Every defect is a treasure

Quality problems that result in adverse outcomes provide opportunities for quality improvement.
A series based on actual examples of care.

Communication and coordination of care among providers

A patient under treatment with clozapine for chronic paranoid schizophrenia dies of overwhelming sepsis.

A 48-year-old male seeks treatment for chronic paranoid schizophrenia. His psychiatrist recommends clozapine and discusses the risks and benefits of the drug with the patient, especially noting the relatively high incidence of agranulocytosis. The patient agrees to the treatment. He understands the clozapine prescription must be renewed weekly, and that renewal is contingent upon satisfactory white blood cell counts.

The patient is highly motivated and follows the medication instructions closely. The few times he is unable to keep his psychiatric appointment, he sees his internist instead for the necessary blood work. The internist then faxes the test results to the psychiatrist.

Sixteen months into the treatment the patient presents to a hospital emergency department complaining of lower abdominal pain and urinary retention. He is admitted, treated for fecal impaction, and discharged the next day. Three days later, he cancels his psychiatric appointment due to continued bowel problems. He reschedules the appointment for later in the week, and reports that his internist is overseeing his care. However, after another 2 days pass, the patient again calls the psychiatrist saying he does not feel well enough to come in for his weekly blood work. The internist instructs the patient to have his internist order the tests. The patient calls the internist’s office that same day and reports a reduced appetite, intake of magnesium citrate, and a small bowel movement.

The internist examines the patient the next morning and finds his abdomen protuberant and diffusely firm; he is unable to palpate the liver or spleen. He notes in the medical record that the patient continues to suffer from fecal impaction. He instructs the patient to restart the magnesium citrate, to telephone the office in 3 days to discuss his status, and to schedule another appointment in the following week. He orders both a complete blood count and white blood cell count, the results of which are to be faxed to the psychiatrist. Because the internist is subsequently unavailable, a practice partner covers for him until the office closes, explaining in lay terms to patients.

Effective informed consent, as illustrated by this physician–patient discussion, enrolls the patient in the decision-making process and may increase the likelihood of compliance with a treatment regimen. Of course, medical concepts such as agranulocytosis should be explained in lay terms to patients.

Over-reliance on a previous diagnosis without considering new information — including the fact that a condition has not responded to treatment as predicted — can lead to error. Documenting the rationale for an initial diagnosis, as well as the bases for confirming or ruling out others, can facilitate reconsideration of the matter as time passes and additional treatment options are pursued.

In the event of abnormal clinical findings, the provider’s response should be commensurate with the risk indicated by the results. A potentially fatal infection warrants direct communication among providers rather than reliance on the patient to both understand and transmit abnormal test results to other treaters.

It is helpful to educate office staff about handling telephone calls and to review periodically the principles of telephone triage. Some staff members may be inclined to ‘protect’ providers from telephone calls; others may over-refer, passing along calls that could be handled more efficiently by administrative staff. In addition to training staff to refer calls appropriately, physicians should make an extra effort to be clear when communicating special or unusual instructions. Misunderstandings can be avoided, for example, by asking staff members to describe what they will do when a particular situation arises.
after which a physician from another practice provides coverage.

The same day, the psychiatrist receives a fax from the internist’s office showing an elevated white blood cell count (21 500/µl). He promptly contacts the patient, urging him to see the internist immediately. He explains that the infection could be fatal if untreated. The patient says he feels better and doesn’t have a fever, but he agrees three separate times during their conversation to see the internist. He calls the internist shortly thereafter, and is told the physician is not in the office. The covering physician is not notified.

One day later, a mental health aide visits the patient at his home and she encourages him to go to the hospital. Again reporting an improvement in his symptoms, the patient declines. Two days later the patient agrees to an emergency visit, but he dies on the way to the hospital as a result of sepsis secondary to peritonitis.

The patient’s family sues the internist, the internist’s practice group, and the psychiatrist, alleging failure to diagnose and wrongful death. The internist settles the case out of court and the family drops the suit against the psychiatrist.