in order to reduce seizure activity. The drug proved effective, but in June 2015 the patient began experiencing blurred vision. Believing it was a side effect of the antiepileptic, Dr. Russell ordered the medication levels checked and instructed the patient to see an ophthalmologist.

In August 2015, Ms. Smith saw Dr. Russell in follow-up and she voiced new complaints of headaches, numbness, and double vision. She stated that she had seen an ophthalmologist who told her there was "something wrong" with her vision, but did not give an official diagnosis. Dr. Russell asked her office staff to request a copy of the patient's ophthalmology records, but this request was accidentally overlooked. Ms. Smith also stated that she had been to the ER twice for her headaches, and that the attending physician had been "worried about her shunt." Dr. Russell again urged the patient to follow up with an

ophthalmologist.

In September 2015, Ms. Smith called Dr. Russell's office and complained of continued headaches. The patient stated she had been to the emergency room due to the headaches and a lumbar puncture had been performed. She reported to Dr. Russell that she was still having headaches when sitting upright. Dr. Russell believed the patient was suffering from low CSF headaches from the lumbar puncture, so she advised Ms. Smith that she needed a blood patch.

Dr. Russell instructed the medical receptionist to schedule the patient for an office visit, blood patch, and labs. However, the medical receptionist could not locate the patient to relay that information or to make an appointment. The details of the communications are not clear, but Ms. Smith's husband called the clinic two days later and told the staff that he was taking his wife to a local hospital to get a blood patch. Dr. Russell thought that a blood patch had been performed, but found out later that it had not.

Soon thereafter, in early October 2015, Ms. Smith was seen again by Dr. Russell because she was nauseous and "passing out." She also had severe headaches with pain radiating down her back, right arm and leg. Dr. Russell performed a fundoscopic eye exam, and a visual field exam, and observed for the first time swelling around the patient's optic discs. She diagnosed the patient with papilledema and ordered an MRI, which showed the shunt in place with no hydrocephalus. Dr. Russell referred the patient to Dr. Taylor for evaluation of the shunt. She again told Ms. Smith she needed to see an ophthalmologist.

Ms. Smith was seen by Dr. Taylor in early November 2015. She voiced new complaints of difficulty walking and increased confusion. Her MRI and a shunt series X-ray were negative, so Dr. Taylor did not recommend surgery except "as a last resort." The next day, Ms. Smith was seen by Dr. Russell. She ordered a CT of the cervical spine to rule out nerve impingement as a potential cause of the headaches, neck pain and numbness. It was normal. The patient admitted she had still not followed up with an ophthalmologist. So, Dr. Russell referred Ms. Smith to Dr. William Miller, an ophthalmologist who worked at the same clinic, to be evaluated for vision issues.

Dr. Miller saw Ms. Smith in early December 2015 and he confirmed the diagnosis of papilledema. He referred the patient to the ER of a local hospital for imaging studies and possible shunt revision. Imaging studies showed the shunt was in good position with no intracranial processes, no disconnection, and no complication. However, given Ms. Smith's symptoms, she was admitted for shunt revision surgery.

Dr. Taylor performed surgery for "likely shunt malfunction" on December 9, 2015. According to Dr. Taylor's operative note and personal reflection, the shunt appeared to be working properly and was not causing any problems. However, a pre-operative MRI showed some sluggish flow; therefore, out of an abundance of caution, Dr. Taylor decided to replace the entire shunt. There were no intraoperative complications and no mention of the shunt malfunctioning. After the uncomplicated shunt replacement, Dr. Taylor told the family that he had cut the old shunt in two places to remove it; they later claimed that he

said the shunt was broken in two places.

Ms. Smith recovered well from surgery, and her headaches decreased. However, her vision continued to worsen. As of May 2016, she was almost completely blind in her left eye and had 20/30 tunnel vision in her right eye.

Ms. Smith filed a lawsuit against Dr. Taylor, Dr. Russell, and their clinic. The lawsuit alleged that Dr. Taylor and Dr. Russell failed to timely act upon signs and symptoms of alleged shunt malfunction in October and November 2015, causing the plaintiff to suffer irreversible vision loss in both eyes. The plaintiff's claim against the clinic was that it failed to have proper procedures in place to facilitate communication between physicians and to ensure timely procurement of outside medical records. The plaintiff disclosed a neuro-ophthalmologist and a neurologist as expert witnesses in the case. Both of the plaintiff's experts were critical of the care and opined the papilledema should have been urgently addressed to prevent loss of vision. The plaintiff also disclosed a practice administrator as an expert witness who stated in her disclosures that the clinic failed to have appropriate policies and procedures or a proper EMR in place to ensure Ms. Smith's relevant ophthalmologic history was known to her providers, to ensure she was timely evaluated by an ophthalmologist, or to facilitate communications between the clinic's neurology and neurosurgery departments. As a side note, after the suit was filed and all of the patient's medical records were obtained through the discovery process, Dr. Russell learned that the patient had seen an optometrist in 2015 – not an ophthalmologist.

Dr. Russell felt the patient's papilledema was a chronic condition rather than an acute condition, which would have been a situation in which time was of the essence. When Dr. Russell made the diagnosis of papilledema, an appointment was made with Dr. Taylor, whose office is across the hall from Dr. Russell's office. Dr. Taylor testified in his deposition that he was not aware of the papilledema diagnosis when he assessed Ms. Smith, and if he had been aware of the diagnosis, he would have referred Ms. Smith to an ophthalmologist.

The defendants had a difficult time finding expert witnesses who were fully supportive of the medical care provided by Dr. Taylor and Dr. Russell. The potential defense expert witnesses felt that Dr. Taylor and/or Dr. Russell deviated from the standard of care by not acting in a timely manner after the diagnosis of papilledema. Another expert thought that the presence of headaches and visual changes should have been considered indicative of a shunt malformation until proven otherwise. Because the flow through the shunt was sluggish, intracranial pressure was building over time.

Our causation defense was bolstered by the fact that Ms. Smith contributed to her injuries by not being cooperative in her care and by self-managing her medications. She failed to see an ophthalmologist as ordered, she failed to take her medications as ordered, and she was generally difficult to get in touch with. She had multiple family members making calls to the office on her behalf, who relayed less than accurate information at times. However, it was undisputed that Ms. Smith's vision loss was most likely caused by papilledema, which was caused by increased intracranial pressure, which caused permanent damage to the

optic nerves sometime in November 2015.

If the communications between the physicians and the patient and the communications between the physicians themselves had been clearer in this case, the patient's loss of vision might have been avoided. The patient testified in her deposition that she did not know the difference between an ophthalmologist and an optometrist. Explaining the difference in those terms might have improved the patient's outcome. Making the referral to the ophthalmologist within their own clinic in a more timely manner may have improved the patient's outcome. Also, Dr. Taylor testified in his deposition that he did not know of Dr. Russell's diagnosis of papilledema when he began treating the patient. Explaining the reason for the referral to Dr. Taylor might have also improved the patient's outcome. Given the breakdown in communications and the patient's medical condition, a mediation was scheduled to try to resolve this case. A settlement was reached at the mediation. Improved communications with the patient and between the physicians might have improved the patient's outcome and may have avoided the loss payment made in this case.

[1] All names have been changed.