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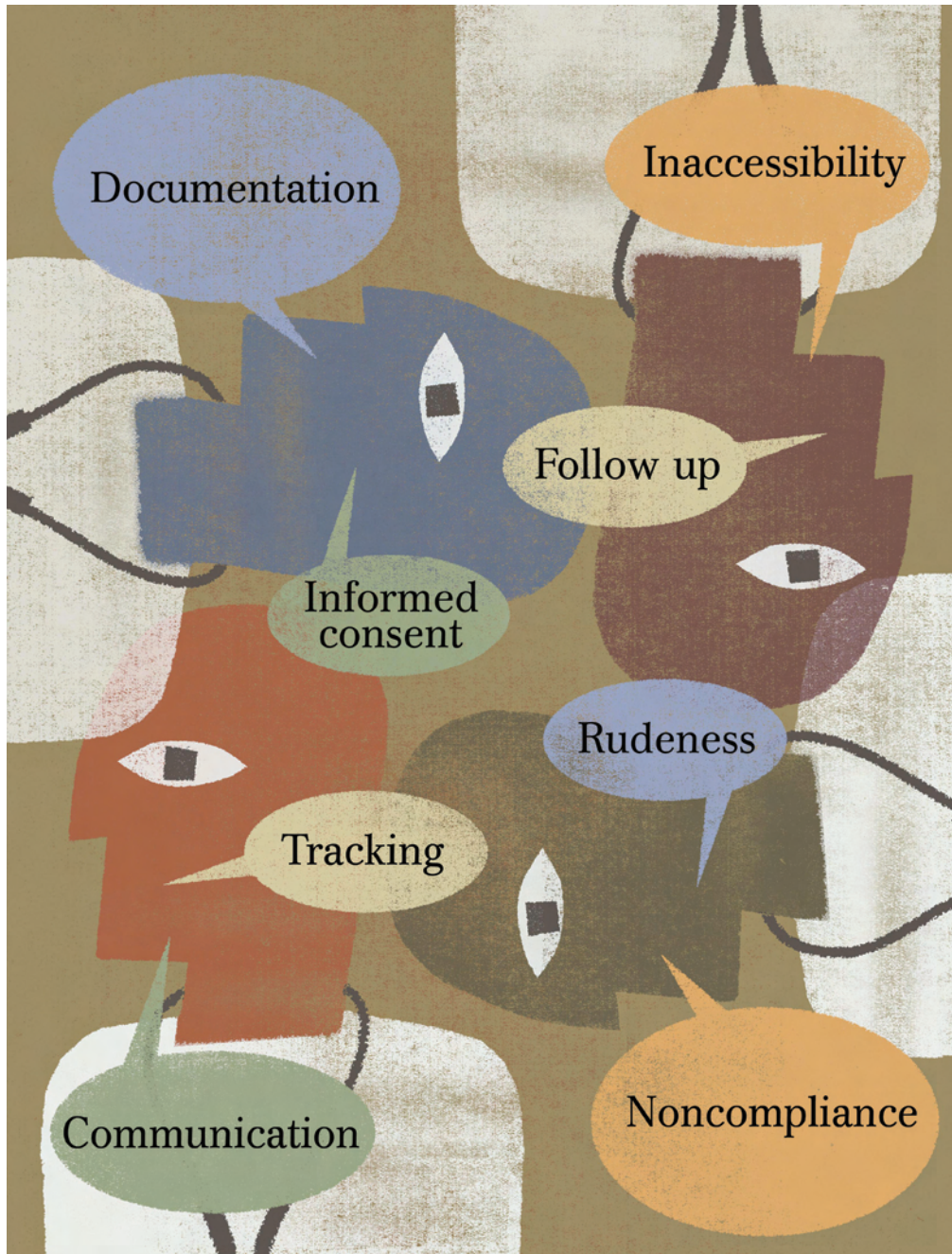
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10 things that get physicians sued



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These closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. These cases illustrate how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting these cases is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

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Not all medical liability suits filed against physicians are prompted by medical errors. Patients often cite interpersonal aspects of care, such as poor communication or feeling rushed, as central to the decision to initiate litigation.¹

“Patients do not necessarily file lawsuits because they believe they were harmed by a medical error. They sue because they believe they were harmed by a medical error and something else happened during their care,” says Jane Holeman, vice president of risk management at TMLT.

This publication will describe 10 common errors that can increase the risk of a malpractice suit, and offer risk management techniques to address these issues. Included with each error is a TMLT closed claim study that demonstrates how the error led to a lawsuit alleging medical liability.

1 Failing to listen to patients, spend adequate time with them, and communicate empathetically with them

Research on why patients sue physicians has repeatedly shown that basic interpersonal skills such as listening and showing respect can be just as important as clinical skills in preventing lawsuits.¹ However, given the time and economic constraints placed on physicians, it is easy to see how these skills can become overlooked.

“Eye contact and attentive listening are important and can go a long way toward building a relationship with the patient,” says Jill McLain, senior vice president of claim operations. “And patients who have a good relationship with their doctors will be less likely to sue if a bad outcome occurs.”

According to Holeman, a key factor in patient satisfaction involves the quality of time spent with the physician, not just the quantity. “Short visits can be effective if the physician will sit down, listen to the patient, and ask the appropriate questions. If the physician spends the entire visit with his or her hand on the doorknob, the patient may feel rushed and may not give complete information to the physician. This is inefficient for everyone,” Holeman says.

But many physicians rightfully ask, “how can I improve a patient’s perception of a satisfactory visit when time is limited?” Holeman offers the following tips.

- Schedule appointment time based on patients’ needs.
- During the appointment, spend time connecting with patients via non-medical conversation.
- Before patients are in the exam room, have them complete a form (see sample on page 5) that prompts them to state the reason for their visit.

Closed claim study: alleged failure to recognize prescription drug abuse

Presentation

A 35-year-old woman came to a family practice clinic on July 31 with complaints of right arm and finger numbness and neck pain. She had a history of lumbar surgery six years ago and lumbar fusion five years ago. The patient also reported that she was seeing a psychiatrist for anxiety, depression, and mood swings. She was currently taking Paxil 40 mg and Thorazine 150 mg. The patient stated that her neck felt like her back did before the fusion.

Physician action

A physician’s assistant (PA) examined the patient and found that she was tender on palpation of the cervical vertebrae and shoulder with a tight trapezius muscle. She was noted to have decreased range of motion of the neck and decreased right arm strength. The initial assessment was neck pain, shoulder pain, neuropathy, and muscle weakness to the right arm. She was prescribed a Medrol dose pack, Darvocet for pain, and Soma for muscle spasms. The office scheduled an MRI of the cervical spine on August 5.

On August 1, the patient called the office complaining of pain. Another PA, with the approval of the supervising physician, called in a prescription for Lortab 10/500 #20 for the patient. The patient did not keep her appointment for the MRI that was scheduled on August 5. On August 6, the patient was

Today's visit

Patient's name _____ Date of birth _____

Main reason for today's visit:

Other concerns I would like to discuss if there is time:

Please check all that apply:

I have prescriptions to be refilled I need the attached forms filled out
 I need a school or work excuse I need a referral for my insurance company

This form can help prompt patients to state the reason for their visit.

prescribed Phenergan, Soma, and Lortab, but Family Physician A denied the request for Darvocet. The patient again called and obtained refills for Phenergan, Soma, and Lortab on August 9.

On August 12, the patient called for refills — Lortab, Soma, Restoril, and Paxil were prescribed with the understanding that no more medications would be prescribed until her MRI was completed. Office staff then contacted the patient's psychiatrist to determine what medication he was prescribing for the patient. The psychiatrist would not respond to their call or fill out the medication form that was sent. The psychiatrist noted that the patient had signed a form that would not allow him to release any information about her care and treatment.

The patient failed to show for the MRI that was scheduled for August 19. When she called on August 23 seeking a refill for Soma, Family Physician B denied the request because the patient had not obtained the MRI.

On August 23, the MRI scan of the cervical spine showed a large right paramedian disc protrusion at C6-7 with a mild impression on the anterolateral aspect of the spinal cord. There was also a large paramedian disc protrusion at C5-6 producing mild neuroforaminal stenosis and pressing upon the right anterolateral aspect of the cord. The MRI results showed changes that would explain the patient's pain. On August 26, Family Physician B called the pharmacy to approve another 5-day supply of Phenergan, Lortab, and Soma.

The patient called the office on August 28 stating that her pain medications were not strong enough. Family Physician B requested that she return to the clinic for a follow-up visit. The patient came that day and complained of neck pain and numbness in the right arm. Family Physician B performed a complete physical exam. He noted that her right arm was weaker than her left, and the right trapezius muscle was tender to palpation. The patient mentioned that Darvocet had not helped her in the past; but Oxycontin had provided relief. The physician diagnosed cervical disc disease, hypertension, and fatigue. He prescribed 40 mg of Oxycontin to be taken twice daily; one Soma every six to eight hours; and for her to keep a log of her blood pressure. Additionally, he noted that he would schedule an appointment with the neurosurgeon for September 26. He ordered a follow-up visit in two to three weeks for a blood pressure check.

At this visit, Family Physician B specifically remembered telling the patient not to take other medication when she took Oxycontin. He also remembered telling her to begin by taking only one pill per day though he wrote the prescription for two pills per day. He recalled providing specific patient education about the risks of Oxycontin.

On September 1, the patient called the clinic complaining of pain. The prescription for Darvocet was refilled to treat the patient's breakthrough pain. The patient's psychiatrist prescribed a 30-day supply of Restoril to the patient on September 2.

The following day, the patient's husband found his wife in the garage passed out and covered in urine. He explained that since he found her at 2 a.m., he thought her condition was a side effect of drowsiness. Neither the patient nor her husband notified any medical providers of this incident.

On September 5, the patient was found dead by her minor children on their return home from school. The medical examiner found that the cause of death was an accidental mixed-drug overdose from Oxycontin and Darvocet. The pathologist stated that he believed the patient consumed Oxycontin and Darvocet well in excess of the instructions in the prescription, and that this was not a case of accidentally taking an extra pill or two. He did not believe it was a suicide because the patient did not consume all the pills from the bottle or leave a note. The cause of death was also not a homicide or natural, so he was left with accident as the only choice when completing the death certificate. Based on the toxicology results, the patient took at least 8 to 10 Oxycontin and at least 6 to 8 Darvocet on the morning of her death.

Allegations

Lawsuits were filed against Family Physician A, Family Physician B, and their practice. The plaintiffs alleged that the physicians failed to realize that the patient was a drug abuser and should have taken steps to place the patient under long-term pain management care.

Lawsuits were also filed against the psychiatrist, the pharmacy and pharmacist who filled the patient's prescriptions, and the physician's assistant at the family practice clinic.

Legal implications

Defense experts fully supported the actions of the family physicians in this case. The patient suffered from physiologic pain brought on by injuries to her cervical and lumbar nerves and her spinal cord. When faced with a patient with clear-cut MRI evidence of a lesion that is capable of causing severe pain, it was appropriate for the family physicians to rely on what the patient said would relieve her pain. The patient required strong pain medication, such as Oxycontin, because other medications failed to relieve her pain. The physicians made a good faith effort to treat the patient and did meet the standard of care in trying to manage a difficult situation.

Regarding causation, the defense argued that the patient took a huge dose of medication, well in excess of that prescribed by the defendants. If she had taken the drugs as prescribed, she would not have died.

During the investigation of this case, it was discovered that the patient had a history of prescription drug misuse dating back more than five years. Her medical records clearly showed that she would manipulate physicians into giving her pain medication and when they finally refused, she would go to another physician. About one month before the patient came to the defendants' clinic, she was dismissed by a neurosurgeon for lying about medications and abusing her medications. Unfortunately, the family physician defendants did not know about the patient's history because she purposefully failed to disclose her previous three treating physicians. She also told her psychiatrist that he could not disclose anything to other medical professionals.

The plaintiffs retained an expert in pain management who supported their allegations. He argued that the family physician defendants should have diagnosed the patient as an addict and initiated an involuntary commitment. However, he could not explain why involuntary commitment was warranted or point to any evidence that the family physicians should have been aware of her addiction. This expert also stated that the results from the MRI mandated an emergency referral to a neurosurgeon. Defense counsel pointed out that the radiologist who read the study did not describe her condition as an emergency or note spinal cord involvement.

The plaintiff's pharmacology expert testified that his primary concern was not with the prescriptions that were given, but with the number of pills that the patient was allowed to receive. He stated that she should not have been permitted to obtain a 30-day supply of Oxycontin. This expert agreed that the patient's early refill requests could easily be explained by "misuse" of the medication and not "abuse." He conceded that the family physicians appropriately used the "carrot and stick" approach by denying the patient refills when she did not obtain the MRI and making sure refills were on time and not early. Further, he agreed that the patient's conduct was noncompliant, unreasonable, and a component that caused her death.

Another weakness in the plaintiff's case involved the actions of the patient's husband (a plaintiff in the case) when he found the patient passed out in the garage. He did not take her to the emergency

department or notify any of her treating physicians. The plaintiff's own expert described this as negligence on the part of the husband and agreed that health care professionals would likely have intervened had this episode been brought to their attention.

Disposition

At the conclusion of the plaintiff's presentation of evidence during the trial, the defense attorney made a motion for directed verdict. The judge granted the motion, concluding that the plaintiffs did not meet their burden of proof that malpractice occurred in this case. (A directed verdict is an order from the judge that one side or the other wins the case. After a directed verdict, there is no longer any need for the jury to decide the case. Motions for a directed verdict are rarely granted as judges tend to let the jury make the decision on whether or not the standard of care was violated.)

At the end of trial, defense counsel interviewed jury members. Those interviewed indicated that they felt the patient's death was an unpredictable suicide and was not due to any fault of the defendants.

Risk management considerations

Documentation was a weakness in this case. There was no mention in the medical records that the patient was warned not to mix Oxycontin with other substances nor were there notations for her to stop previously prescribed medications. Family Physician B testified that he remembered appropriately educating the patient about the dangers of Oxycontin, but he did not document this in the record. Two expert reviewers also noted that though the patient had a clear history of depression, there was no documentation by Family Physician A about her depression history or whether she was at risk for intentional overdose. Thorough documentation would have greatly benefited the physicians in this case.

When viewed retrospectively, the patient's actions — requesting early refills, delaying the MRI, requesting stronger pain medication, asking for a specific pain medication — could be viewed as “red flags” for drug misuse or abuse. Conversely, these actions could also be justified because the patient had significant pain, according to objective, diagnostic evidence. The defendants appropriately provided the patient with pain medication to support her until she could see a neurosurgeon. Physicians in similar situations can have patients sign a contract consenting to the pain management therapy as directed by the physician. The agreement is intended to protect the patient's access to appropriate controlled substances and to protect the physician's ability to prescribe for the patient in pain.

The patient reported her mental health status, including medications prescribed by a psychiatrist. Had the physicians' clinical interview skills been based on building a partnership, exchanging information, and shared decision making, this patient's fragile status may have been recognized. Active listening, trying to get to the patient's perspective, focusing on her emotions with empathy may have identified the need to intervene more assertively in the management of her pain. This type of conjecture after the outcome provides an opportunity to reflect on one's communication skills and identify areas for improvement.

2 Maintaining illegible or incomplete documentation

Accurate, legible, and complete documentation can be the best defense against a malpractice claim. What would your medical records look like to another physician, a plaintiff's attorney, or a jury? Poor documentation practices can impede care and may signal to the patient that the physician is careless or does not care to follow the patient closely.

“Poor documentation alone will not generally send a patient to an attorney, but could lead to a suit once the attorney sees the records,” McLain says. “Poor documentation also makes the case more difficult to defend.”

Physicians should also be aware that the Texas Medical Board can discipline physicians if their medical records are incomplete or illegible. The rules for medical records as governed by the TMB include the word “legible” in their description of an adequate medical record. The TMB rules for medical records are as follows:

“165.1. Medical Records

(a) Contents of Medical Record. Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an “adequate medical record” should meet the following standards:

- (1) The documentation of each patient encounter should include:
 - (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - (B) an assessment, clinical impression, or diagnosis;
 - (C) plan for care (including discharge plan if appropriate); and
 - (D) the date and legible identity of the observer.
- (2) Past and present diagnoses should be accessible to the treating and/or consulting physician.
- (3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
- (4) The patient's progress, including response to treatment, change in diagnosis, and patient's non-compliance should be documented.
- (5) Relevant risk factors should be identified.
- (6) The written plan for care should include when appropriate:
 - (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
 - (B) any referrals and consultations;
 - (C) patient/family education; and,
 - (D) specific instructions for follow up.
- (7) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
- (8) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
- (9) Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.
- (10) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient's status. Paragraphs (1)-(10) of this subsection may be modified to account for these variable circumstances in providing medical care.”²

Another documentation pitfall involves “correcting” medical records after an unexpected outcome or notice of a claim. Altering the medical record after the event — even if you believe the information will assist in your defense — is detrimental. An addendum to the medical record may be allowed if done in a timely manner and clearly identified. Include the date and time, a reference to the date and time of the actual encounter, reason for the addendum, the added information, and author's signature.

“Remember that part of good patient care is maintaining complete and legible documentation that is available for review by the primary physician and any consultants,” McLain says.

Closed claim study: failure to perform adequate preoperative evaluation

Presentation

The patient was a 37-year-old woman with a history of severe sickle cell anemia. Her frequent sickle cell crises resulted in multiple organ dysfunction, including the liver, kidneys, and brain. Poor IV access led to insertion of central lines and port-a-caths. She suffered from edema of the head and neck secondary to superior vena cava syndrome. The patient also had sleep apnea, hypertrophic tonsillitis, and a history of congenital deafness. She used sign language to communicate.

The patient's primary care physician documented that she had multiple episodes of respiratory distress and hypertrophic tonsillitis. It was recommended that the patient have a tonsillectomy to prevent upper-airway obstruction and the edema of her head and neck.

Physician action

The patient arrived at the hospital at 7:30 a.m. for a tonsillectomy and removal of her non-functioning port-a-cath. With the assistance of the nursing staff and her father, the consent, the medical history, and the “anesthesia patient evaluation” forms were completed at 8:10 a.m. There were no time notations as to when the patient was visited or when the forms were reviewed by the anesthesiologist, the defendant in this case. An anesthesia form signed by the defendant indicated that the pre-anesthesia form was reviewed, and that the patient was identified, interviewed, and examined. The anesthesiologist gave the patient an American Society of Anesthesiology (ASA) score of 3.

The patient was taken to the operating room at 9 a.m., and the surgery began at 9:18 a.m. The anesthesia record showed that anesthesia was started at 9 a.m. and ended at 11 a.m. Anesthetic agents included midazolam 2 mg at 9 a.m.; propofol 100 mg given at 9 a.m.; succinylcholine 100 mg given at 9:15 a.m. and again at 9:45 a.m.; and fentanyl 50 mg given at 9 a.m. and 9:45 a.m. Sinus rhythm was recorded at 10:15 a.m. and then no rhythm was recorded. The heart rate remained in the 80s until 10 a.m., but then dropped to the 70s. Blood pressure was maintained at 110/50-60 mm Hg until 10:15 a.m., but then dropped to 70/30 mm Hg. The patient was extubated (time not recorded) and transferred to the PACU.

A nurse and the anesthesiologist noted that the patient became apneic at 10:25 a.m. A code was started and the patient was bagged and reintubated by the anesthesiologist at 10:28 a.m. Chest compressions were started at 10:30 a.m. The patient was successfully resuscitated and the code was stopped at 10:45 a.m.; however, the patient developed severe hypertension and remained comatose. At 10:50 a.m., arterial blood gases were pH at 7.047; pCO₂ at 104.5; and pO₂ at 145.7.

The patient was admitted to the ICU at 11:45 a.m. The general consensus among her physicians was that she suffered an anoxic brain injury. She remained comatose and died three weeks later.

A review of the records in this case revealed a time discrepancy during the recovery period. The nurse's notes from the recovery room begin at 10:25 a.m. The print out of the rhythm strips and the blood pressures that are included with the postoperative nurses' notes also occur at 10:25 a.m. This is in conflict with the times recorded on the anesthesia record that place the end of the procedure at 11 a.m. The recovery room nurse documented at 10:25 a.m. "patient in room with anesthesia doctor and operating room nurse. O₂ sat not obtainable. Sinus bradycardia rate 40-20 bpm. Oral airway inserted by doctor Ambu bag applied."

On the anesthesia patient evaluation sheet, the anesthesiologist wrote "uneventful anesthesia and recovery. Bigeminy. PS-patient had to be reintubated and ventilated until she was able to breathe on her own, post-resuscitation."

Allegations

A lawsuit was filed against the anesthesiologist and his professional association. The allegations included negligence and failure to perform adequate preoperative evaluation; failure to maintain peripheral IV access; failure to adequately ventilate; failure to monitor changes; failure to timely respond to changes; and failure to correct hypoxia and acidosis.

Legal implications

The major clinical features of sickle cell anemia are chronic hemolytic anemia, recurrent pain in the extremities, abdomen, and back, and a predisposition to thrombosis. Red blood cells from patients with sickle cell disease assume a sickle-like shape upon deoxygenation.

The plaintiff's anesthesiology expert stated that the defendant breached the standard of care in a number of ways. According to this expert, the defendant should have known that a patient with sickle cell anemia, sleep apnea, and limited peripheral access would require very close observation, and present venous access and airway management problems. The defendant failed to plan for these problems. He also stated that the defendant extubated the patient before she was completely awake and before she could protect and maintain her airway. Further, the patient was clinically unstable during transport to the PACU, and the defendant failed to recognize her symptoms of inadequate ventilation after extubation. The defendant should have immediately reintubated the patient, and this would have avoided her subsequent pulmonary arrest and her severe anoxic brain injury.

The plaintiff's expert was also critical of the defendant's documentation, stating "A sloppy, poorly documented anesthesia record connotes a sloppy, poorly planned and managed anesthesia!"

An anesthesiologist who reviewed this case for the defense stated that the defendant was not familiar with the complexity of the patient's condition and was "caught off guard." No true preoperative consultation was completed in the records, and the usual anesthetic options were not evaluated for the patient or documented. He was also critical that the defendant used 40% oxygen mixture and only 1000 cc of fluid hydration, no temperature monitoring, and seemed to give little consideration to the problems related to her superior vena cava syndrome. The patient ended up in a sickle cell crisis with hypotension and hypoxemia.

Other anesthesiologists who reviewed this case for the defense were critical of the defendant's lack of documentation, decision to extubate the patient in the OR, and the fact that he gave the patient an ASA score of 3.

Disposition

Due to the lack of expert support and documentation issues, this case was settled on behalf of the anesthesiologist.

Risk management considerations

According to one anesthesiologist who reviewed this case, when providing anesthesia for a patient with sickle cell anemia, the challenge is to keep that patient from going into crisis. "One has to consider maintaining hydration, normal thermia, good blood flow, avoidance of tourniquets, positioning, and especially oxygenation . . ."

The physician's most powerful tool for communication is the patient medical record. In reviewing this case, the experts agreed that the lack of documentation by the anesthesiologist contributed to the difficulty in defending the case.

This case also highlights the need for a physician to thoroughly document a patient history and his or her own thoughts and actions. It is vital that physicians be aware of the symptoms and patterns that a patient has been experiencing — information often best gathered via a complete medical history and a thorough exam.

In evaluating this case for the defense, consultant anesthesiologists questioned the defendant's designation of an ASA score of 3 for this patient. There was also concern about the defendant's ability to assess and respond to the inherent problems of providing anesthesia for a patient with sickle cell anemia.

3 Failure to establish standards of conduct for office staff

Rude behavior by office staff and a bad outcome may be all it takes to initiate a lawsuit — even if the rudeness and the bad outcome have nothing to do with each other. These behaviors can include rudeness, insensitivity, or inattention to patients.

To address this problem, develop a policy and procedures manual for the practice. This manual can ensure that staff act in accordance with the policies in place. A policy and procedures manual can also reinforce staff accountability and serve as a staff orientation tool.

"Staff must be adequately trained and monitored," Holeman says. "Make them aware of the policies and procedures through regular training. Document this training and address unacceptable behavior when you see it." Maintain an office culture that is patient friendly. To evaluate the "friendliness" of your practice, consider using patient satisfaction surveys or have a friend or colleague call or visit and report the experience to you.

Closed claim study: failure to diagnose myocardial infarction

Presentation

A 51-year-old man came to the emergency department (ED) of a regional medical center at 2:55 p.m. on Thursday. The patient had previously been seen at his employer's health clinic for complaints of mild chest pains, right arm pain, left arm pain, and thigh pain. Before that visit, the patient had played one hour of tennis, which he did each day. His employer's clinic called his family physician who instructed him to go to the ED immediately.

Physician action

The triage nurse at the ED reported that the patient was complaining of chest tightness since 10 a.m. and joint discomfort. The discomfort worsened with activity. His initial vital signs were: blood pressure, 151/101 mm Hg; pulse, 106 bpm; respirations, 22. He was placed on a monitor and pulse oximeter, and was noted to be in no acute distress.

An emergency medicine physician examined the patient at 3:25 p.m. He noted the patient was in mild distress, but was otherwise asymptomatic. When specifically questioned by the physician, the patient refused to use the term “chest tightness” for what he had experienced, but rather called it a “chest sensation.” He told the physician his symptoms had started the day before, and that he had a physical completed by his family physician one month earlier. He reported that he took no medications, had no prior surgeries, and borderline high blood pressure. He played tennis for exercise, did not smoke, but drank beer.

The physician completed a thorough physical exam, and the results were normal. He ordered a monitor, chest x-ray, pulse oximeter, oxygen, a heplock, and lab work including a CBC, UA, Chem7, cardiac enzymes, and PT/PTT. He ordered two baby aspirin to be given during the work-up. The physician’s recollection is that the patient’s chest sensation was not continuing at the time he saw him.

The patient’s lab results and chest x-ray were within normal limits. An EKG revealed a normal sinus rhythm with nonspecific T-wave changes laterally. Because the patient did not have chest pain during the ED visit, and his symptoms had started (as reported to the physician) more than 24 hours earlier with no enzyme elevation, the physician did not recommend admission. At 5:15 p.m., the emergency physician called the patient’s family physician to schedule a follow-up appointment. Though the details of the conversation were not documented, an appointment was scheduled for Friday morning.

The patient was given two baby aspirins and discharged at 5:30 p.m. He was instructed to follow up with his family physician, resume a normal diet and take ibuprofen 3 times a day. He was further advised to rest, and report to the ED if persistent or worsening symptoms arose.

The patient did not keep the Friday follow-up appointment. He died two days after the ED visit (Saturday) while playing basketball with his son. The autopsy report listed the cause of death as “a cardiac arrhythmia due to myocardial ischemia due to severe coronary atherosclerosis (heart attack).”

Allegations

Lawsuits were filed against the emergency medicine physician and the patient’s family physician. The plaintiffs alleged that the emergency medicine physician was negligent for not immediately admitting the patient to the hospital. Allegations against the family physician involve the scheduling of the patient’s follow-up appointment.

Legal implications

The plaintiffs were able to locate credible expert testimony that both physicians fell below the standard of care. An emergency medicine expert stated that the patient should have been admitted for serial EKGs and cardiac enzymes to rule out acute coronary syndrome. A prompt stress test should also have been scheduled. The plaintiff’s emergency medicine expert indicated that had the patient been admitted, he would still be alive. The family physician expert claimed the standard of care was breached when the patient’s appointment was rescheduled by the physician’s office staff. He further stated that if the patient had been seen as scheduled, it was likely that investigation, treatment, referral, or advice could have been given that would have prevented his death.

Defense consultants who reviewed this case noted that an appropriate cardiac work-up was completed in the ED. This work-up showed that the patient was not having a myocardial infarction at the time of the ED visit. Further, the patient was appropriately referred to his family physician for follow up the next day but failed to keep that appointment. To the defense experts who reviewed this case, including two cardiologists and three emergency medicine physicians, the main weakness of the case was that the physician did not admit the patient or order repeat EKGs or cardiac enzyme tests.

The emergency physician stated that there were four pieces of information that he did not receive from the patient: history of playing tennis when the pain started; history of high cholesterol; history of having been seen at his employer’s health clinic that day; and history of a prior cardiac work-up by a cardiologist. If the physician had known that the patient’s pain started when he was playing tennis, he would have admitted him as an urgent, but stable patient.

This case was complicated by conflicting testimony from the family physician and the emergency physician about the scheduling of the follow-up appointment. The family physician testified that he told the emergency physician to have the patient call his office the next day to schedule an appointment. The emergency physician testified that the family physician said to have the patient come in the next day at 11:30 a.m., but because the front office was closed, to call the next morning and confirm that time. The conversation between these two physicians was not documented.

The patient's wife and the family physician also gave conflicting accounts regarding the rescheduled appointment. The patient's wife testified that when her husband called on Friday to confirm the appointment, a staff person told him the physician was booked all day and could not see him. An appointment was made for him on Monday.

The family physician's medical assistant testified that when the patient called, he stated he was feeling better and did not want to come in that day. She told him that was fine and to come in on Monday, and in the meantime to follow the doctor's instructions from the hospital. The medical assistant did not check with the physician before telling the patient it was all right to come in on Monday. This conversation is documented in the medical record as "feels better and wants to wait until next week." However, the medical assistant also testified that she made this entry on Monday after the office had learned that the patient died. The entry was dated Friday.

Patient accountability became an issue in this case. In his discharge instructions, the defendant told the patient to "rest." The patient's wife acknowledged that the patient knew he should not play sports. The patient did not follow those instructions, and was playing basketball when he collapsed and died. Additionally, the patient failed to follow up with his family physician as instructed.

Disposition

This case was settled on behalf of the emergency physician and the family physician. Though it was felt that the patient shared a good percentage of responsibility for the outcome, defense experts were concerned that the patient was not admitted to the hospital and that his appointment was changed at the family physician's office.

Risk management considerations

Many medical liability claims against physicians involve the actions of office staff. Developing guidelines describing staff responsibility and decision making in regard to patients will serve to prevent staff from exceeding their authority and rendering advice without your knowledge.

Strict protocols for documentation in the medical record apply to physicians and staff. Phone calls function as a key component of health care. In this case, the conversation between the emergency and family physicians was not documented. Secondly, the phone call between the patient and medical assistant was not documented contemporaneously but was written as a late entry that was not identified as such.

It is frustrating that patient accountability was not the sole focus of this claim. In retrospect, if the patient had been admitted from the emergency department, he might be alive today.

4 Being inaccessible to patients

Perceived "inaccessibility" can occur when patients experience the following: long wait times for appointments; failure to return phone calls and messages; long automated phone messages when calling the office; and inattention during hospitalization.

"Such inaccessibility may be interpreted by patients that the physician does not care," Holeman says. She urges physicians to have policies in place for returning patient phone calls. It is also important to tell patients what to expect regarding returned calls and to meet those expectations. Many practices use prompts that tell patients when they can expect returned phone calls.

"Long, automated phone messages and menus are by nature annoying, but in some practices they are necessary. If you must use such a message, give the caller the option to speak to a person early in the message," Holeman says.

To minimize wait times for patient appointments, instruct staff on triaging and assigning priority appointments. "Scheduling every patient for the same brief visit can be inefficient for everyone. Staff can ask callers a set of standard questions and then schedule appropriate appointment times," Holeman says. Patients who cannot be accommodated by the physician should be referred to another physician or to the emergency department (ED).

“The accessibility of the physician when a patient is in the hospital is another huge issue,” McLain says. “Family members may wait all day at the hospital to ask the doctor questions. When they do see the doctor, they often feel rushed and their questions are not fully answered.” This can be addressed by clear communication with the family about what to expect, when the physician will be there, or by arranging a time to talk to the family.

Closed claim study: failure to examine and diagnose *C. difficile* infection

Presentation and physician action

A 69-year-old woman had been treated by her family physician for hypertension, asthma, osteoporosis, COPD, urinary tract infections, and allergic rhinitis over a period of four years. The physician last saw the patient on May 5 for a sprained ankle.

On June 23, the patient called the physician’s office complaining of back pain in her left side radiating to her leg. Lumbar x-rays were ordered, but were never completed. Pharmacy records indicate that a prescription for hydrocodone was filled on June 28. The physician authorized hydrocodone refills on July 4, July 11, and July 18. The physician testified at her deposition that it was her “guess” that the hydrocodone was given for persistent back pain.

On July 7, the patient called the office with complaints consistent with a urinary tract infection. The physician prescribed a seven-day course of Cipro, and the prescription was filled that day.

On July 22, the patient called complaining of a persistent, productive cough. The physician prescribed a 10-day course of Ceftin and Tussionex. On July 28, the patient again called the office reporting that she was not feeling better and had a slight fever. The physician prescribed Tessalon Perles and recommended that she continue the antibiotics. The patient called again on July 29 to report gas pain and loose bowel movements. The physician told the patient to discontinue the Ceftin and she called in a five-day course of Cipro. The patient was also advised to take Immodium. During these calls, the physician never spoke directly to the patient. All the telephone contacts and documentation of the telephone contacts were completed by the receptionist, an employee with no formal medical training.

On July 31, the patient came to the emergency department (ED) of a local hospital with symptoms of diarrhea and a low-grade fever. The ED physician found the patient to be hypotensive and dehydrated. Lab studies indicated an elevated white blood cell count and hyponatremia. Intravenous fluids were started and the patient was admitted under the care of an internal medicine physician to rule out sepsis, colitis, or diverticulitis. A KUB film showed layered and dilated loops of small bowel, believed to be an ileus. Stool cultures revealed antibiotic-induced *Clostridium difficile* bacteria. The internist requested a surgical consult. The surgeon believed that the patient had pseudomembranous colitis secondary to *C. difficile* infection. He recommended naso-gastric suction and fluid resuscitation, and noted that if the patient’s condition worsened she would require a subtotal colectomy.

Over the next two days, the patient’s condition deteriorated. She remained hypotensive and oliguric despite IV fluids, dopamine, and vancomycin. A nephrologist was consulted and he recommended continued conservative treatment.

On August 3, the patient’s urine output decreased to zero and she became severely acidotic. The surgeon took the patient to the OR for exploratory surgery. He resected a large segment of ischemic distal ileum. The colon was described as normal in appearance. The patient’s condition deteriorated after surgery and life support measures were discontinued.

Allegations

A lawsuit was filed against the family physician, alleging that she negligently failed to see the patient on July 28 and July 29 and failed to diagnose *C. difficile* colitis that led to the patient’s death.

Legal implications

Family physician defense consultants who reviewed this case could not support the defendant’s actions. Both consultants stated that the physician should have seen the patient on either July 28 or July 29 when she called and reported no improvement in her symptoms and new-onset diarrhea. Failure to see the patient in the office at this point was below the standard of care. In her deposition, the family physician testified that antibiotic-induced *C. Difficile* infection “was not on her radar screen” with respect to the patient’s telephone complaints.

While the defense consultants were critical on standard of care issues, they were both supportive in their causation opinions. Both family physicians and an infectious disease expert claimed that the cause of death was due to ischemic and infarcted small bowel. “Her acute onset of GI symptoms and progression of illness that was fatal within 5 days is more likely due to ischemic infarcted bowel than complication of *C. difficile* colitis. *C. difficile* in the stool was a by-stander. The *C. difficile* colitis affects the colon and very rarely the disease is seen above the distal end of the ileum. Her colon is reported as completely normal.”

Conversely, the plaintiffs were able to locate expert testimony that linked the patient’s death to the *C. difficile* infection. This family physician expert stated that the *C. difficile* infection caused the patient to become dehydrated and hypotensive. This led to a decrease in blood perfusion to the small intestine that caused its infarction and the patient’s death. Under cross examination, this expert conceded that there was no good scientific basis for his causation opinions.

The defense disputed this causation argument based on the general surgeon’s description of the patient’s colon during surgery. The colon appeared normal and *C. difficile* pseudomembranous colitis so severe as to kill a person should cause the colon to appear abnormal even by external examination. However, the subsequent physicians (the general surgeon and the internal medicine physician) did not support the defense causation argument. Both stated that the infection contributed to the patient’s death.

Disposition

This case was taken to trial. During jury deliberations, a settlement was negotiated and payment was made on behalf of the family physician with her consent. The jury returned a defense verdict based on the causation arguments.

Risk management considerations

When physicians hire and train their staff members, the assignment of duties is expected to reflect the background and skills of the employee. Physicians may delegate many tasks to staff, but maintain the responsibility to verify each staff member’s competency to perform as trained. Allowing a receptionist to gather information from a patient with physician decision-making based on the content of the message may be acceptable with established, well-known and reliable patients. However, treating a patient based on phone messages needs to be done judiciously. It reflects more prudent practice for the physician who does not have medically trained or licensed staff for phone triage to speak directly with the sick patient. This defendant physician would likely have elicited more information and scheduled the patient for an office visit. Diagnosing and treating by phone can become a “slippery slope”, as in this case.

Although not a focus of the allegations in this claim, the treatment of the patient’s complaint of back pain with radiation to the left side was also treated via phone with pain medication prescribed and lumbar x-rays ordered. The x-rays were never done and this was not discovered or followed in the defendant’s practice. All practices need to implement a system to verify receipt of reports for outside tests (e.g. lab, imaging studies), and response from consultants. Such a system will allow discovery of the patient who did not comply or the absence of a report. Such delays in continuity of care may lay the foundation for failure to diagnose and treat in a timely manner.

5 Failure to order and follow up on indicated tests or delay in ordering such tests

Employ a tracking system to ensure that patients have obtained recommended tests. A tracking system can minimize exposure to allegations of failure to diagnose and treat and can lead to better patient care.

“Sometimes patients just need a reminder. Maybe they could not make it to the lab on the day of the appointment and then they forgot that they needed lab work. A tracking system can remind both patients and physicians that tests need to be completed,” McLain says.

According to Holeman, a tracking system does not need to be complicated. “It can be as simple as a box of index cards or a ‘tickler’ sheet that staff use to make phone calls. Also, some electronic medical records have a tracking feature that can be used. The important thing is to make tracking a routine procedure in your practice,” she says.

Along with tracking, have a written procedure for handling test results when they are received, and for following up on results that have not been received. This procedure should specify that test results are to be thoroughly reviewed before they are filed in a patient's chart. Ideally, the reviewer should initial and date the reports and document what needs to be done.

Sometimes patients who have sued their physicians claim that test results were never communicated to them, or that the physician was delinquent in providing those results. Timely notifying patients of their test results should be a high priority. Routinely noting in the record that the patient was provided with those results, and including the date and initials of the person who contacted the patient, can help to prevent such allegations.

Closed claim study: failure to diagnose lung cancer

Presentation

This case involves a 59-year-old man with more than 40 years smoking history, chronic obstructive pulmonary disease, sleep apnea, chronic bronchitis, emphysema, and obesity. The patient was seen in the emergency department (ED) for complaints of respiratory problems. A chest x-ray noted a "possible 1 cm pulmonary nodule superimposed over the anterior end of the left 5th rib," which was not present on patient's film taken seven months earlier. The radiologist recommended a left rib series, which was not done because the patient checked out against medical advice. This report was faxed to the patient's internal medicine physician, the defendant in this case.

Physician action

The defendant's partner had his nurse call the patient to inform him of the abnormal results of the chest x-ray and to have the patient return to the clinic in the near future. This call was not documented in the record and the practice did not schedule the patient for an appointment. Two months later, the patient came to the ED and was hospitalized after a serious episode of respiratory distress. The chest x-ray showed "a nodular density over the left anterior 5th rib measuring 2.7 cm." This report notes the defendant as the ordering physician and the report was in the patient's medical record at the defendant's practice. There is no indication that this report was reviewed and the defendant testified he did not see the report.

The patient came to the clinic the following month, was diagnosed with bronchitis and treated by the defendant. Two months later, the patient was admitted to the hospital by the defendant's partner who was on call. Differential diagnosis was pneumonia or empyema. Chest x-ray noted "a mass-like infiltrate" measuring 5 cm in diameter. A repeat film two days later noted "the previously described nodule or mass was totally obscured by pleural effusion." Four days later, a PA and lateral of the chest again noted the "large left basilar mass and suspected consolidation completely obscured by overlying effusion," and could not be evaluated. Two days later a CT scan of the chest was ordered. The radiologist noted the pulmonary windows showed no discreet mass and suspected the mass-like density adjacent to the heart border on earlier films represented some focal lung consolidation or loculated fluid. Three days later, an empyema of the left chest was drained. X-rays were done twice to confirm chest tube placement. Four days later, after removal of the chest tube, the last film before patient's discharge noted "moderate opacification remained in the left lung base," but was slightly improved since the previous study.

Thirty-four days later, the defendant ordered a chest x-ray to rule out pneumonia. That report noted an apparent mass-like infiltrate, again seen in the frontal view. The radiologist noted the lack of change of that focal infiltrate raised the possibility of neoplasm and recommended a CT scan. Seven days later, the CT scan was done and revealed a "4.5 x 3 cm mixed density mass seen inferior laterally in the inferior lingular segment of the left upper lobe abutting the pleural surface." The radiologist noted that malignant neoplasm along with some associated loculated effusion remained a definite consideration. Eleven days later, biopsy of the lung tissue was performed and pathology indicated non-small cell and squamous cell carcinoma. At last report, the patient remains under the care of an oncologist and has received multiple courses of chemotherapy.

Allegations

A lawsuit was filed against the internal medicine physician. The allegations included failure to diagnose cancer in a timely manner and failure to refer and treat in a timely manner.

Legal implications

It was felt by those representing the defendant that causation would be extremely difficult to prove due to the noncompliant nature of the patient. Physician reviewers had disparate opinions as to whether an earlier diagnosis of seven months would have made a difference in treatment choices and prognosis. However, negligence can be implied with the lack of timely follow-up and aggressive action in response to the abnormal chest x-ray seven months before diagnosis.

The defendant explained that he was too busy to review every report sent to his office, and he had no system delegating that responsibility to a staff member with guidelines to bring abnormal studies to his attention. This was viewed as an impossible hurdle to overcome in assigning liability in this claim. Failure to meet the standard of care with regard to timely follow up on test results, and aggressive action to confirm or rule out a diagnosis of cancer was acknowledged as a significant weakness by some of the reviewers.

Disposition

Even with the acknowledgment of the lack of patient personal responsibility and the presence of comparative negligence, concerns were identified regarding the defense of the physician particularly in light of no practice protocol to review all patient reports. Due to the uncertainty of a jury trial, this case was settled.

Risk management considerations

Physician/patient accountability is unequal in health care. Recognizing this inequity, physicians should be proactive in designing and implementing processes that assure standards are met. These measures will help decrease risk and liability as well as increase defensibility. Several issues can be identified in this claim where well-designed and implemented processes may have made a difference.

Losing track of a patient who requires continuity of care, particularly in response to any abnormal report, places a physician at risk. Rather than advising the patient to “return to the clinic in the near future,” give the patient a scheduled appointment. That patient is then on your schedule and if the appointment is not kept, he/she can be contacted and this action documented in the medical record. Without question, patients should be responsible for their health care. But if the patient is not compliant, a “no show” follow-up appointment is advisable.

Timely review and appropriate follow up on all patient reports whether lab, imaging, other diagnostic tests, or reports from consultants should be a routine practice protocol. The ordering/referring physician has this responsibility and allowing reports to be filed in the patient’s record without review cannot be defended. Physicians are encouraged to write their initials, the date of review and orders for follow up on the reports to verify their actions.

Failing to document phone calls to and from patients leaves a “hole” in the record and with a legal process that takes years to resolve, memory will fade along with reliable information. The medical record should have a designated place for documentation of phone calls both during and after hours.

Patient noncompliance needs to be documented and, when necessary, the physician may terminate the physician/patient relationship. When this is determined to be the best course of action, notify the patient via certified and U.S. mail and place a copy of the letter in the medical record. In the letter, advise the patient to select another physician and offer to be available to the patient for medical emergencies only in a time frame from 15 to 30 days based on physician availability in the community. Avoid any actions and comments that can be construed as abandoning the patient.

6 Failing to refer when appropriate, failure to track referrals, and failure to communicate with referring physician

While it is true that patients have a duty to comply with their physicians’ recommendations, including following through with referrals, it is common for them to claim that the physician either did not stress the importance or did not explain the reason for the referral. In fact, they sometimes claim that they were given an option, as opposed to a recommendation, to see a consultant.

Implementing a system to track referrals can improve patient care and reduce liability exposure. The system can provide a method for: verifying that the patient keeps the appointment; confirming receipt of the consultant report; prompting a call to the consultant if a report is not received; making sure the physician sees the report; and arranging for a follow-up appointment if necessary. If the patient fails to keep the appointment with the specialist, the staff can then contact the patient with a reminder of the importance of following through with that recommendation. These steps should be documented in the patient's chart.

As with reports of test results, written procedures for handling consultant reports can prevent problems and improve patient compliance. Initialing and dating reports after careful review can provide useful documentation if a lawsuit is filed.

“Another problem we see frequently involves communication between physicians. While written communication will often suffice, there are some situations in which a discussion needs to take place,” says McLain. “It is also important to document your discussions with other physicians and any joint treatment plans resulting from the referral.”

Closed claim study: failure to inform subsequent treating physician

Presentation and physician action

A 25-year-old woman came to her ob-gyn to begin prenatal care on October 17. She was given a due date of May 4. This was the patient's third pregnancy.

A sonogram performed in the ob-gyn's office on December 9 revealed bilateral hydronephrosis and a distended bladder in the fetus. The ob-gyn recommended a perinatology consultation.

The patient was seen by a perinatologist on December 15. An ultrasound confirmed bilateral hydronephrosis with a slightly enlarged bladder. The perinatologist's impression was a partial bladder outlet obstruction. The patient returned on December 23, and was seen by another perinatologist. A second sonogram was performed and the perinatologist's impression was bilateral renal pelviectasis.

Reports from both sonograms were provided to the ob-gyn, who noted the results in the patient's prenatal record. There was no documentation that the ob-gyn discussed these findings with the patient. On February 13, the ob-gyn admitted the patient to the hospital due to her complaints of back pain and fever. A bilateral renal ultrasound of the patient revealed moderate to marked right hydronephrosis and moderate left hydronephrosis. The radiologist recommended a repeat sonogram for evaluation of fetal kidneys in a few weeks. The ob-gyn did not order this sonogram.

On April 25, the ob-gyn admitted the patient for induction of labor. A male infant was delivered without complication. The baby weighed 6 pounds, 13 ounces and his APGAR scores were 8/9. The baby was given routine newborn care while in the hospital. He and the mother were discharged on April 26. The ob-gyn did not advise the attending pediatrician of the baby's abnormal renal condition.

The pediatrician saw the baby for a well check on April 28. The pediatrician's note from this visit included the following statement: “urethral opening: one and LOW.” The baby subsequently made several visits to the pediatrician for well checks and routine illnesses.

On November 3, the baby was brought to a local children's hospital with severe dehydration. He was admitted in renal failure secondary to renal dysplasia. The baby was ultimately diagnosed with chronic kidney failure and placed on peritoneal dialysis. Approximately 30 months later, the child underwent a kidney transplant with a kidney donated by his father. He is making a good recovery.

Allegations

A lawsuit was filed against the ob-gyn, alleging negligence in failing to discuss the hydronephrosis with the parents before delivery and failing to advise the pediatrician so follow-up care could be initiated. The plaintiff's expert alleged the child would require additional transplants in the future and had a reduced life expectancy as a result of the transplant.

Legal implications

This case was reviewed by three ob-gyns, a pediatrician, a pediatric nephrologist, and a pediatric urologist. They were all critical of the ob-gyn's failure to advise the parents and pediatrician of the condition of the fetus before delivery.

The two perinatologists (also named in the lawsuit) said they would testify that they reported their findings as consultants to the ob-gyn, and it was her responsibility to discuss the findings with the parents and the pediatrician. Likewise, the pediatrician said she would testify that she was never advised of or provided a copy of the findings by the ob-gyn, which she would have expected.

The defendant explained that she informed the mother of the fetal kidney condition, and that she referred her to the perinatologist because of the finding of bilateral hydronephrosis on ultrasound. The ob-gyn claimed that she discussed the baby's condition with the mother throughout her pregnancy, but none of these discussions were documented. Further, the ob-gyn said she did not know the identity of the pediatrician, although the pediatrician's name appears in her records. The ob-gyn said it was her expectation that the pediatrician would look at the mother's chart after delivery. The ob-gyn thought the patient's prenatal and labor and delivery records would be combined with the baby's hospital record and reviewed by the treating pediatrician.

Causation became an important issue in this case. Among the experts who reviewed the medical records, there was a legitimate difference of opinion as to whether earlier diagnosis would have altered the outcome. Defense experts in pediatric urology and perinatology stated that the child's renal failure was the result of a congenital anomaly, unrelated to the actions of the ob-gyn. Given the end-stage renal failure suffered by the baby within 6 months of his birth, nothing could have been done that would have changed the baby's condition or outcome. Other consultants advised that earlier treatment could have possibly salvaged the kidneys and avoided the need for dialysis and transplant.

Disposition

Based on the reviews of defense consultants and the anticipated testimony of the codefendants and pediatrician, this case was settled with the consent of the ob-gyn.

Risk management considerations

Communication lapses among physicians, their patients, and other health care providers are frequently the focus of malpractice claims. When issues relevant to patient care are not clearly documented in the medical record, the stage is set for allegations that conversations related to continuity of care never occurred. The comprehensive medical record is a chronological document of each patient's condition and care. The physician who orders tests or referrals holds the responsibility to verify that the test or consult was done, to review the reports, to determine the next course of care, and to inform the patient.

When prenatal testing identifies fetal abnormalities, taking the time to inform the pediatrician would seem appropriate. One may surmise that continuity of care will be extended to the fetus and newborn. That pediatrician then has time to plan for the birth, perhaps consult a neonatologist or other pediatric specialist, and be available at, or soon after delivery.

7 Inappropriately prescribing medications

When patients experience adverse reactions to or lack of benefit from prescribed medications, lawsuits can result. These suits allege such errors as: failing to check the patient's chart when prescribing medication; prescribing improper dosages; failing to consider and advise patients of potential side effects or interactions with other drugs; prescribing drugs outside the physician's specialty; and prescribing drugs for nonpatients.

Given the significant amount of direct-to-consumer advertising of prescription and over-the-counter drugs, physicians frequently receive requests from patients for drugs they have seen advertised. Physicians would be well advised to resist patient pressure for drugs with which they are not familiar. There are a number of information sources available. Physicians who use reliable sources to educate themselves about the drugs they prescribe will be better able to explain their rationale if they should be sued individually, or as a part of mass tort litigation.

When possible, it is helpful to provide the patient with information about the drug, and to document discussions and any handouts given. Documenting the information provided can be helpful if the physician's actions must be defended in litigation.

To avoid allegations related to improper prescribing, consider the following guidelines.

- Check the patient's medical record when prescribing or refilling a medication. Request that the patient come for an office visit, if appropriate, before authorizing a refill.

- In the patient's chart, record medications and allergies in a central location. Update this information at each visit.
- Be familiar with the drug prescribed. Refer the patient to a specialist if he or she requires a drug that is outside your scope of practice.
- When prescribing drugs off-label or in dosages exceeding those recommended, document your rationale. Also document that you discussed the risks and benefits of the treatment with the patient.
- When a patient calls with complaints of unusual symptoms, the prescribing physician should be alerted.
- If a pharmacy calls to question a prescription, check the original order.
- Make sure handwritten prescriptions are legible and that dosages are correctly noted.

Closed claim study: medication error

Presentation

A 50-year-old Asian man was referred to a nephrologist for renal insufficiency. The patient had a history of ankylosing spondylitis and scleroderma. He had an elevated serum creatinine, low creatinine clearance, anemia, and proteinuria. The patient had previously been prescribed 5 mg of prednisone daily for treatment of his renal disease.

Physician action

The nephrologist, the defendant in this case, felt there was no evidence of acute sclerodermal crisis to account for the patient's renal failure. He placed the patient on an ACE inhibitor. After 10 weeks, the patient's creatinine failed to improve and proteinuria was still significant. The nephrologist believed the patient had an undefined connective tissue disorder characterized by probable membranous glomerulonephritis renal lesion. He followed the patient for several weeks. In the interim, the patient had seen his rheumatologist, who increased his prednisone to 10 mg daily.

When the nephrologist next saw the patient, he documented that he discussed the possibility that renal replacement therapy would be needed. According to the physician, the patient indicated he did not want to go on dialysis because he was afraid it would impair his ability to work. The patient's kidney function continued to deteriorate. During the next visit, the nephrologist decided to place the patient on 120 mg of prednisone every other day to see if renal function would improve. The physician sent an email to his nurse stating, "Kidney function is slightly worse. As a last ditch effort to keep him off dialysis we need to have him take prednisone 120 mg every other day."

The next day, the nurse called in the prescription to the pharmacy for prednisone 120 mg every day, and completed the medication summary in the chart to reflect 120 mg daily. Using the practice's computerized records system, the nurse emailed a copy of the prescription back to the nephrologist, which reflected 120 mg daily. When the nephrologist, who had been out of town, returned 10 days later he simply signed off on several emails (including the prescription) without opening them. He clicked a signature box and deleted the prescription from his email list.

The pharmacy's computer flagged the prescription because the dosage was too high. The pharmacist called and spoke to the nurse, who confirmed the dosage. The patient's wife also questioned the dosage, and was told by the nurse that the dosage was correct. (The nurse later testified that she confirmed the dosage in the computer system by looking at her documentation rather than the actual physician's order.)

Nine days after beginning the daily prednisone, the patient came to the clinic for a Procrit injection. He complained to the nurse of tremors, esophageal burning, hiccups, stomach pain, and swallowing problems. The nurse emailed the nephrologist, who had just returned to the office, and told him of the patient's complaints. The physician never saw this email and may have clicked it off his email list as he had done the prescription.

Eight days later, the patient called and spoke to the nephrologist, who was unaware of the prescription error. The patient indicated he was not feeling well, and the nephrologist advised him to drop his prednisone back to 10 mg per day. An appointment was scheduled for the next day. When the patient was seen the next day, he had extremely low blood pressure, elevated heart rate and was going into shock.

The patient was admitted to a nearby hospital where he was diagnosed with severe dehydration, gastrointestinal bleeding, and symptoms of sepsis. Despite aggressive treatment from a number of specialists, the patient died two days later.

An autopsy performed on the patient did not identify a cause of death. However, chronic gastritis was identified with angio-invasive GMS positive microorganisms most consistent with aspergillosis. Multiple ulcers were found in the colon with full penetration through the muscular wall with reactive peritonitis. The center of the ulcer showed prominent necrosis. The patient was also found to have interstitial lung fibrosis bilaterally.

Allegations

A lawsuit was filed against the nephrologist. The allegations included:

- prescribing a high dose of prednisone;
- failure to properly supervise staff in placing an order of prednisone;
- failure to monitor patient's progress; and
- failure to give appropriate medical orders to stabilize the patient's deteriorating condition.

The nurse and the practice association were also named in the lawsuit.

Legal implications

In reviewing this case, defense consultants were critical of the prescription error by the nurse and her failure to detect the error when questioned by the pharmacist and the patient's wife. There was further criticism of the nurse for not reporting the patient's symptoms of esophageal burning to a physician.

Regarding the physician's action in this case, defense experts expressed their greatest concern regarding the sign-off of the email prescription. The physician indicated that he did not read the email because the manner in which he pulled it up on the computer screen did not show the text of the email. Some experts believed the physician had a right to expect the prescription would be called in as ordered and it was not necessary to read the email sent to him regarding the prescription. However, the physician did sign off on the prescription, an official physician's signature on a chart. There was speculation that a jury might hold the physician at least partially responsible for the prescription error since he signed off on it.

The plaintiff's attorney was able to retain credible experts who were critical of the physician's decision to initiate steroid therapy and who related the patient's death to the prescription error. However, the defendant's decision to place the patient on alternate-day high dose steroids was very well reasoned. One of the plaintiff's own experts agreed with this decision, as did defense experts. Defense experts also agreed with the plaintiff's assertions that daily high dose steroids likely contributed to the patient's death. Though most believed that the patient's underlying systemic sclerosis was the primary cause of his death, placing him on steroids likely caused him to become sufficiently immunocompromised that he could not fight the infection when the perforations in his colon occurred. This led to overwhelming sepsis and organ failure.

Disposition

This case settled before trial with the physician's consent.

Risk management considerations

Both the nurse and physician made errors in this patient's health care. The information reviewed for this study did not include why the nurse did not respond to the pharmacist's appropriate query regarding the prednisone prescription. Was the nurse too busy? With an electronic medical record, confirming the physician's order would not take long. Faced with days of email, was the physician also too busy to open and read all orders requiring his signature? Electronically signing an order is an affirmation that it is correct.

Whether a paper or electronic record, standards of care and documentation requirements remain the same. There were two opportunities for the nurse to confirm the prescription with queries from the pharmacist and the patient's spouse. A third opportunity to intervene and stop the daily dose was in the physician's hands when reviewing email and signing off on orders. A physician cannot defend his/her actions if established standards are not followed. Signing off on unread orders would likely be considered below the standard of care by a jury.



Improper care of patients during emergency situations

Treating patients by phone when an examination is warranted can be risky. Patients can be poor historians and may inaccurately describe their symptoms. Additionally, the physician cannot assess the patient's appearance, body language, or symptoms by phone.

“Treating patients over the phone is not a problem per se. In some cases it may be appropriate. Careful judgment should be used when deciding whether phone advice and treatment is sufficient,” Holeman says. “When possible, check the chart. Determine if the patient has ever experienced this problem before? When was the patient last seen in the office? Is this a recurring issue for the patient?”

Implement written protocols for telephone triage that include:

- which staff members can answer patient questions;
- specific questions to ask the caller;
- when to notify the physician; and
- which calls warrant a visit to the office or ED.

Document the patient's request, symptoms, and any advice given. If the patient is told to go to the ED, document this directive in the medical record.

Another situation that warrants discussion involves interaction between treating physicians and the caregivers in the ED. “We have received a number of claims in which plaintiffs alleged that the patient's primary care physician or specialist inappropriately relied on the ED physician or resident because the physician did not want to come to the hospital,” McLain says.

Other claims involving emergency care have alleged lack of adequate communication between the physicians at the hospital, such as emergency physicians or residents, and others such as radiologists or specialists.

When contacted by an ED physician, documenting any advice given over the phone can later serve to correct any confusion about what was communicated. The ED physician is probably documenting the conversation, but sometimes that documentation is inconsistent with the recollection of the physician calling in. Additionally, if you are asked to fax copies of medical records or reports, confirm that the ED received the materials. Document the confirmation in the medical record.

Closed claim study: Failure to diagnose cornual pregnancy

Presentation

A 33-year-old woman came to the emergency department (ED) complaining of bilateral abdominal pain, back pain, and shortness of breath. She reported that she was nine to 10 weeks pregnant. The patient also had a history of pelvic inflammatory disease (PID) and sickle cell anemia.

The patient's vital signs were normal, but she had tenderness along her abdomen. Blood work indicated she had a WBC count of 8,000 and mild anemia. The emergency medicine physician ordered an ultrasound to determine if the pregnancy was normal.

Physician action

The radiology technician completed the ultrasound and contacted the on-call radiologist at his home at 3 a.m. The technician told the radiologist that the images were of poor quality even though the ultrasound had been done twice. The radiologist had the technician send him a copy of the images via teleradiology. After reviewing the images, he determined that the pregnancy was intrauterine but “abnormal.” He reported this finding by phone to the ED physician. However, the ED physician claimed that the radiologist reported that the ultrasound showed a normal intrauterine pregnancy. “Normal intrauterine pregnancy” was written in the ED records.

The ED physician discharged the patient at 6:40 a.m. after giving her meperidine, promethazine and antibiotics. The final diagnosis was abdominal pain due to intrauterine pregnancy, gastroenteritis or possible PID. She was told to rest at home and follow up with her obstetrician. The ED physician later stated that the patient was discharged because she refused hospitalization, but this was not indicated in the medical records.

A second radiologist reviewed the ultrasound images when he arrived at 8 a.m. He noted that the ultrasound showed an intrauterine cornual pregnancy, a pregnancy in which implantation occurs in the uterus at its junction with the fallopian tube. He recommended that the patient be brought back in for further studies to evaluate the position of the pregnancy. According to his testimony, he asked the radiology technician to call the patient and have her return. The patient was never called. The technician stated that the radiologist never requested that she call the patient.

The patient continued to suffer from abdominal pain at her home before calling EMS at 9:44 a.m. When she arrived at the hospital, she complained of acute pain and difficulty breathing. Ten minutes later she stopped breathing and CPR was started. She was sent to the OR for an emergency laparotomy due to suspected ruptured ectopic pregnancy. CPR was continued throughout the surgery. The surgeon located and removed the cornual pregnancy from the left side of the uterus and noted between 1.5 and 2 liters of blood in the abdominal cavity. Despite CPR and several defibrillations, the patient was pronounced dead at 12:17 p.m. The pathologist found the cause of death to be ruptured ectopic cornual pregnancy complicated by acute shock and exsanguination.

Allegations

A lawsuit was filed against the radiologists and the ED physician. The allegations included:

- failure to properly interpret the ultrasound resulting in a premature discharge from the ED (first radiologist);
- failure to provide the diagnosis to the ED in a timely manner resulting in failure to call patient back to the hospital (second radiologist); and
- failure to perform a pelvic exam, failure to call for an OB consult, and prematurely discharging the patient (ED physician).

Legal implications

Cornual pregnancies are extremely rare and some physicians may never encounter them in their careers. They also have a high mortality rate and, according to radiology experts reviewing this case, are very difficult to diagnose.

While acknowledging the poor quality of the ultrasound films, the plaintiff's radiology expert stated the final diagnosis of intrauterine pregnancy was incorrect. The patient did not have an obvious extrauterine ectopic pregnancy, but a pregnancy in an unusual position that was neither extrauterine nor intrauterine. In any case, according to the plaintiff's expert, the failure to diagnose the cornual pregnancy led to the patient's inappropriate discharge from the hospital and her eventual death.

TMLT radiology consultants had mixed opinions about the first radiologist's interpretation, but all agreed the images were consistent with a cornual pregnancy. One reviewer commented that the radiologist should have asked for a repeat exam or should have come to the hospital to review the ultrasound. Another consultant stated that the radiologist did not rule out ectopic pregnancy just by advising the ED physician that this was an abnormal pregnancy.

The second radiologist's interpretation of "an intrauterine pregnancy of questionable location" was considered appropriate, but consultants were concerned that he dictated the need to call the patient back rather than contacting the ED physician. In his deposition, the radiologist said that if he had been certain the patient had an ectopic pregnancy, he would have contacted the patient immediately. Since this diagnosis was a "gray area" and since he was informed that the patient had been discharged from the ED, he asked the technician to contact the patient.

Regarding the actions of the ED physician, plaintiff's experts stated there was not enough information about the patient's condition to discharge her. Even after receiving word that the pregnancy was not ectopic, he should have performed a pelvic exam and obtained an ob-gyn consult. A pelvic exam would have yielded additional information to make the diagnosis. An ob-gyn consult should have been ordered because he had a pregnant patient in severe pain without an ectopic pregnancy. Defense experts argued that a pelvic exam was not necessary since an ultrasound had been ordered. An obstetric consult was also not necessary because the patient was already under the care of an obstetrician and it was determined, based on the ultrasound, that her condition was not life threatening.

Of great concern in this case was the communication between physicians and the apparent lack of documentation about what was discussed. The first radiologist should have documented his interpretation by faxing a report to the hospital immediately. Though the ED physician did document that the radiologist reported a "normal intrauterine pregnancy," he did not document that he wanted to hospitalize the patient but she refused. For the second radiologist, a call to the ED physician advising

him of the need for follow-up studies would have been more appropriate than dictating the need for call back in the report.

Disposition

This was a complex case involving multiple physicians. Finger pointing became a concern, as each party to the suit gave differing versions of the events. These facts, along with the lack of documentation and the communication issues, led to the decision to settle the case on behalf of all three physicians. The ED physician contributed 50% and each radiologist contributed 25% to the settlement.

Risk management considerations

In hindsight, actions that might have made a difference in the outcome of this claim have been mentioned above. None of these actions are extraordinary in nature, but reflect a commitment to the delivery of quality patient care and the documentation of that care. Are oral reports acceptable in teleradiology? Was the impression clearly understood in physician-to-physician communication? It seems unlikely that the ED physician would ignore the word “abnormal.” That is not what he heard. A report emailed or faxed would alert him to “intrauterine but abnormal.” Are images of poor quality satisfactory for interpretation away from the facility? What protocols are in place to determine when the on-call radiologist comes in?

Clearly, communication and timely action may influence outcomes when studies are abnormal and follow up is required. The practice of radiology lends itself to well-defined systems that guide when the ordering physician is told of abnormal findings and any recommendations for further studies. Document this contact. Practicing prudent risk management and implementing well-designed systems to observe the standards of care will promote quality health care and reduce the exposure a radiologist encounters on a daily basis.

Documentation in the medical record will strengthen a physician’s defensibility. Relying on memory months or even years after an event is dangerous. The recommendation for admission and the patient’s refusal should be in the record. In addition, asking the patient to sign an informed refusal form reflects his or her part in the decision making process. If the patient is leaving against medical advice, that decision needs to be clearly and objectively documented.

9 Failure to obtain informed consent

“Informed consent is not a piece of paper. It is a discussion between the patient and the physician regarding the risks and benefits of a procedure, treatment, test, or medication,” Holeman says.

In Texas, informed consent is governed by statute and is overseen by the Texas Medical Disclosure Panel (TMDP). The panel includes six physicians and three attorneys who review all treatments and procedures to determine which procedures require informed consent and which do not. Procedures and treatments are then assigned to a list. Those requiring disclosure of risks and benefits are put on List A. Those that do not require disclosure of specific risks are identified in List B. The panel periodically examines new treatments or procedures and assigns them to one of the lists. The lists, TMDP rules and forms can be viewed at Title 25, Texas Administrative Code, Part 7 at [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.viewtac](http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac).

When offering any treatment or procedure to a patient, the physician must make these determinations:

- if the treatment or procedure appears on List A, then disclosure specified by the panel must be followed;
- if the treatment or procedure appears on List B, no specified disclosure is legally required;
- if the treatment or procedure does not appear on either List A or List B, the physician must then disclose all material and inherent risks which could influence a patient in making decisions.

“It is also important to realize that informed consent is a non-delegable duty. The physician is responsible for discussing the risks and benefits and obtaining consent,” Holeman says. “A signed form is not a substitute for a detailed discussion.”

Additionally, it is important to note that, by statute, the TMDP may not require disclosure of the risks of certain surgeries, procedures or medications. However it is best to disclose those risks that a reasonable person would want to know in making the decision.

A final piece of advice regarding informed consent — document the discussion in the medical record. The notes should indicate that the patient was informed of the risks, benefits, and alternatives of the offered treatment, and that the patient expressed a desire to proceed.

Closed claim study: failure to discuss risks of VBAC

Presentation

A 32-year-old woman at term in her pregnancy was admitted to the hospital by her obstetrician for induction of labor. This was the patient's second pregnancy. The first child was delivered by low transverse cesarean delivery for fetal distress. According to the obstetrician, the patient desired a trial of labor with this pregnancy.

Physician action

Upon admission, the physician attempted cervical ripening with prostaglandin gel. Initially, the patient experienced some irregular contractions that resolved after approximately 30 minutes. At that time, the physician left the hospital with the patient contraction free. Less than an hour after the physician left, the patient had severe abdominal pain and fetal heart tones were difficult to detect. Twenty minutes later, the nurses called the physician who ordered a stat cesarean delivery. The physician contacted a colleague at a nearby hospital to deliver the child while she returned to the hospital.

When the physician arrived, the physician's colleague was waiting on the anesthesiologist. The procedure started shortly thereafter. They found a ruptured uterus with the baby floating free in the abdomen. The child was significantly impaired and died several days later.

Allegations

A lawsuit was filed against the ob-gyn. The allegations were:

- failure to properly inform the patient about the risk of uterine rupture with a VBAC delivery;
- failure to remain in close proximity to the patient while undergoing prostaglandin gel cervical ripening; and
- alteration of medical records regarding informed consent.

The plaintiff also alleged the ob-gyn wanted a trial of labor.

Legal implications

Negligence is the failure to use ordinary care, that is, failure to do that which a health care professional of ordinary prudence would have done under the same or similar circumstances or doing that which a health care professional of ordinary prudence would not have done under the same or similar circumstances.

The plaintiff's attorney found an expert to support the allegations. However, TMLT consultants were supportive of the physician's actions. They felt the decision to try labor was appropriate if the previous cesarean delivery had been a low transverse incision. The defense consultants also indicated it was appropriate for the physician to leave the hospital following the application of the prostaglandin gel, as the initial contractions were rapidly corrected.

Even though there was a good possibility that this case could have been successfully tried, the defense was undermined when the physician admitted making late entries in the patient's medical record about the discussion of the risks. The physician's credibility was seriously damaged on the issue of informed consent. The patient and the patient's husband both testified in depositions that it was the physician's recommendation to try vaginal delivery. They testified that no explanation regarding the risks involved in VBAC delivery, including the possibility of uterine rupture, was given to them. They also testified that it was their desire to have the second child by cesarean delivery and they never wanted to have a trial of labor.

Disposition

The patient testified that she has been to a counselor, a psychologist, and a marriage counselor related to problems following the death of the infant. She is currently taking antidepressants and her marriage has suffered. Future fertility is questionable and pregnancy risky. This case resulted in a settlement before trial. Medical records alteration, the death of a child, and the resulting emotional problems of the mother, were major factors in the decision to settle this case.

Risk management considerations

Defense experts felt that the decision for trial of labor following a previous cesarean delivery was appropriate; unfortunately, the lack of documentation regarding the informed consent discussion was absent. The physician may have had the discussion with the patient, but failed to document it contemporaneously. The physician later added information regarding the informed consent discussion in the space between September and March entries. The copy of the record the patient obtained before filing the claim does not include the February entry.

At the time of the patient encounter, it is appropriate for a physician to review entries and, if necessary, supplement that information with a “late entry.” Late entries should clearly be identified as such and include the reason for the lateness of the entry. It should reference the date and time of the actual encounter, but should clearly state the date and time of actual entry / documentation and be signed by the person making the entry. Entries should be made at or near the time of the patient encounter. After the fact entries may be viewed as “alterations” to the medical record.

Altering the medical record seriously jeopardizes a physician’s credibility. Upon reviewing the medical record when served with a notice of a claim or lawsuit, physicians may be tempted to add information they believe will assist in their defense. While the information itself may be accurate, the addition of such information after the event is frequently detrimental to the defense of the case. Plaintiff’s attorneys will use this information to discredit the physician. While there may have been no breach of the standard of care, situations such as this are difficult to defend at trial and frequently result in settlements out of court.

ACOG guidelines recommend that the patient be informed about the risks and benefits involved with VBAC. The patient should make the decision based on receiving the appropriate information. Informed consent can be documented on a form that clearly documents the information given to the patient, the risks and benefits, and the patient’s understanding and desire for VBAC. A staff person may witness the patient’s signature on the consent form; however, it is recommended that the physician document the informed consent discussion in the medical records as well.

10 Allowing noncompliant patients to take charge

These situations can include a patient leaving the ED when the physician suggests admission or a patient leaving the hospital before his or her condition is stabilized.

“Physicians should resist attempts by patients to talk them into anything other than what their best medical judgment deems appropriate,” says McLain.

Physician recommendations and patient noncompliance should be objectively and adequately documented. If a patient suffers a bad outcome as the result of his or her noncompliance, they may try to shift the blame to the physician. “Patients often claim that the physician did not explain the severity of their condition or the potential consequences of going against medical advice. Thorough, contemporaneous documentation can help dispel these allegations,” says McLain.

Another risk management strategy for these situations includes requiring that the patient sign informed refusal or “Against Medical Advice” forms.

Closed claim study: unstable transfer

Presentation

A man in his mid-30s came to the emergency department (ED) of a county hospital with complaints of difficulty breathing. The patient was admitted to this hospital by an emergency medicine physician.

Previously that day, the patient was refused admission at another hospital based on his not being a county resident and inability to pay. The physician at this hospital instructed the patient to seek care at the hospital in the county where he lived. Additionally, the patient was told that if the admitting hospital did not have the ability/equipment to treat the patient, the patient could then be transferred to the original hospital at the request of the admitting hospital.

Physician action

The diagnosis of acute pneumonia was made based upon the history and physical examination. The patient was started on IV antibiotics and respiratory therapy. No further testing was done and the records are unclear as to why no further diagnostic testing was performed. The physician stated that the family wanted him to rely on the tests and chest x-rays already performed elsewhere that day since they did not have the financial resources to pay for additional testing.

Initially, the patient improved with IV antibiotics and respiratory therapy. Later the second day, the patient was found to be in severe respiratory distress and acidotic. Nurses' notes indicate the patient also had mental lethargy. The family requested that the patient be transferred to the hospital where the patient was originally seen. The emergency physician called the receiving hospital to discuss the case, and the patient was then scheduled for transfer to a hospital better equipped to handle his condition.

The patient was not intubated prior to transfer. The medical records are unclear as to whether the intubation was not done for physical reasons such as patient size, consciousness or refusal of consent on the part of the family. Also, there was conflicting testimony between the sending and receiving physicians regarding the necessity of intubation before transfer.

The patient went into respiratory distress during the transfer and was in cardiac arrest at the time of arrival at the receiving hospital. Resuscitative measures were unsuccessful and the patient died approximately 20 minutes later.

Allegations

A lawsuit was filed against the emergency medicine physician. The allegations included:

- failure to intubate prior to transfer;
- transferring an unstable patient;
- delay in transferring a critically ill patient to a facility better equipped to handle his condition; and
- wrongful death.

Legal implications

Breach of duty is a deviation from the standard of care. According to *Texas Medical Jurisprudence*, negligence is defined as the lack of ordinary care. "Ordinary care is that degree of care that a reasonably prudent physician would have exercised under the same or similar circumstance." The standard of care generally must be established by expert testimony. The experts in this case felt that the physician fell below the standard of care by not intubating this patient before discharge and transferring an unstable patient.

In an emergency situation involving a conscious adult patient, the treating physician should remain objective and assertive in following his/her own medical judgment in the treatment of a patient, regardless of the family's refusal to consent to treatment.

Just as consent to treatment should be documented, so should refusal of treatment. Likewise, treatment not rendered when indicated should be documented in the medical chart, with a medical rationale, to substantiate the deviation from the standard of care.

Disposition

The case was settled with physician's consent. Damages involved the death of a man in his mid-30s who was survived by his wife and two minor children.

Risk management considerations

- Do not allow family to dictate when it contradicts your best professional judgment.
- Be aware of the extent and limitations of treatments available at your facility, and of transfer laws and agreements for accepting and transferring patients in need of care.
- Document all discussions with family, including informed consent and refusal.
- Document phone conversations with other physicians.
- When your recommended care or the decision to not provide treatment deviates from the standard of care, document your rationale in the patient's medical record.

References

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2. Texas Medical Board. Board Rules Chapter 165.1-165.5 Medical Records. Available at <http://www.tmb.state.tx.us/rules/rules/165.php>.

