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Is expert witness in malpractice suit making false, misleading statements?

A witness' testimony could be excluded

(Editor's Note: This is the second of a two-part series on expert witness testimony in medical malpractice cases. This month, we report on how a witness could be prevented from testifying and what actions could result in physicians being accused of witness tampering. Last month, we covered possible approaches if witnesses for the plaintiff give inaccurate testimony.)

Did a plaintiff's expert rely on a study that was not yet available at the time that the incident at issue took place, or a study that was discarded by the medical community in favor of a more recent consensus?

That reliance might be grounds for the witness to be excluded from testifying, says **Scott Perlmuter**, JD, a litigation attorney with the Cleveland, OH-based firm of Novak & Pavlik.

While state law varies on the precise bounds of appropriate expert testimony, experts uniformly are required to employ reliable and prevailing methodology in arriving at their opinions, he explains.

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"Your familiarity with the most up-to-date studies and peer-reviewed data in the subject matter of the case — and how that research has developed in recent years — can be a valuable resource in your defense," says Perlmuter.

With proper support, motions can be filed to preclude an expert witness from offering testimony in a case, says **Maureen M. Vogel**, JD, a shareholder with Polsinelli Shughart in Kansas City, MO. Previous court transcripts typically are public records that can be obtained and used to demonstrate habitual false testimony, Vogel adds. "This information could be used to support a motion to strike the expert from testifying in a case," she says.

Defense counsel will research expert witnesses and determine, among other things, whether their testimony has been disallowed in any other court and the reasons for that ruling, says Vogel. "Habitual false testimony of a witness could be reported to the state

INSIDE cover

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board where the physician is licensed to practice," she adds.

Courts will exclude an expert's testimony if the court finds the opinion is not based on information generally relied upon by members in their field, says **Kenneth C. Brostron**, JD, an attorney with Lashly & Baer in St. Louis, MO. "Experts cannot rely on their personal views — only the standard of care, relying on those standards generally relied on by members of his profession," adds Brostron.

Experts who testify have a qualified immunity as to claims of slander; therefore, such claims require elements of proof regarding knowledge and malice that are difficult to prove, he notes. "The most effective method against unscrupulous experts is to prepare vigorously and refute the expert at every point to discredit him or her," Brostron says. "The jury verdict and the transcript record will follow the expert until he or she no longer are used."

Disqualification unlikely

Judges generally are reluctant to entirely exclude the testimony of a party's expert, but ensuring that a plaintiff's expert is thoroughly cross-examined prior to trial on their methodology is crucial to the defense, says **Charles Emerman**, MD, professor and chairman of emergency medicine at Case Western Reserve University in Cleveland, OH.

"If the expert is well-published in the area of the case and their testimony contradicts their prior writings, that contradiction can be used to attack the credibility of the witness," Emerman says. "It may prove to be the compelling bit of evidence that sways the jury."

It is the work of counsel to seek to disqualify an expert, but there are steps the defendant physician can undertake to assist in their own defense, he advises. "As a party to the case, you can participate in each aspect of the legal proceedings," Emerman says. Physician defendants can take these steps:

• Review commonly used textbooks, guidelines, policy statements, and prominent literature.

"You should not undertake this research except under as part of the instructions of your lawyer, so that it becomes part of their work product," Emerman emphasizes.

• Assist counsel in identifying areas of inconsistency in the expert's courtroom testimony and deposition testimony.

• Appear at the testifying expert's depositions.

"You have the opportunity to inform your counsel, during the conduct of the

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An expert's testimony could be excluded if there is a history of habitual false testimony, or if he or she doesn't employ reliable and prevailing methodology in arriving at opinions. Physicians should allow this problem to be handled by the defense, as litigants who attempt to influence a witness' testimony might face accusations of witness intimidation. Other approaches:

- ✦ Review literature only as part of the instructions of your attorney.
- ✦ Inform counsel of misleading, false, or exaggerated statements.
- ✦ Don't personally take any action against an expert witness.

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Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195, (joy.dickinson@ahcmedia.com), Editor: **Stacey Kusterbeck**, Production Editor: **Kristen Ramsey,** Senior Vice President/Group Publisher: **Donald R. Johnston.**

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deposition, of statements that you think are misleading, false, or exaggerations," says Emerman.

Sanctions are possible

Several professional societies have established review processes and sanctions for expert witness testimony, says **Karen Domino**, MD, MPH, chair of the American Society of Anesthesiologists (ASA)'s Committee on Professional Liability and professor of anesthesiology and pain medicine at the University of Washington in Seattle.

In 2003, for example, the ASA established an Expert Witness Testimony Program in which an ASA member may file a complaint against any other ASA member for giving expert testimony that violates the ASA Expert Witness Ethical Guidelines. The guidelines call for truthful, thorough, and impartial testimony, says Domino, and if an expert's testimony is found by the Committee on Expert Witness Testimony Review to be unethical, the society may sanction a member. "If a state board or medical society has disciplined an expert based on false testimony, defendants in a medical negligence case would seek to have that fact admitted into evidence," says Vogel.

The American Academy of Orthopaedic Surgeons is fighting a jury verdict that found the society unfairly portrayed a former member who acted as an expert witness.[1]

Louise B. Andrew, MD, JD, FACEP, principal of MDMentor.com, a resource for litigation stress support for physicians, says, "Several experts have now sued physician defendants who have brought ethics complaints against them in several medical societies, so it would not surprise me to see this happening again in the wake of the judgment, if upheld on appeal." *(See related story, below, on avoiding allegations of witness tampering.)*

> ***"An expert is there to offer their opinion, and you will have a difficult time prevailing in a claim against their opinion."***

Physician defendants must separate the expert's opinion from the expert's assertion of facts, says Emerman. "An expert is there to offer their opinion, and you will have a difficult time prevailing in a claim against their opinion," he says.

Misstatements about medical facts, such as exaggerated claims about the effectiveness of a particular therapy, are more likely to be the subject of review, according to Emerman. "In some states, the provision of expert testimony is considered to be the practice of medicine," he says. "As such, sanctions may be available through the state medical boards."

Reference

1. Graboff v. the Colleran Firm. (E.D. Pa. Nov. 8, 2010).

SOURCES

For more information on expert witness testimony, contact:

- Louise B. Andrew, MD, JD, FACEP, Victoria, British Columbia, Canada. Phone: (425) 609-0039. Email: mail@mdmentor.com.
- Kenneth C. Brostron, JD, Lashly & Baer, St. Louis, MO. Phone: (314) 436-8305. Fax: (314) 621-6844. Email: brostron@lashlybaer.com
- Karen Domino, MD, MPH, Professor, Anesthesiology and Pain Medicine, University of Washington, Seattle. Phone: (206) 616-2673. Fax: (206) 543-2958. Email: kdomino@uw.edu.
- William Sullivan, DO, JD, Frankfort, IL. Phone: (708) 323-1015. Email: wps013@gmail.com.
- Maureen M. Vogel, JD, Shareholder, Polsinelli Shughart, Kansas City, MO. Phone: (816) 395-0605. Fax: (816) 817-0223. Email: mvogel@polsinelli.com. ✦

Avoid accusations of witness tampering

Once litigation has begun, it is unwise for a defendant to personally take any action against an expert witness, warns **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois Medical Center in Chicago and a practicing attorney in Frankfort, IL.

While the definition of witness intimidation varies between states, many state statutes parallel the federal definition of witness intimidation., says Sullivan. The definition of witness intimidation in federal statutes is expansive and includes the use of intimidation, threats, or harassment with the intent to influence, delay, or prevent the testimony of any person in an official proceeding or which ultimately does delay, hinder, or dissuade a witness from giving testimony, he notes.

"The maximum sentence for witness intimidation under federal statutes is a fine and 20 years in prison," says Sullivan.

Lawful actions taken with the sole intention to cause a witness to testify truthfully may be presented as an affirmative defense to the crime of witness intimidation, acknowledges Sullivan. However, he adds, "this affirmative defense does not prevent witness intimidation charges from being filed and does not preclude the need to retain a criminal attorney whose fees will likely not be covered by medical malpractice insurance."

A defendant radiologist in a 2004 malpractice suit was investigated for witness tampering after anonymously sending a plaintiff's expert an article that advocated blacklisting physicians

who testify against their colleagues, reports Sullivan. "Eventually, the radiologist admitted sending the letter after the judge threatened to obtain DNA samples from all of the defendants in order to match it with DNA from the letter," says Sullivan.

In another instance, an emergency physician was accused of witness tampering after filing ethics charges against an opposing expert during a medical malpractice case. "Even if the expert's testimony was inappropriate, the action taken by the physician was perceived as being intended to influence the expert's testimony," explains Sullivan.

The only advisable recourse against an expert witness who makes inappropriate statements during litigation is to provide one's attorney with any available information that would rebut the testimony and discredit the witness, advises Sullivan.

"After a trial has ended, witness intimidation is no longer a concern. Then, the physician may consider filing ethics charges against the expert for inappropriate testimony," says Sullivan. ✦

Do EMRs reduce or increase lawsuit risks?

Research from Harvard Medical School points to fewer claims

A study from Harvard Medical School that tracked 275 Massachusetts physicians found that 49 claims related to alleged malpractice occurred before implementing electronic medical records (EMRs), and only two claims occurred after EMRs were adopted.[1]

"Hospitals are putting a tremendous amount of resources toward getting all providers of care to use these systems effectively," says **Gloria H. Everett**, president and CEO of MedAmerica Mutual Risk Retention Group, a Walnut Creek, CA-based provider of malpractice insurance and risk management consultative services. "The last thing anyone wants is a mishap in this area."

Tom Baker, JD, a professor of law and health sciences at the Philadelphia-based University of Pennsylvania Law School, says concerns about medical liability are overblown generally, and the vast majority of patients who are injured through malpractice do not bring lawsuits. "That means that concern about liability should never be used as an excuse to avoid improving services," says Baker. "This is especially important with EMRs, because EMRs are one of the most important patient safety technologies ever developed."

Risk reduction strategies with EMRs are the same as always, says Baker: good communication with patients, detailed and careful documentation of treatment, and good follow-up with patients who experience complications.

Baker says, however, that during medical malpractice litigation, "there are a number of ways where plaintiff attorneys may focus on variances of clinical documentation. The expanded use of audit trails and metadata can yield a plethora of data that users may not be aware of."

Many physicians are unaware that every time they interact with the EHR in any way, it creates an electronic footprint that is discoverable by plaintiff counsel, adds **Sandeep Mangalmurti**, MD, JD, a lecturer in law and fellow at the University of Chicago's Section of Cardiology.

Everett says, "As this plays out through the court system, I believe we are going to have a new expert witness in the courtroom, and that is going to be the IT expert." For example, if the healthcare provider believed he or she entered information that was not in the record or in a place in the record that was not intended, the IT expert would be called upon to explain how that could happen or explain there are many "pop ups" in the EMRs, and often they are ignored appropriately.

Rushed implementation?

Michael Vigoda, MD, MBA, chief medical information officer at the University of Miami Health System, says, "In the rush to adopt EMRs, we must recognize that the mere introduction of a new technology does not guarantee improvements in quality patient care."

After go-live, monitoring of documentation by compliance officers with timely feedback to providers might serve as a risk-reduction tool for inadequate or sloppy documentation, he advises. "When the technology works for the physicians and is incorporated into their workflow, that is when we will be able to determine if EMRs reduce the risk of a malpractice claim," he says.

If EMRs hinder communication

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The number of malpractice claims decreased from 49 to two after electronic medical records (EMRs) were implemented at 275 physician practices, but many insurers believe that medical claims rise during the transition from paper to electronic records. To reduce risks:

✦ Have compliance officers monitor documentation with timely feedback to providers.
✦ Ensure EMRs reflect the day-to-day practice of medicine.
✦ Avoid cutting and pasting information from previous visits.

between patient and physician, then there will be negative consequences, says Vigoda, but if communication is improved such as by automated release of lab results to a patient portal, then EMRs "may very well be a contributing factor to a reduction in malpractice claims."

Feedback on risks

Mangalmurti says that while EHRs have the potential to reduce physicians' liability exposure, "they are not a silver bullet."

As for whether EMRs increase or decrease malpractice risks, Mangalmurti says "the jury is still out. I think it's quite likely that they do both. We'll see how it plays out in courts as cases slowly percolate up the system."

Legal risks might increase during the initial implementation because systems are half paper and half electronic, he says, or because the EHR is poorly designed or a physician is not using it correctly. *(See related stories on shortcuts that increase legal risks, below, and inappropriate "cutting and pasting," p. 30.)*

Physicians need to be involved in making sure that EHRs reflect the day-to-day practice of medicine from the beginning, as opposed to scrambling to make changes to the system only after problems occur, Mangalmurti advises.

> ***"I don't think physicians fully appreciate the diversity of EHRs that are out there."***

"I don't think physicians fully appreciate the diversity of EHRs that are out there," he adds. "Some of them are quite good, and some are not so good."

Reference

1. Quinn MA, Kats AM, Kleinman K, et al. The relationship between electronic health records and malpractice claims. *Arch Intern Med.* 2012;1-2. Doi:10.1001/archinternmed.2012.2371.

SOURCES

For more information on legal risks involving audits of charting in electronic medical records, contact:

• **D. Jay Davis Jr.**, JD, Partner, Young Clement Rivers, Charleston, SC. Phone: (843) 720-5406. Fax: (843) 579-1355. Email: jdavis@ycrlaw.com.

• **Gloria H. Everett**, President and CEO, MedAmerica Mutual Risk Retention Group, Walnut Creek, CA. Email: EverettG@mmrrg.com.

• **Sandeep Mangalmurti**, MD, JD, Lecturer in Law and Fellow, University of Chicago Section of Cardiology. Phone: (773) 702-9494. Email: Sandeep.Mangalmurti@uchospitals.edu.

• **Michael Vigoda**, MD, MBA, Chief Medical Information Officer, University of Miami Health System. Phone: (305) 585-7037. Email: MVigoda@med.miami.edu. ✦

Avoid risky shortcuts when you use EMRs

Some shortcuts that physicians have traditionally taken with paper charting might resonate poorly with juries when they do the same thing in an electronic medical record (EMR), warns **Sandeep Mangalmurti**, MD, JD, a lecturer in law and fellow at the University of Chicago's Section of Cardiology.

In one published case, an anesthesiologist prospectively documented events before they occurred, which led to credibility concerns about other documentation by the anesthesia care team.[1]

Michael Vigoda, MD, MBA, chief medical information officer at University of Miami Health System, says, "Ultimately, the anesthesiologist's practice had to settle the case on this basis." Vigoda is lead author of the paper that emphasizes the value of educating physicians about the hazards of continuing with paper-based documentation practices.[1]

"Using our electronic data, we developed an automated notification system that alerted physicians within 24 hours that their record contained improper documentation, specifically referencing the particular case and notation in question," says Vigoda. Within six months, the number of cases with prospective documentation decreased from more than 80% to less than 0.5%, he reports.

"Education was the key and timely feedback was the tool that we used to accomplish this," he says. "We capitalized on the opportunity to use the EMR to improve our clinical practice."

Inappropriate late entries

Making a late entry to appear as though it was part of the original note, or charted at the time of the original note, also could have serious consequences, warns **Rolf Lowe**, JD, an attorney with Rogers Mantese & Associates in Royal Oak, MI.

Always acknowledge late entries as a new or amended note, he advises.

"Attempts to backdate entries or add to prior notes can have repercussions on many levels, from a false claim action to an action by a state licensing board, not to mention evidence that could be harmful in a malpractice suit," Lowe says. "Digital forensics experts can easily identify when the entries were made."

Reference

1. Vigoda MM, Lubarsky DA. The medicolegal importance of enhancing timeliness of documentation when using an anesthesia information system and the response to automated feedback in an academic practice. *Anesth Analg* 2006; 103(1):131-136. ✦

'Cut and paste' can make case indefensible

While defending a physician in a medical malpractice lawsuit, **D. Jay Davis Jr.**, JD, a partner at Young Clement Rivers in Charleston, SC, and chair of the firm's Medical Liability Practice Group, learned that a nurse had made a habit of "cutting and pasting" information for patient evaluations in the electronic medical record (EMR) to save time.

"The implications of this are obvious and rise to the level of fraud," says Davis. "The actions in that case made a defensible case indefensible. Cut and paste demonstrates an extreme lack of care for the patient."

In this case, the patient ultimately was diagnosed with an epidural abscess. "The forms the nurse used included four-hour checks of the patient's neurological status by the nurse. She cut and pasted findings for everything included in this section," says Davis.

The initial evaluation had accurate findings that the patient was moving all extremities well. "The problem was the patient developed paralysis between the initial evaluation and the later entries," he says. "It became very clear when the patient was paralyzed and transferred to surgery that he could no longer 'move all extremities well.'" Davis says that although newer EMRs have removed this option, it still exists in some older systems.

Physicians need to fill in extensive documentation to get reimbursed fully for a visit, which has led to a "cutting and pasting phenomena," says **Sandeep Mangalmurti**, MD, JD, a lecturer in law and fellow at the University of Chicago's Section of Cardiology. "It could be quite innocent, and the physician may have come up with an independent, evolving assessment of what's going on with the patient, but that may not be captured," he says.

A note that was clearly cut and pasted from a previous visit appears as though the physician wasn't paying attention, Mangalmurti says. If the physician is caught cutting and pasting, he says, "there is no there is no explanation that sounds good. The only thing you can say is, 'I was in a rush and had a lot of things to do.'" ✦

Was order texted? Patients are at risk

While a resident was entering an order to discontinue warfarin, she was distracted by an incoming personal text message that interrupted the order, and the patient continued to receive the drug for three days.[1]

The patient required emergency open heart surgery, which the team members thought was due to spontaneous bleeding into the pericardium from receiving the extra doses of warfarin.

"Today's young physicians often text while doing care-related tasks. I would encourage clinicians to avoid personal texting entirely while delivering patient care," says **John D. Halamka**, MD, MS, chief information officer of CareGroup Healthcare System in Boston and associate dean for educational technology at Harvard Medical School. "All our ordering systems are web-based and accessed via a secure https session. We do not support texting in any clinical context, because it is not secure nor auditable."

There are emerging products in the marketplace such as TigerText (http://www.tigertext.com) that enable healthcare organizations to host secure texting systems within their firewalls, notes Halamka, but CareGroup has not implemented such products. "Given that provider order entry via a certified EHR [electronic health record] is a requirement of meaningful use, I see no role for texting in ordering processes," he says.

"I would encourage clinicians to avoid personal texting entirely while delivering patient care."

Here are some liability risks involved with texting orders:

• There is no way to verify that the intended recipient actually received, or acted on, the order.

Paul A. Anderson, director of risk management publications for the Plymouth Meeting, PA-based ECRI Institute, a nonprofit organization that researches approaches to improve

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If orders are texted, there is an inability to identify the person sending the text, and there is no way to permanently keep the original message. Other risks of this practice:

✦ There is no way to verify that the intended recipient actually received, or acted on, the order.
✦ Auto corrections on smartphone dictionaries could cause errors or delays.
✦ There is a possibility of an unauthorized person sending in orders.

patient care, says, "The intended recipient's phone could be off or not able to get a signal, or the recipient could just ignore the phone because they're in the middle of some other task."

• Because medical terms and abbreviations are unlikely to be in a smart phone's dictionary, these may be autocorrected.

"If the ordering physician doesn't notice the change, it could change the message into nonsense and delay care," says Anderson. "Or it could introduce a clinically significant error, leading to, for instance, a wrong drug being ordered."

From the point of view of the person receiving the order, there's no way to verify that the person sending the order is who they say they are, he adds. "The risk here is that someone who's not authorized to do so sends in orders, whether that's some third party using the physician's phone, or, less likely, some third party 'spoofing' the physician's phone to impersonate them," says Anderson.

Technological solutions are being developed by EHR providers and other vendors to address identification and verification issues for texted orders, notes Anderson. "Before implementing any of them, a physician practice should ask to speak with references who have implemented it and should put the system through its paces to assess how it handles these risks," he recommends.

Key questions to answer are: How easy is it to send the order to the wrong person? Does the text sync with the medical record appropriately? Can you confirm that the recipient received and acted on the order? "In the absence of such a solution, texting really should be avoided," says Anderson, noting that there could conceivably be an emergency situation in which texting is the only available form of communication and the risks are outweighed by the need to supply the order immediately.

"In general, though, even a verbal or telephone order is preferable to a texted order," he says. "In those scenarios, at least the two parties have an opportunity to interact and ask questions. Both parties know that the other is listening at that moment."

Reference

1. Agency for Healthcare Research and Quality. Cases & Commentaries: Order interrupted by text: Multitasking mishap. December 2011.

SOURCES

For more information on liability risks of texting orders, contact:

• Paul A. Anderson, Director, Risk Management Publications, ECRI Institute, Plymouth Meeting, PA. Phone: (610) 825-6000, Extension 5244. Fax: (610) 834-1275. Email: panderson@ecri.org.

• John D. Halamka, MD, MS, Chief Information Officer, CareGroup Healthcare System, Boston. Email: jhalamka@caregroup.harvard.edu. ✦

Negligent retention or hiring: Bigger verdict?

If a plaintiff sues not only a physician but also the physician group that contracts to provide services at the hospital, the plaintiff might argue a negligent hiring or negligent retention theory, says **Joseph P. McMenamin**, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods.

According to this argument, the physician group owes a duty to patients to exercise due care in selecting physicians entrusted with the responsibility to care for them, he explains.

When a plaintiff perceives that an injury has occurred at the hands of a physician group's employee, the plaintiff might allege that the physician group knew or should have known that the employee was incompetent or unfit, says **Karen B. Everitt**, BSN, JD, regional vice president of risk management at ProAssurance Companies in Birmingham, AL. The plaintiff might allege that the physician group should have never hired the employee or terminated the employee before the injury occurred.

The plaintiff attorney could argue that the group should not have hired the physician named in the suit due to multiple previous suits as a result of misdiagnoses, disciplinary actions, or licensing difficulties, for example. "The argument is that because you were careless in the way you handled [the background check], I have a claim against you," McMenamin says.

Avoid allegations

Everitt gives these risk-reducing strategies to avoid a negligent hiring allegation:

• Obtain a copy of the candidate's licenses and/or certifications from the original source.

• Run the candidate's name through

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Plaintiffs might argue a negligent hiring or negligent retention theory, with the possible goal of seeking a higher verdict. They may claim that a physician should not have been hired or retained because the group should have known the physician was unfit or incompetent. To reduce risks:

✦ Obtain copies of licenses and certifications from the original source.
✦ Verify that the candidate is not barred from participation in federally funded health care programs.
✦ Validate and annually re-evaluate competency, especially in clinical skills.

the Department of Health and Human Services Office of the Inspector (OIG) General List of Excluded Individuals and Entities, which lists individuals who cannot participate in federally funded healthcare programs due to Medicare or Medicaid fraud, patient abuse, and certain felony convictions. *(The OIG's online searchable database used to enter the name of an individual or entity and determine whether they are excluded is at http://oig.hhs.gov/exclusions.)*

• Find out if the candidate is registered in national and state sex offender registries. *(The website for the Dru Sjodin National Sex Offender Public Website is nsopr.gov.)*

• Validate competency at the beginning of the employment relationship, and annually re-evaluate competency, especially in clinical skills.

To prove that a physician group negligently retained the employee, the plaintiff must show the jury that the employee had conduct or tendencies that would have been apparent or discovered if the physician group had exercised reasonable care when hiring the employee, says Everitt.

In some states, negligent hiring is not included as an allegation under the state's medical malpractice act, she adds. The negligent hiring allegation gives the plaintiff an avenue to seek a higher verdict than available under some state medical malpractice acts, because damages from a negligent hiring action wouldn't be subject to state medical malpractice caps, Everitt says.

If a claim is filed for negligent hiring, depending on state law, the defendant might be able to argue that there is no cause of action for negligent hiring if the doctor is an independent contractor and not an employee, says McMenamin. "The defendant could argue that the prejudicial outcome of discovery of the doctor's personnel file, for example, would greatly outweigh its probative value, since the theory is that on this particular occasion Doctor A breached the standard of care, and it doesn't matter what he did the previous week, the previous month, or the previous year," he explains.

The defense argument would be that the jury should not be distracted by the physician's previous problems, when the real question is, "How did he perform on this particular occasion?" says McMenamin.

SOURCES

For more information on negligent hiring and negligent retention theories, contact:

• Karen B. Everitt, RN, JD, Regional Vice President, Risk Management, ProAssurance Companies, Birmingham, AL. Phone: (205) 802-4703. Fax: (205) 414-2805. Email: keveritt@proassurance.com.

• Joseph P. McMenamin, MD, JD, FCLM, Partner, McGuireWoods, Richmond, VA. Phone: (804) 775-1015. Fax: (804) 698-2116. E-mail: jmcmenamin@mcguirewoods.com. ✦

Don't fail to follow up on findings: Avoid suits

If a chest X-ray ordered by a specialist has suspicious findings requiring follow-up, the patient's primary care physician might not even be aware that the test was ordered. Still, in the event a malpractice lawsuit is filed, the primary care doctor could be held accountable for following up, says **Marlene Nazarey**, RN, MSN, CPHRM, risk control director at Chicago-based CNA HealthPro, a provider of insurance coverage for the healthcare industry.

"The specialist who ordered it needs to ensure the primary care doctor is aware of the result," she adds.

If the patient becomes symptomatic and has a chest X-ray in the future, or the radiologist compares previous X-rays with the patient's current one, it would then be discovered that the patient had an abnormality on a previous film that wasn't addressed, Nazarey says. "Now the patient is symptomatic, and the disease may have progressed," she says. "This could result in a delay to diagnose or failure to diagnose claim if it's not acted on at the time of the initial test."

To ensure that incidental findings aren't overlooked, physicians need a follow-up system with these components, advises Nazarey:

1. When physicians order tests, they should have a system in place which notifies them that the results have not been received.

"Sometimes the lab or imaging center may have a problem, and the results are not provided to the physician," says Nazarey. The system, whether paper or electronic, needs to flag physicians so it will become obvious to them that they didn't get a result back from tests that they ordered.

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A primary care physician might not be aware that a diagnostic test was ordered by a specialist, but he or she could be liable for lack of follow-up if the patient sues.

✦ Alert physicians if results don't come back.
✦ Ensure physicians acknowledge and act on reports that need intervention.
✦ Send the ordering physician an acknowledgment that results were received by specialists.

2. The physician needs to review all the results that come back to the office.

"If a physician misses an abnormal result, and it is just filed away in the medical record, it could go unaddressed," Nazarey says. "The system needs to make sure that the physician acknowledges and acts on any reports that need intervention."

3. If the test results need to be sent to another medical provider, the system should send the ordering physician an acknowledgement that the other provider received the results.

Nazarey says that in certain situations, the physician might want to communicate written or verbally with the specialist, to clarify which provider is going to take care of which aspects of the patient's care.

"I've seen cases where one provider thought the other was following up on a certain need of the patient, and vice versa," she says.

4. The patient needs to be informed of the results.

"The patient needs to know what he or she needs to do. It may be that the patient needs to come back to the physician for further evaluation, or needs a repeat test done in a week or month," says Nazarey.

Sharing results is key

Mistakes are rarely made and incorrect actions are rarely taken when a physician has all of the information needed to make a decision, says **Timothy J. Ward,** senior vice president of Marsh USA in Greenville, SC.

"In our current age, with incredible technology in both diagnostic testing and information technology, it still comes down to having clear roles in how this information will be shared," he says.

Physicians cannot have tunnel vision when looking at diagnostic studies, and must confirm that significant incidental findings are properly communicated to the patient and their primary healthcare provider, emphasizes Ward.

"When information is not properly communicated, it can't be acted upon," he says. "This leads to problems for the patient and the physician." *(See related story on the role of EMRs in ensuring follow-up, below.)*

SOURCES

For more information on liability risks of failing to follow up on incidental findings, contact:

- **Marlene Nazarey**, RN, MSN, CPHRM, Risk Control Director, CNA HealthPro, Chicago. Phone: (424) 206-9840. Fax: (424) 206-9870. Email: marlene.nazarey@cna.com.
- **Dennis Olson**, CPHRM, Vice President, Risk Management, Physicians Insurance, Seattle. Phone: (206) 343-6501. Email: dennis@phyins.com.
- **Timothy J. Ward**, Senior Vice President, Marsh USA, Greenville, SC. Phone: (864) 240-4366. Email: Timothy.J.Ward@marsh.com. ✦

EMRs can flag lack of follow-up on findings

Keep in mind: There also are risks

If a referring physician asks another physician to do a test to look for a fractured left clavicle, the testing physician might focus on the left clavicle and make his finding with just a cursory overview of the rest of the test field, says **Dennis Olson**, CPHRM, vice president of risk management for Physicians Insurance in Seattle.

Therefore, the testing physician might overlook or fail to comment on the small shadow in the bottom left corner of the lung. "Subsequently, two years later there is a cancer diagnosis, and a retrospective look at the initial test shows the shadow, which now is clearly identified as early signs of the cancer," says Olson. "Thus, a missed diagnosis claim ensues."

Could an electronic medical record (EMR) system prevent this lawsuit from happening? "Certainly, there are alerts or other functional capabilities within an EMR system that could be configured to provide a physician with a checklist to consider when reviewing a scan," says Olson. "The challenge is the alerts are only as good as the programming."

EMR systems allow for reminders of needing to follow-up on incidental findings along with suggested additional treatment options, and they can allow for automatic routing to all of the appropriate parties, including physicians and patients, he says. "They can provide documentation of when and where actions were taken, to establish timelines, chronology, and move responsibilities and accountabilities," Olson says.

EMRs can be overwhelming, however, so the simpler the alerts or checklists, the more likely they are to be considered by an end-user physician, says Olson.

Elke Kirsten-Brauer, executive vice president and chief underwriting officer for MGIS Underwriting Managers, a business unit of the Salt Lake City, UT-based MGIS Companies, says that EMRs can help physicians to "become more clinically consistent" in looking at lab results or reports and following up on this information.

"However, EMRs can also work against the physician or practice, in cases where the system acknowledges the information was relayed, but no intervention or action was documented," says Kirsten-Brauer. ✦

Elective inductions may raise legal risks

Compared with women who entered labor spontaneously, elective induction was associated with a 67% increased chance of requiring a cesarean delivery, according to a study on over 28,000 births in South Australia from 2006 to 2007.[1]

These researchers compared women who had undergone spontaneous onset of labor, induction of labor for recognized medical reasons, and induction of labor for "non-recognized" reasons. Induction for non-recognized reasons also increased the chance of the newborn infant requiring nursery care in a Special Care Baby Unit by 64%.

Compared with children born at 41 weeks, children born at 37 weeks had a 33% increased chance of having severe reading difficulty in third grade, and a 19% greater chance of having moderate problems in math, according to a just-published study of 128,000 New York City public school children.[2]

Greater malpractice risks

Late preterm inductions nearly tripled from 1991 to 2003, during which time obstetricians' professional liability premiums doubled.[3] "Studies estimated that almost half of this premium increase is attributable to late preterm elective inductions," says **James M. Shwayder**, MD, JD, professor and chair in the Department of Obstetrics and Gynecology at the University of Mississippi Medical Center in Jackson.

There is clear evidence that late preterm induction results in higher neonatal morbidity and mortality rates compared with infants born at term. There is also data to support decreasing neonatal intensive care admissions for infants born between 37 and 39 weeks of gestation.[4] Adverse outcomes include adverse respiratory outcomes, mechanical ventilation, newborn sepsis, hypoglycemia, and prolonged hospitalization.

"There is no question that resulting complications surrounding labor and delivery raise the specter of malpractice," says Shwayder. "The logical conclusion is that complications ensuing from elective induction place a physician at greater risk for suit."

There is clear evidence that late preterm induction results in higher neonatal morbidity and mortality rates compared with infants born at term.

References

1. Grivell RM, Reilly AJ, Oakey H, et al. Maternal and infant outcomes by onset of labour at term: a population-based cohort study. *Acta Obstet Gynecol Scand* 2012; 91(2):198-203.
2. Noble KG, Fifer WP, Rauh VA, et al. Academic achievement varies with gestational age among children born at term. *Pediatrics*; originally published online July 2, 2012. Doi: 10.1542/peds.2011-2157.
3. Murthy K, Grobman WA, Lee TA, et al. Obstetricians' rising liability insurance premiums and inductions at late preterm gestations. *Med Care* 2009; 47:425-30.
4. Oshiro BT, Henry E, Wilson J, et al. Decreasing elective deliveries before 39 weeks of gestation in an integrated health care system. *Obstet Gynecol* 2009; 113:804-11.

SOURCE

For more information on liability risks of elective inductions, contact:

• **James M. Shwayder**, MD, JD, Professor and Chair at the University of Mississippi Medical Center, Jackson. Phone: (601) 815-9114. Fax: (601) 984-6904. E-mail: jshwayder@umc.edu. ✦

Executive Summary

Complications ensuing from late preterm elective induction place physicians at greater risk for malpractice suits, which are linked to higher professional liability premiums.

- ✦ Late preterm inductions result in higher neonatal morbidity and mortality rates compared with infants born at term.
- ✦ Late preterm inductions nearly tripled from 1991 to 2003, while liability premiums doubled.
- ✦ Complications include adverse respiratory outcomes, required mechanical ventilation, newborn sepsis, hypoglycemia, and prolonged hospitalization.

Actions after suit may worsen physician's woes

If you learn you are named in a lawsuit, your first impulse is likely to be accessing the patient's medical record.

"Even though you will be extremely curious and concerned, you should not access the patient's file, especially if it is in electronic form," advises **Stephen W. Coles**, JD, an attorney with Nexsen Pruet in Greensboro, NC.

Electronic medical records keep track of who accesses the records and when, and a physician does not want to leave an audit trail that shows multiple viewings of electronic records, he explains. "It is preferable to wait for your attorney

Executive Summary

Physician defendants should not access the patient's medical record until an attorney is involved and the action is protected by discovery. Take these steps:

✦ Give paper charts to the attorney immediately to avoid allegations the chart was altered.
✦ Avoid discussing the case with anyone except your professional liability carrier and your attorney.
✦ Never attempt to contact the patient or family members.

to become involved before you access the records," he says. "You can then access the records at his direction. Such action would be protected from discovery because it involves legal advice and work product."

A good plaintiff's lawyer will ask you about all the things you did when you first found out about the lawsuit, and you will be under oath and have to respond honestly and fully, warns Coles. Take these steps if named in a lawsuit:

• If a patient has a paper chart, lock it up or put it someplace secure.

"If you get an attorney, it is preferable to get it to the attorney as soon as possible so that no allegations can be made that the chart was altered in any way," Coles says.

• Never alter the chart in any way.

"This is true even if you find mistakes when you go back to the chart," Coles says. "If and when the case ever goes to trial, altering the records can cause a catastrophe."

• You should not discuss the case with anyone except your professional liability carrier and your attorney.

"Initially, it is advisable not to talk to family, even spouses," Coles says. "The same holds true for your partners."

You can tell them you have been sued and by whom, but do not talk to them about details until an attorney is retained and conversations can be protected from discovery due to attorney/client privilege and the work product rule, he advises.

"Remember, if the plaintiff finds out you said anything to others, that can be used at trial," Coles says. "Do not make any notes or diary of events until you are represented by counsel."

• Never contact the patient or family members.

This advice applies in every single circumstance, even if you believe that family members might be on your side.

"Never try to talk to people in an effort to sway their opinion about what did or did not happen," says Coles.

SOURCE

For more information on actions to take after being named in a lawsuit, contact:

• Stephen W. Coles, JD, Nexsen Pruet, Greensboro, NC. Phone: (336) 387-5130. Fax: (336) 387-8909. Email: scoles@nexsenpruet.com. ✦

COMING IN future MONths

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✦ How to protect your assets if named in suit

✦ Surprising reasons why claims get dismissed

✦ Dramatically cut legal risks with patient callbacks

CME OBJECTIVES

After reading *Physican Risk Management*, the participant will be able to:

- describe the legal, clinical, financial, and managerial issues pertinent to physician risk management;
- explain the impact of risk management issues on patients, physicians, legal counsel, and management;
- identify solutions to risk management problems for physicians, administrators, risk managers, and insurers to use in overcoming the challenges they face in daily practice.

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.

2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CME Questions

1. Which is true regarding testimony of a plaintiff's expert witness, according to Maureen M. Vogel, JD, a shareholder with Polsinelli Shughart?

A. Experts are not generally required to employ reliable and prevailing methodology in arriving at their opinions.

B. Habitual false testimony could be used to support a motion to strike the expert from testifying in a case.

C. Courts will never exclude an expert's testimony simply because the expert's opinion is not based on information generally relied upon by members in their field.

2. Which is true regarding a plaintiff's use of negligent hiring or negligent retention theory, according to Karen B. Everitt, BSN, JD, regional vice president of risk management at ProAssurance Companies?

A. No state laws permit defendants to argue that there is no cause of action for negligent hiring if the doctor is an independent contractor and not an employee.

B. To prove that the physician group negligently retained the employee, the plaintiff must prove that the employee had conduct or tendencies that would have been apparent or discovered if the physician group had exercised reasonable care when hiring the employee.

C. Negligent hiring is an applicable allegation under all state medical malpractice acts.

D. It is never possible for the plaintiff in any state to use a negligent hiring allegation to seek a higher verdict than available under the state's medical malpractice act.

3. Which of the following is recommended for physicians named in a lawsuit, according to Stephen W. Coles, JD, an attorney with Nexsen Pruet?

A. Even before contacting an attorney, physicians should immediately access the patient's electronic medical record to review the care provided.

B. A physician should access the patient's medical records only at the direction of his or her attorney, because such action then would be protected from discovery.

C. It is acceptable to give partners details of the suit even before an attorney is retained.

D. It is advisable for physicians to contact family members of the plaintiff if he or she believes they are sympathetic to the physician.

4. Which of the following is true, according to William Sullivan, DO, JD, FACEP, an emergency physician at University of Illinois Medical Center and a practicing attorney?

A. Lawful actions taken with the sole intention to cause a witness to testify truthfully cannot be presented as an affirmative defense to the crime of witness intimidation.

B. Once litigation has begun, it is unwise for a defendant to personally take any action against an expert witness.

C. The definition of witness intimidation in federal statutes does not include the use of intimidation, threats, or harassment with the intent to influence, delay, or prevent the testimony of any person in an official proceeding or which ultimately does delay, hinder, or dissuade a witness from giving testimony.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Failure to diagnose pregnant woman's fetal defects including missing limbs leads to $4.5 million verdict

By **Jonathan D. Rubin**, Esq.
Partner
Kaufman Borgeest & Ryan
New York, NY

Ericka Saint-Hilaire, JD, RN, MPH
Associate Attorney
Kaufman Borgeest & Ryan
Valhalla, NY

Carol Gulinello, RN, MS, CPHRM
Vice President, Risk Management
Lutheran Medical Center
Brooklyn, NY

News: A 30-year-old pregnant woman's medical team, including ultrasound sonographer and the supervising physician, failed to diagnose her fetus's numerous defects, including missing limbs. A lawsuit was filed against the hospital, ultrasound sonographers, and supervising physician by the child's mother and father on his behalf. Prior to trial, the plaintiffs settled their claims with the hospital for an undisclosed amount. The plaintiffs' claims against the ultrasound sonographer and supervising physician proceeded to trial. Following trial, the jury returned a verdict of $4.5 million.

Background: A 30-year-old female had an ultrasound performed on March 12, 2008, at the hospital and she learned she was approximately 7.8 weeks pregnant. On March 13, 2008, and March 22, 2008, the woman reported to the hospital's emergency department for vaginal bleeding. However, she was reassured each time that the ultrasounds continued to show normal amniotic fluid, fetal motion, and fetal limb movement.

As a result of this lawsuit, the hospital changed its protocols and now identifies each limb of the developing fetus during an ultrasound.

The patient scheduled an anatomical survey ultrasound that was performed on June 4, 2008. A physician prepared the preliminary obstetrical ultrasound report but failed to confirm the presence or absence of legs or arms, normally part of the minimal elements of a standard examination of fetal anatomy. The supervising physician signed the ultrasound report. Genetic counseling and a Level II ultrasound were scheduled because the ultrasound report had diagnosed the fetus's echogenic cardiac focus and unilateral pylectasis.

The patient reported to the hospital for the Level II ultrasound with a sonographer. The sonographer's preliminary report again failed to confirm the presence or absence of legs and arms, and the supervising physician signed each report.

On Oct. 15, 2008, the patient present to the hospital in labor and gave birth to her son via cesarean section. Upon assessment, it was noted that patient's newborn son suffered from aplasia and hypoplasia, with both arms absent below a short humerus, an absent leg with a rem-

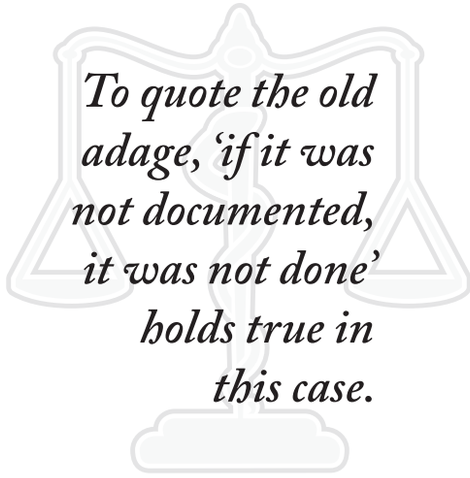
FINANCIAL DISCLOSURE: Co-Authors **Jonathan D. Rubin**, Esq., **Ericka Saint-Hilaire**, **Carol Gulinello**, and **Philip Nash**, co-authors, and Executive Editor Joy Dickinson report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

nant foot, and three small toes and other anomalies. The mother testified at trial that it was heartbreaking to see her son's condition.

A lawsuit was filed against the hospital, ultrasound sonographers, and supervising physician by the child's mother and father on his behalf. The plaintiffs argued that the hospital negligently breached their duties to provide reasonable care in accordance with prevailing professional standards when they failed to detect the unknown fetal defects. The plaintiffs also argued that the defendants failed to report the minimal elements of a standard fetal anatomy ultrasound, failed to report the minimal elements of a Level II ultrasound, failed to confirm the presence or absence of legs and arms during the ultrasounds, failed to diagnose fetal hypoplasia of the upper extremities and aplasia of the left lower extremity, and failed to inform the plaintiffs of the existing fetal defects. The child's parents also claimed that because of the hospital's negligence, they were unable to make an informed decision about whether to terminate the pregnancy.

Prior to the trial, the plaintiffs' agreed to settle their claims against the hospital. Their remaining claims against the supervising physician and the sonographer proceeded to a jury trial. At trial, the mother testified at trial that had she known about her son's abnormalities, she would have terminated the pregnancy. She also testified about the difficulty her son has playing with toys and how uncomfortable it is for him to wear a prosthetic leg. The plaintiff's also presented expert testimony that detailed the level of care the child will need over the course of his life and the price of various prosthetics and equipment that will be required. In response, the defense argued that ultrasounds are not foolproof tests. They presented the jury with the mother's signed consent forms, which acknowledged that ultrasound results are not a warranty of a normal fetus.

As a result of this lawsuit, the hospital changed its protocols and now identifies each limb of the developing fetus during an ultrasound. This change brings the hospital in line with national standards. After the trial, one juror stated that the jury wanted to send a message that the care received in this case was unacceptable and there was no reason for this to happen.



To quote the old adage, 'if it was not documented, it was not done' holds true in this case.

The jury returned a verdict of $4.5 million for the damages sustained by the patient. The jury determined that the supervising physician was 85% liable and the sonographer was 15% liable. To date, according to court records, an appeal has not been filed.

What this means to you: For informational purposes, the difference between a Level I and Level II ultrasound is the level of detail a practitioner can expect to receive from each study.

A Level I ultrasound is performed before 12-14 weeks of pregnancy and will indicate the fetal anatomy measuring heart, head, limbs, and overall gestational size. If anomalies are detected, there is time for early intervention.

The Level II ultrasound also will focus on the fetal anatomy and is usually performed between the second and third trimester of pregnancy, or 18-22 weeks. It will reveal a greater level of detail such as the size of the fetus (gestational age, fetal growth, and weight), organ formation, presence and absence of extremities, amount of amniotic fluid, any maternal cervical changes that might indicate premature labor, and sometimes the sex. If anomalies are discovered, it is still early enough in the pregnancy for intervention.

Additionally, all ultrasound machines that are designated to perform OB/GYN ultrasound examinations have highly specialized software that includes all the standardized elements recommended by the American College of Obstetricians and Gynecologists (ACOG) or American Institute of Ultrasonic Medicine (AIUM) for Level I and Level II ultrasonography. As part of the routine printed ultrasound report, the presence or absence of limbs, as well as the testing elements listed above, would be standard in the fetal anatomy scan.

According to this case study, this patient underwent 3 Level II ultrasound examinations. At this stage of gestational age, fetal extremities would have been very clearly visualized. It is unclear why there was no mention of the fetal extremities in the formal printed ultrasound reports or in the subsequent physician documentation.

Therefore, from a risk management perspective, the implementation of a standardized checklist would be a prudent corrective action. The checklist should include the required criteria for Level I and Level II sonograms. A checkbox noting that all prior ultrasound exams were reviewed for comparison should be included as well. Both physicians and sonographers must be required to complete the checklist and address each of the criteria listed. A comment section documenting the acknowledgment

of the ultrasound results followed by a signature of the physician and sonographer would be required for completion. An audit should be performed by the obstetrics department to ensure compliance with required documentation.

To quote the old adage, 'if it was not documented, it was not done' holds true in this case.

Reference:

15th Judicial Circuit, Palm Beach County, FL. Case No. 50 2010 CA 004745. 2011 WL7070236. ✦

Hospital's missed total arterial blockage results in jury verdict of $6.4 million

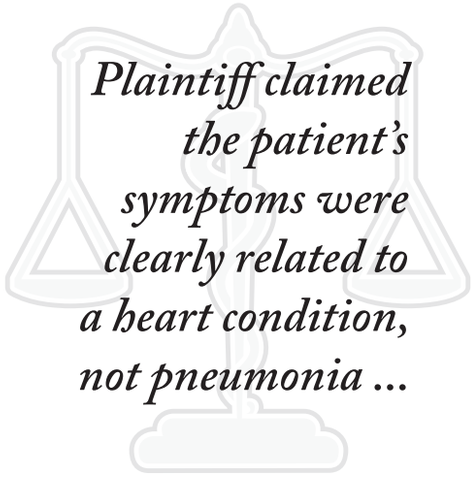
By **Jonathan D. Rubin**, Esq.
Partner
Kaufman Borgeest & Ryan
New York, NY

Philip Nash
Law Clerk
Kaufman Borgeest & Ryan
Garden City, NY

Carol Gulinello, RN, MS, CPHRM
Vice President, Risk Management
Lutheran Medical Center
Brooklyn, NY

News: A 37-year-old man was transported to the emergency department complaining of chest and shoulder pain after playing basketball earlier in the day. EMS workers noted the man experienced atrial fibrillation en route to the hospital. At the hospital, he was given ibuprofen and azithromycin, diagnosed with having pneumonia and syncope, and released. Three months later, the man passed out during a game of basketball, suffered a seizure, and was taken again to the emergency department. He was diagnosed with an acute heart attack with cardiac arrest as a result of a total arterial blockage to the left anterior descending coronary artery. He suffered anoxic brain injury and required the use of a ventilator. The man died in a long-term care facility two months later. The estate administrator brought a lawsuit on behalf of the surviving children against the treating physicians and the hospital and alleged negligent care and wrongful death resulting from the first emergency department visit. The jury returned a verdict of $6.4 million.

Background: A 37-year-old man was transported to the emergency department on May 31, 2009, and was complaining of chest and shoulder pain. He first began to experience the pain during a game of basketball earlier in the day. En route to the hospital, EMTs reported the man experienced atrial fibrillation. Once at the hospital, the man told a nurse that chest pain was radiating down his right arm. An EKG was ordered, which indicated early myocardial infarction. The man's white blood cell count also was elevated. One of the treating physicians noted the man reported chest and shoulder pain and that he showed signs of acute coronary syndrome. However, the treating physicians diagnosed the man with pneumonia and syncope, gave him ibuprofen and azithromycin, and released him several hours after he first presented at the emergency department.



On Aug. 30, 2009, three months after his release from the emergency department, the man collapsed while playing basketball and suffered a seizure. EMTs arrived and found the man vomiting, spitting, and coughing before going into shock and needing to be resuscitated. The man was brought to the same hospital as on May 31. He was found to have total arterial blockage to the left anterior descending coronary artery and suffered a heart attack with cardiac arrest and anoxic brain injury. Now ventilator-dependent, the man was placed into a medically induced coma. He was transferred to a long-term care facility on Oct. 7 where he died on Nov. 12, 2009.

A lawsuit was filed against two emergency department physicians and the hospital by the estate administrator on behalf of the five surviving children. Plaintiff argued the defendants violated the standard of care when the man was first brought to the emergency department on May 31, 2009, and that the hospital's guidelines were not followed. Plaintiff claimed the defendants failed to admit their patient for a full cardiac work-up and order cardiac biomarkers and a lipid panel after the results of his EKG. Plaintiff claimed the patient's symptoms were clearly

related to a heart condition, not pneumonia, and that this condition was treatable had the patient been properly diagnosed.

In support of the hospital and physicians, the defense argued that the treatment received in the emergency department and diagnosis of pneumonia was consistent with the symptoms exhibited by the patient. The defense also argued that if the patient were truly suffering from early myocardial infarction when he first presented to the emergency department on May 31, he would have exhibited other symptoms or complaints between the time of his discharge in May and collapse playing basketball on Aug. 30. The defense argued that the record did not indicate any such complaints by the patient between his two emergency department visits. The defense also referenced the patient's criminal record and statement to hospital workers that he had smoked marijuana earlier in the day on May 31, which seemingly was an attempt to limit the jury's damage calculation for the children's loss of guidance and moral upbringing.

After a weeklong trial, the jury returned a verdict of $6.4 million for the damages sustained by the patient. The two emergency department physicians were found 98% negligent, and the hospital was determined to be 2% negligent. The defense has filed an appeal.

What this means to you:
Literature has shown that although coronary artery disease (CAD) can develop in young adults and might be more prevalent than one might think, it still might not be the first consideration by the treating physician when a young patient comes into an emergency department setting with complaints of chest pain. This scenario is especially relevant if there has been no prior history of a cardiac event or other related symptoms. Although this patient had a history of atrial fibrillation while en route to the hospital and classic symptoms of a cardiac event — chest pain radiating down the arm and positive EKG in the ED — the ED physician's thought process was swayed by an increased white blood cell count and other "consistent" symptoms of pneumonia. It seems that he/she did not at all consider a cardiac event and, in fact, ignored blatant cardiac symptoms.

Clearly this patient was denied the benefit of a full cardiac workup which, at a minimum, should have included an overnight admission,

performance of two cardiac biomarkers (troponin levels and creatine phosphokinase [CPK]), serial EKGs and, possibly, a stress test. If the results of this cardiac workup proved negative for a cardiac diagnosis, then a diagnosis of pneumonia should be considered, but not until then.

The defense argued that that if the patient were suffering from a myocardial infarction when he first presented to the emergency department in May, he would have exhibited other symptoms between the time of his discharge and collapse in August. The defense based this argument on the fact that the patient did not mention any suspicious complaints in the time between the two emergency department visits. This defies logic. CAD can be an insidious disease and without appropriate treatment, his condition was likely to deteriorate over time. Additionally, based on his overall condition upon arrival to the emergency department in August, he would likely be a poor historian as it related to prior symptoms.

Unfortunately, according to the case study, there was no documentation by the treating physician articulating his/her clinical thought process while providing evidence to substantiate one diagnosis versus another upon discharge.

From a risk management perspective, this case is one of a knowledge deficit on the part of the emergency department physician treating this patient. A corrective action plan would include a significant educational component with subsequent monitoring of performance.

An educational curriculum would include; a review of a chest pain protocol; a review of EKG interpretations with a focus on diagnosis of myocardial infarctions; a review of symptoms of low-, intermediate-, and high-risk cardiac patients with respective appropriate testing modalities; and review of appropriateness of documentation including discharge summaries and follow-up treatment plan.

In addition to the education for the emergency department treating physician, I would recommend a focused random concurrent review of his/her charts of all patients presenting with complaints of a cardiac nature and who have an EKG performed during their visit.

The lack of documentation, poor clinical judgment, and overall knowledge deficit made this case indefensible.

Reference

Court of Common Pleas of Philadelphia County, Pennsylvania. Case No. 091203310. ✦