PHYSICIAN Risk Management

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A growing number of lawsuits involve poor communication — multiple MDs involved

Plaintiff lawyers paying close attention

It's an increasingly common scenario in a malpractice suit: A primary care physician refers a patient to a specialist, and each assumes the other is communicating the need for follow-up or further testing.

"I see more and more cases in my practice where several physicians are involved, and no one physician has taken action," says **Judy Greenwood**, JD, a Philadelphia, PA-based plaintiff attorney. "Test results are forwarded by one physician to another, with the test results unread, incompletely read, or misunderstood."

"I see more and more cases in my practice where several physicians are involved, and no one physician has taken action."

Several recent lawsuits involved pathology reports containing specific follow-up recommendations in the body of the report, which were not included in the diagnosis section. "These were glossed over and never acted upon, and never communicated to the patient," says Greenwood.

Vanessa Mulnix, RN, MSN, CPHRM, CPHQ, senior risk management consultant at ProAssurance Cos. in Okemos, MI, is seeing increasing numbers of claims involving poor communication across all specialties and settings. More physicians involved in the average patient's care mean more opportunity for communication to break down, Mulnix explains. "Pretty soon the physicians are playing phone tag, and six or eight hours can easily go by without them connecting," she says. "Plaintiff attorneys are now looking at communication separately as a causative factor in a claim."

Better communication needed

A recent medical malpractice lawsuit involved a kidney dialysis patient whose physician ordered her a regimen of enoxaparin six times the recommended dose for a patient in her circumstances. The patient bled to death three days after the regimen was started.

Patrick Malone, JD, a healthcare attorney with Patrick Malone &

INSIDE

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Associates in Washington, DC, says, "Two consultant nephrologists testified that they did not see the handwritten order in the chart. The pharmacist and nurses also failed to note anything unusual about the order, which had no documentation in the chart about its purpose."

Malone says this event could have been prevented with a better communications system, which could have included any or all of the following:

- an electronic record system allowing any physician, nurse, or pharmacist to quickly see the entire list of the patient's current medications;
- a requirement by the hospital that the rationale for any "high-alert" medication, such as an anticoagulant, be clearly stated in the order or a progress note;
- regular interdisciplinary rounds or other formalized oral communications;
- clear communication to the patient of the need for, and dosing rationale of, any drug being used in a manner outside of the manufacturer's label.

Executive Summary

An increasing number of malpractice suits involve poor communication between multiple providers, including failure to follow up on abnormal findings, according to risk managers and attorneys interviewed by Physician Risk Management.

✦ Plaintiff attorneys are looking at communication separately as a causative factor in a claim.
✦ Physicians must be prepared to prove information was sent to another provider.
✦ Systems must track ordered tests and incoming test results.

Prove you sent info

Be prepared to prove information was sent to another provider, Mulnix says. Often, one physician defendant claims a crucial piece of information was sent to another provider, but the second provider insists it never happened. "Now you have a touchy situation where there is a disagreement," she says.

A fax log showing a test result was sent and received, or an EMR audit trail showing that a test result was forwarded to another physician, can provide the necessary evidence to help a defendant physician to be dismissed from the claim, says Mulnix.

Physicians understandably become impatient at communications redundancies that seem unnecessary and inconvenient much of the time, but the patient safety net works well only when these communications safeguards are always functional, says Malone. "It makes for better patient care, less preventable harm, and fewer occasions when lawyers like me come calling with difficult questions about why communications fell apart," he says.

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Each MD takes responsibility

The best way to avoid the pitfalls of having several practitioners involved is for each physician to assume the responsibility for communicating with the patient, Greenwood says. She recommends these practices:

• Each physician should have a system in place to document that test results have been reviewed and communicated to the patient.

• Specialists should keep the primary caregiver or other referring physician in the loop regarding recommendations for further testing and follow-up.

• Primary care doctors receiving test results or reports from other physicians should separately review the information and communicate with the patient to ensure follow up.

"Medicine in the 21st century is a team sport," says Malone. "When the team fails to communicate together effectively, patients are easily and unnecessarily harmed." *(See related story on documentation that got a physician defendant dismissed, below, and story on lawsuits alleging failure to follow up on abnormal results, p. 16.)*

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MD got dismissed due to this documentation

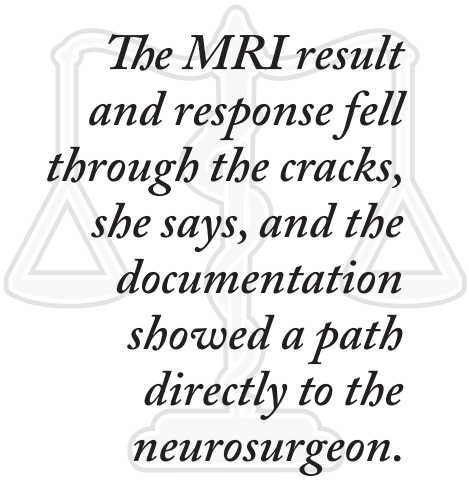
A repeat MRI was ordered by a family physician, along with a consultation with a neurosurgeon, for a 35-year-old male who presented with increasing neck and lower back pain.

The radiologist interpreted a worsening C6-7 disk herniation and instructed the radiology staff to contact the ordering physician with the interpretation. At the same time, the neurosurgeon contacted the radiology department and instructed the results of the MRI to be called in to the ordering family physician.

Radiology staff informed the ordering physician of the radiologist's interpretation and documented this contact. Three days after the MRI, the patient contacted the neurosurgeon requesting the results, and the practice contacted him two days later to set an appointment for five days later.

"The day before the appointment, the patient presented to the hospital with difficulty in moving his lower extremities," says **Vanessa Mulnix**, RN, MSN, CPHRM, CPHQ, senior risk management consultant at ProAssurance Cos. in Okemos, MI. The neurosurgeon performed emergency surgery, and the patient was discharged to rehab with a diagnosis of incomplete quadriplegia with improving gait dysfunction.

"Named in the suit were the neurosurgeon, the radiologist, and the hospital," says Mulnix. "The medical record as well as the documentation in the PACS [picture archiving and communication system] was reviewed." The following information was found:



• The documentation in PACS included the time the radiologist interpreted the MRI, the time he instructed staff to contact the ordering physician, and the time the radiology staff member contacted the ordering physician.

• The ordering physician documented the receipt of the MRI results, as well as the mailing and faxing of the results to the neurosurgeon.

• The ordering physician's patient medical record also included documentation of the fax number to which the report was sent.

• The faxed report, including the neurosurgeon's initials and the date the report was reviewed, was found in the patient's medical record at the neurosurgeon's office.

There was clearly documented evidence that the radiologist had timely communicated the need for communication of the MRI results to the referring physician, and there was timely documented communication of those results to the referring physician.

"These factors prompted dismissal of the radiologist from the suit after a fairly short period of time of eight months," says Mulnix. "This clear documentation also minimized the expense of defending the claim."

The ordering physician was not named in the litigation. The MRI result and response fell through the cracks, she says, and the documentation showed a path directly to the neurosurgeon. "This was a significant medical outcome for the patient, and one which could have had a large payout for the radiologist, were it not for the documentation," says Mulnix. ✦

Suit alleged failure to follow up on result

These types of cases are 'extremely difficult to defend'

After a hospitalized patient was discharged, an abnormal lab result was sent to her primary care provider. That provider apparently filed the lab result in the patient's chart without recognizing the abnormality. The patient later died from a condition related to the abnormal lab result, and the family sued for malpractice.

"The case went to trial with a laundry list of defendants, including treating physicians, the hospital, and the lab which ran the results. The lab won summary judgment, and two physicians had awards against them," reports W. **Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr in Albuquerque, NM.

In another malpractice case, a diagnosis of a coagulopathy required two tests, the first of which was ordered by a fellow working in the practice who left when he finished his rotation. The patient received the first test, but when she received the second lab slip in the mail, she thought it was for the test she already had obtained. The practice didn't follow up, and the patient never got the second test.

"The coagulopathy wasn't discovered until much later," says Maggiore. "A lawsuit resulted, and the jury returned a verdict against the doctor who owned the practice, even though she had never even seen the patient. The primary care doctor was also found liable." The physician had written a letter to the patient's primary care physician saying her office would follow up as needed, but no follow-up occurred, she explains.

Cases alleging a failure to follow up on an abnormal test result are "extremely difficult to defend," says Maggiore. "Patients seen by multiple providers are at high risk for having a test result fall through the cracks due to poor communication between providers." To reduce risks, Maggiore recommends these practices:

• Avoid telling patients, "We will only call you if something is abnormal."

Instead, physicians should tell patients that if they don't receive a call, they should call the office to obtain the test result.

• Have a system in place for tracking ordered tests and incoming test results to ensure these are acted on, and that patients are informed.

This system can be as simple as a notebook in which the doctor writes the date, patient's name, and tests ordered, with a place to document when the test result comes in.

• Make referrals in writing and request copies of all test results.

"Doctors who appear clueless about the care their patients are receiving from other providers don't fare well in depositions," she says. ✦

Radiology misreads are tough to defend

Claims also involve failure to communicate results

Radiology errors are difficult to address in medical malpractice claims because at that point in time, everyone, including the jury, knows the patient's injury.

"Plaintiff's experts almost never have trouble finding evidence of the injury to be 'clear' on the image, even if that is not the case," says **William R. Forstner**, JD, an attorney with Smith Moore Leatherwood in Raleigh, NC.

In cases in which there are separate reads and something was missed on both readings, the claim is generally more defensible for all of the named physicians, says Forstner. "It is my view that a jury is more willing to accept that one doctor performed a negligent read or made another mistake necessitating a malpractice award than to conclude that several doctors all made the same 'unforgivable' mistake," he says.

Forstner has encountered several situations involving allegedly incorrect radiology reads in which one physician performed a preliminary read and a radiologist performed a second read. or one radiologist performed an initial read with a brief handwritten interpretation and an over-read later was completed by another radiologist.

"Multiple independent interpretations of an image can add a degree of credibility to the claim that the alleged

Executive Summary

Radiology errors are difficult to address in medical malpractice claims because the patient's injury is known to everyone.

✦ If two separate reads both missed the finding, this generally makes claims more defensible.

✦ Write a thorough report to show the film was carefully reviewed.

✦ Address any discordant findings between the ordering physician and the radiologist.

error was not obvious to any reasonably competent doctor," says Forstner. "Additionally, a thorough report, which may identify non-essential issues, can be helpful to show that the radiologist is carefully reviewing the film."

Radiology errors can result in malpractice lawsuits not only naming radiologists, but also any physician who interprets the studies with or without the aid of a radiologist and anyone who relies upon studies interpreted by a radiologist, warns **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC.

Those claims deal primarily with miscommunications, or failures to follow up on an interpretation the radiologist has included in a report, he says. For example, the radiologist notes an incidental finding which might or might not be unrelated to an acute presentation, but the incidental finding is nevertheless worth investigating after the treatment for the acute condition. The ordering physician then never follows up with the radiologist about the incidental finding, or never pursues his or her own investigation at the next appropriate interval.

Typically, claims arising out of radiology errors fall into one of two categories: allegations that a film was mis-read, or allegations that the results were not adequately communicated to the ordering physician, Shuirman says. "Mis-reading a film can result in claims of failing to diagnose a disease which could have been treated in a more timely fashion or diagnosing a disease which is not truly present and which thus leads to unnecessary treatment," he says.

"Pull quote from article could go here but wouldn't have to — only when appropriate."

Claims can implicate a radiologist for not phoning in a particularly acute or worrisome finding; or can implicate the ordering physician for not following up with the radiologist, if results are never received or for failing to investigate equivocal findings.

"Moreover, when an ordering physician and a radiologist have discordant conclusions from a particular study, claims can arise if the ordering physician and radiologist do not take adequate steps to reconcile their discordant conclusions," says Shuirman.

For example, a radiologist reports a finding which is thought to be incidental, and its significance is downplayed. The ordering physician either doesn't believe that the incidental finding exists or believes it to be of such low significance that it isn't worthy of investigation.

Radiologists could defend such a claim by saying that they made their finding known by including it in the report, and ordering physicians then would have to explain why they didn't investigate it further.

"A plaintiff's expert, in such a scenario, is likely to impose a duty on the ordering physician to at least have discussed the finding with the radiologist, since the radiologist's finding was of some threshold significance to have been mentioned in a report in the first place," says Shuirman. *(See related story, below, on documentation that can make claims more defensible.)*

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When a radiology finding is missed, make case defensible

Did a radiologist contact the ordering physician about a finding? If so, it is important for the radiologist to document why the call was made, when the conversation with the ordering physician occurred, and the substance of any conversation had, advises **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC.

"The cases we see often raise the question of whether a radiologist should call the ordering physician to report an acute or worrisome finding," Shuirman says. "A plaintiff's expert is likely to offer an opinion that when in doubt, a call should be made."

This situation might result in the radiologist frustrating the ordering physician when the finding has little clinical correlation to the patient. "But it is often important for the radiologist to establish why some calls are made and why other calls are not," Shuirman says. "Moreover, it is important for the radiologist to clearly document what other recommended follow-up studies may have been discussed."

Here are some factors that can make these claims more defensible for the ordering physician:

• Distinguishing between findings which they made on their own read versus findings simply relayed by the radiologist.

"We have seen several cases in which it is nearly impossible to determine when or if an ordering physician received results from a radiology study from a simple review of the chart," says Shuirman.

• Investigating equivocal findings.

"Too often, we see claims where an

equivocal radiology study was not investigated further," he says.

A plaintiff's expert can retrospectively look at a later study and extrapolate what would have and should have been found, if only the initial ordering physician had thought to investigate further, explains Shuirman.

• Documenting communications with the radiologist, including addressing any discordant findings between the ordering physician and the radiologist. "This would help reveal the analysis and decision-making of the ordering physician, which should make it easier to defend, if such judgment should be questioned in a claim or suit," says Shuirman. ✦

Patient can't hear you? Legal risks abound

If a hearing-impaired patient asked you for a sign language interpreter, would you readily agree or ask that the patient communicate with written notes instead?

A New Jersey rheumatologist chose the latter option when one of his patients asked for a sign language interpreter. Though no negligence was alleged, the patient sued the physician for disability discrimination and was awarded $400,000 by a jury, with half of the award for punitive damages.[1,2]

Larry Downs, Esq., CEO of the Medical Society of New Jersey in Lawrenceville, says the way that disability discrimination situations are handled by courts, by advocates for the deaf, and by physicians "really varies. It is not well-settled, and that creates risk for physicians and access problems for the hearing-impaired."

The case was settled before it reached the appellate stage. The settlement amount wasn't covered by liability insurance, adds Downs, as disability discrimination claims are not included in professional liability policies.

The Borngesser v. Shore Medical Center case, which sets the standard in New Jersey, established a standard of patients and physicians communicating in a manner that is mutually agreed upon, whereas the above case set a different standard requiring physicians to provide a certified sign language interpreter.[3]

"It was a shame we didn't get a chance to appeal that case," says Downs. "It would have been nice to have a court reinforce or follow Borngesser."

Downs says that while it's always a good idea for physicians to consider a sign language interpreter for first visits and major decisions, effective communication also can occur if the patient can participate in their care by written note or technology such as telehealth systems. "We were anxious to have an opportunity to argue that point; but unfortunately, it remains murky to this day," Downs says.

MDs often unaware

Some patients with hearing loss try to compensate by reading lips or simply nodding an understanding of what the physician is saying, when they haven't truly understood.

"Hearing loss is not apparent when looking at a person unless they have a hearing aid or cochlear implant," says **Henry C. Fader**, JD, an attorney with Pepper Hamilton, Philadelphia, PA. Fader represents the Hearing Loss Association of America, a national advocacy group for the hearing impaired.

History and physical questionnaires rarely ask about hearing loss, and patients with hearing loss will not always self-identify due to their concern over social stigma, he adds. "In my experience, physicians do not understand the legal risks involved if they do not make accommodations and have alternative services available such as a sign language interpreter," says Fader.

As with foreign language interpreters, there are certified American Sign Language (ASL) interpreters who can be called into the physician's office to interpret for the deaf patient, says Fader. "But what about the patient who is struggling with hearing loss brought on by age or occupation? They, too, are entitled to reasonable interpretation services," he says. Fader says such services might include:

- real-time captioning;
- using a hearing loss interpreter with technical medical knowledge;
- if patients have hearing aids, having a "looped" physician's office so that, through amplification and the use of microphones, the patients can have their hearing enhanced;
- making other electronic assistive devices available on a temporary basis in the medical office to help hard-of-hearing patients communicate with the medical professionals.

Technology available to connect American ASL interpreters in Canada with deaf patients by telehealth systems could increase the standard of care for such patients, adds Fader. The Ontario Telehealth Network recently established links to patients by wireless technology in the Thunder Bay Regional Health Sciences Centre in Thunder Bay,

Executive Summary

Physicians face possible disability discrimination claims if they fail to provide a sign language interpreter for hearing-impaired patients. Medical malpractice risks involve:

✦ a failure to properly communicate with the patient;
✦ lack of informed consent if the patient could not hear the physician;
✦ discrimination for failure to provide reasonable accommodations.

Ontario, Canada. Using wireless technology in all 22 intensive care unit beds and the emergency department, ASL language interpreters were made more accessible to deaf patients.

"Medical malpractice risks stem from a failure to properly communicate with the patient, lack of informed consent if the patient could not hear the physician, and discrimination for failure to provide reasonable accommodations," says Fader. *(See related story, below, on cases involving hearing-impaired patients.)*

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Two 2013 cases on failure to provide interpreter

Due to inadequate communication between patient and caregiver as a result of the patient's hearing loss can certainly lead to misinformation and misdiagnosis resulting in medical malpractice. "However, the greatest potential for loss arises out of a violation of federal and state anti-discrimination laws," says **Henry C. Fader**, JD, an attorney with Pepper Hamilton in Philadelphia, PA.

These actions may be brought by a federal, state, or local enforcement agency that oversees discrimination of the disabled and can lead to lawsuits arising from a violation of statutes and regulations meant to protect the disabled, says Fader.

"In addition to the potential for medical malpractice, a stronger case could be brought by a patient for failure to obtain appropriate informed consent," he explains.

Most state courts view the failure of obtaining a valid informed consent as an action that can negate a defense on the merits in a malpractice action, says Fader. "Most risk managers would agree that failure to obtain the appropriate informed consent as the worst-case scenario in any malpractice action," he says. "The plaintiff would argue that due to the inability to hear and understand the physician, that the consent could not be valid."

In a 2013 case in the Western District of Washington, the U.S. District Court refused to dismiss a deaf patient's disability discrimination claim for a hospital's failure to provide an American Sign Language interpreter.[1]

"The allegations went beyond the violation of the Americans with Disabilities Act," says Fader.

The plaintiff alleged that the lack of an interpreter interfered with the patient's ability to receive "full and equal" medical treatment, interfered with the patient's understanding of his treatment and treatment options and the opportunity to ask questions about his treatment, and excluded the patient from providing informed consent.

In another case, a psychiatric evaluation of a deaf resident without a sign language interpreter led to a 2013 settlement agreement with one of the nation's largest long-term care providers.[2] "The use of written notes and gestures was deemed to be discrimination against the resident," says Fader.

In its announcement of the settlement, the Department of Health and Human Services asserted that "the patient's care was unnecessary and significantly compromised by the stark absence of interpretation service." The investigation was undertaken when the Office for Civil Rights determined that the facility in question failed to take appropriate steps to ensure effective communications with the patient leading to problems in care delivery, notes Fader.

"These breakdowns in communication could lead to liabilities for the provider," he says.

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Residents make more errors when they work shorter shifts

More handoffs are one reason

While many believe that legal risks would be reduced as a result of the Accreditation Council for Graduate Medical Education's reduction in resident shift lengths from 30 to 16 hours, two recent studies suggest that the opposite is true.[1,2]

In one study, 2,323 medical interns serving before and after the new duty

hour requirements were surveyed, and the percentage who reported concern about making a serious medical error increased from 19.9% to 23.3%.[1] **Srijan Sen**, MD PhD, the study's lead author and assistant professor of psychiatry at University of Michigan Health System in Ann Arbor, says he was surprised at the study's findings.

"Going into the 2011 duty hour reforms, it was clear that interns do not function optimally after working 24 hours in a row," he says. "So I was hopeful that that reducing the maximum shift length would lessen the number of hours worked by fatigued physicians and ultimately help both interns and patients."

One important implication is to be as vigilant as possible during patient handoffs, says Sen. "There is good evidence that handoffs have increased substantially with the new duty hour rules," he underscores. "These are high-risk time periods for poor communication and errors."

Handoffs are concern

Another study found that patient handoffs among residents increased from three for those working 30 hours straight, to as many as nine handoffs for those working 16-hour shifts.[2]

Researchers compared three work schedules. Some residents worked a pre-2011 schedule (on call every fourth night with a 30-hour limit on consecutive hours). Two other groups worked under the new rules. One group was on call every fifth night but worked only 16 hours straight, and a second group worked a night float schedule that required working a regular week on the night shift and not more than 16 hours per shift.

Interns and nurses perceived a higher quality of care under the 30-hour limit. The night float model was eliminated before the study was over because there were such a large number of people who believed the quality of care had declined.

The original premise of the 2011 rules was that shorter shifts leads to residents sleeping more, resulting in less fatigue and fewer errors, says **Sanjay Desai**, MS, the study's lead author and director of the residency program for internal medicine at Johns Hopkins Hospital in Baltimore. "While [the premise] seems logical, it breaks down fairly fast," says Desai. "We have learned that patient safety is an exceptionally complex science. Manipulating any one variable necessarily affects many other relevant variables. The net effect is unpredictable."

To reduce risks, Sen advises improving handoff training and aligning schedules better with residents' natural circadian rhythms. "Ultimately though, I think we will have to take steps to actually reduce the amount of work asked of residents rather than just reducing the hours," he says. Currently, residents are being asked to do the same amount of work as prior residents, but in less overall time.

"In the cases where additional resources, such as nurse practitioners and physician assistants, have been brought online to reduce the non-educational work burden of residents, the quality of care appears to have been maintained or even improved," says Sen.

Executive Summary

The number of handoffs and concerns about serious medical errors increased as a result of the Accreditation Council for Graduate Medical Education's reduction in resident shift lengths from 30 to 16 hours, according to two recent studies. To reduce risks:

- ✦ improve handoff training;
- ✦ align schedules with residents' natural circadian rhythms;
- ✦ reduce the amount of work asked of residents.

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Will med/mal suit be filed? Here's how attorneys decide

A medical malpractice case must have several characteristics

Did the physician act as a reasonably careful professional? If not, did the failure to act in this manner cause a significant injury?

These are the two most important factors plaintiff attorneys consider when deciding whether to pursue a malpractice claim, according to **Steven M. Levin**, JD, founder and senior partner at Levin & Perconti in Chicago. "We are often asked to review cases that show that malpractice was committed, but there is no relationship between the malpractice and the patient's injury or death," Levin says.

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Plaintiff attorneys look for cases in which physicians' failure to act as reasonably careful professionals caused a significant injury. Here are factors they consider when deciding whether to file suit:

✦ whether the chart has good documentation of the physician's thought process;

✦ whether the harm that occurred is significant enough to merit the time and expense involved;

✦ caps on non-economic damages and expert witness requirements.

At times, the firm initially pursues cases because the practitioner's misconduct is so significant, but attorneys later realize that it is difficult or impossible to link the misconduct with the patient's injury or death. "In other words, we take the case because we are horrified by the conduct and do not pay enough attention to whether the conduct really caused significant harm," Levin says.

If the chart includes careful documentation of the physician's thought process and shows the physician has appropriately advised the patient about options, "we most likely would not take that case," says Levin. "If the record is poorly documented, has gaps, or is contradictory, this raises our antenna."

Here are factors that make it more likely the plaintiff attorney will decide not to pursue the claim:

• Cases in which malpractice was committed, but the injury that resulted is not significant enough to merit the time or expenses involved in prosecuting a malpractice case.

"We want to make sure we can connect the malpractice to the harm caused, and that the harm that occurred is significant enough to merit the emotion, time, and expense involved in bringing these matters to conclusion," says Levin.

Caps on non-economic damages in Texas and other states are now a factor when plaintiff attorneys are looking at the potential value of the case to see if it's worth their while, says **Jennafer Groswith**, JD, an attorney with Wilson Elser Moskowitz Edelman & Dicker in Dallas.

The decision to file a lawsuit involves careful consideration of the strength of the liability case and the amount of the damages, says **Joshua M. McCaig**, JD, a shareholder with Polsinelli Shughart in Kansas City, MO. "If both factors are favorable, the case will likely be filed. If both are weak, it likely will not," says McCaig. "In situations where the facts are good but damages are minimal — or vice versa — an attorney may consider filing suit just to negotiate a quick settlement."

• Cases in which the plaintiff has difficulty finding an expert to testify that the standard of care was breached.

State requirements regarding expert reports are another factor for plaintiffs to consider, such as Texas's Chapter 74 statute requiring the plaintiff to file an expert report to say the physician was negligent within 120 days of making a claim. "It has to be pretty detailed in terms of laying out what the standard of care is, how the physician breached that standard of care, and providing the causal nexus between the alleged negligent act and the injury that was sustained," Groswith says.

Groswith is aware of several malpractice cases that were dismissed after 120 days because the plaintiff couldn't provide this expert report.

"We also have the opportunity, if they file an expert report that we believe to be inadequate, to file an objection which will be heard before the court," she says. If the judge determines the plaintiff didn't made a good faith effort to comply with the statute, the case gets dismissed.

• Clear, thorough documentation of the physician's decision-making process.

"As a defense attorney, I am constantly telling physicians to document their differential diagnosis," says Groswith. If the chart clearly shows the diagnosis was considered and why it was excluded, this charting can deter a plaintiff from pursing a failure to diagnose claim.

Physicians often go through the differential diagnosis in their head without writing it down or document much too sparsely. "We've heard it and said it one thousand times, but juries think that if it wasn't documented, it wasn't done, even if the doctor swears up and down that it was," says Groswith. "It's like trying to prove a crime with circumstantial evidence."

Good documentation, for better or worse, gives the plaintiff attorney and expert a clear understanding of the care provided and limits their ability to create an argument. "If the documentation is poor, it provides wiggle room to create liability where it may not exist," says McCaig.

When McCaig was contacted by a plaintiff attorney about a possible misdiagnosis case, he obtained a copy of the medical records and pointed out the records of his client that clearly documented the findings of a radiology report and the client's reasonable reliance on the findings of the report. "By taking the time to document thoroughly and describe what he relied upon for his own treatment plan, he was able to avoid being added to the ultimate lawsuit," says McCaig.

• Cases in which there is evidence that the physician was acting in the patient's best interest.

"We look for cases where there is malpractice, plus other conduct that shows that the healthcare practitioner was acting inappropriately because of concerns other than the health of the patient, such as arrogance, rushing, factory-type medicine, and systemic failures," says Levin. *(See related story, p. 22, on obtaining an early analysis from an expert.)*

SOURCES

- **Jennafer Groswith**, JD, Wilson Elser

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Early analysis of claim could deter plaintiff

Defense attorneys should offer strong opinion by expert

If a physician defendant believes a malpractice lawsuit is baseless, one strategy to prevent protracted litigation is for defense attorneys to hire an expert early on to review the case.

"The expert wouldn't necessarily prepare a report, since that would then be discoverable, but could give an opinion as to whether the case has merit," says Jennafer Groswith, JD, an attorney with Wilson Elser Moskowitz Edelman & Dicker in Dallas. "We ended up getting a case settled for much less than it otherwise would have been, by getting a leading expert on heparin-induced thrombocytopenia. Had the expert been able to present his findings early on, it might have curtailed the litigation altogether."

If defense attorneys educate the plaintiff attorney early about the weakness of their claim before they make a significant monetary investment in a case, they sometimes drop it, says Joshua M. McCaig, JD, an attorney with Polsinelli Shughart in Kansas City, MO. Early analysis and having good expert support is the first step, says McCaig, who generally makes an initial phone call to engage the opposing attorney and then follows up with a written analysis of why the case has no merit.

"In certain situations, I will even let the attorney meet with my client or speak with my experts if it may influence their decision to dismiss the case," adds McCaig

Recently, McCaig was contacted by a plaintiff attorney and obtained a quick review by a well-qualified expert fully supporting the care of the family practice physician. At the end of the call, the attorney said he was not going to file the lawsuit. "I suspected that the plaintiff attorney would not have a great expert, if he had one at all, so I let him question my expert," he says. "While this will not work for every case, if you have a strong liability defense, it should be considered." Normally, experts aren't disclosed until the deadline to allow for time to complete discovery, but a report with an expert's strong favorable opinion might be worth producing earlier in the process. "If you let the plaintiff attorney know they are barking up the wrong tree, that could be an effective strategy," Groswith says. ✦

Consent refused? Take appropriate action

The courts are most likely to side with the doctor

(Editor's Note: This is a two-part series on legal risks involving parents refusing medical care for a child. This month, we cover reporting obligations for physicians in this scenario. Last month, we covered what to document to reduce risks.)

In 2002, a police officer took custody of a 5-week-old febrile infant girl after her parents refused to consent to a spinal tap to rule out meningitis.

"The physicians were concerned that failure to timely diagnose and treat meningitis could lead to death or permanent brain injury. Additionally, published guidelines recommend a spinal tap in this situation," says **Jonathan M. Fanaroff**, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

The parents sued the police department, hospital, and physician, and alleged a violation of their constitu-

Executive Summary

If a parent's refusal to consent to treatment is life-threatening for the child or places the child at risk of serious harm, physicians have a legal duty to report this to the appropriate child protection agency or law enforcement.

✦ Child protection agencies and courts are empowered to take emergency custody of the child and provide consent for medical treatment.

✦ The federal government has deferred to states to define abuse/neglect.

✦ Physicians should be familiar with reporting obligations and state definitions of neglect.

tional rights. A federal jury rejected the parent's claims and found in favor of the police, hospital, and physicians.[1]

Parents are the primary decision-makers when it comes to medical treatment for their children, and this is the basis for the requirement to obtain parental informed consent, says Fanaroff. "Parents have an obligation, however, to provide needed medical care for their children," he says. "Additionally society has an interest in protecting children from harm. This is known as the doctrine of parens patriae."

When a parent's refusal to consent to treatment is life-threatening for the child or places the child at risk of serious harm, then the physician has a legal duty to report the situation to the appropriate child protection agency or law enforcement. "Child protection agencies, as well as the court system, are both empowered to take emergency custody of the child and provide consent for medical treatment," says Fanaroff.

Though Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) in 1974, the federal government has deferred to states to define abuse/neglect, notes **John W. Miller II**, principal at Sterling Risk Advisors, Marietta, GA. The CAPTA amendments of 1996 and 2003 contained no federal requirement for a parent to provide any medical treatment for a child if that treatment is against the parent's religious beliefs. "However, CAPTA also designates that there is no requirement that a state either find, or be prohibited from finding, abuse or neglect in cases where parents or legal guardians act in accordance with their religious beliefs," says Miller.

In almost every state, physicians are mandatory reporters and are legally required to report suspected child abuse or neglect when presented with reasonable cause, says Miller.

"An [against medical advice] discharge or elopement can rise to the level of neglect depending upon your state's definition," adds Miller. "Be familiar with your state's definitions of neglect. Be aware of your obligations to report such activity to the proper authorities." *(The U.S. Department of Health & Human Services' Child Welfare Information Gateway provides searchable by state definitions of child abuse and neglect, along with definitions for who are mandatory reporters in each state and what duties they have to report suspected abuse. Go to http://1.usa.gov/LsWxGs.)*

Reference

1. Mueller v. Auker, 576 F. 3d 979-Court of Appeals, Ninth Circuit 2009.

SOURCES

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COMING IN FUTURE MONTHS

✦ How physicians should disclose errors to patients

✦ Liability risks of hospital-acquired infections

✦ What risks physicians are legally obligated to tell patients

✦ Avoid legal pitfalls with late EMR entries

CME OBJECTIVES

After reading *Physician 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 should physicians do to avoid allegations of failure to follow up on abnormal test results, says W. Ann Maggiore, JD, an attorney at Butt Thornton & Baehr?**
   A. Always instruct patients, "We will only call you if something is abnormal."
   B. Tell patients that if they don't receive a call, they should call the office to obtain the test result.
   C. Avoid telling patients that they should call the office if they don't receive a call.
   D. Do not make referrals in writing.

2. **Which can make suits involving radiologist errors more defensible for ordering physicians, according to Ryan M. Shuirman, JD, an attorney at Yates, McLamb & Weyher?**
   A. The ordering physician should distinguish between findings which he or she made on their own read versus findings simply relayed by the radiologist.
   B. If findings were relayed by the radiologist, the ordering physician should not specify this in the chart.
   C. If there is a question regarding the accuracy of the interpretation, the ordering physician should always trust his or her judgment over the judgment of the radiologist.
   D. Ordering physicians should address discordant findings verbally, as opposed to documenting this in the medical record.

3. **Which is the most effective approach to reduce liability risks involving residents, according to Srijan Sen, MD, assistant professor of psychiatry at University of Michigan Health System in Ann Arbor?**
   A. Discontinuing efforts to align schedules with residents' natural circadian rhythms.
   B. Asking residents to do the same amount of work in less overall time.
   C. Improving handoff training.
   D. Having residents work a night float schedule of a regular week on the night shift and not more than 16 hours per shift.

4. **Which is true regarding a physician's actions when a parent refuses care for a child, according to Jonathan M. Fanaroff, MD, JD?**
   A. The physician has no legal duty to report a parent's refusal to consent to treatment even if the refusal places the child at risk of serious harm.
   B. Child protection agencies and the court system are empowered to take emergency custody of the child and provide consent for medical treatment.
   C. Physicians are not legally required in any state to report suspected child abuse or neglect when presented with reasonable cause.
   D. A patient's discharge against medical advice or elopement cannot rise to the level of neglect in any state.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

16-year-old male awarded $450,000 for failure to diagnose appendicitis

6 days later, primary care doctor finds infection

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News: A 16-year-old male was awarded $450,000 for his doctor's failure to diagnose appendicitis before the appendix ruptured. The patient presented at the hospital with pain in his abdomen. Blood tests and X-rays failed to indicate appendicitis, and the patient was sent home. Six days later, the patient was examined by his primary care physician, and blood tests indicated that an infection was present. The patient was directed to the hospital, where it was determined that his appendix had ruptured and he was suffering from sepsis.

Background: Patient was a 16-year-old male who presented with abdominal pain at the hospital. After conducting blood tests, the hospital doctor determined that his pain arose from constipation, and she prescribed an enema and laxatives. The doctor advised that if the pain continued, the patient should be examined by his primary care physician. Six days later, the patient continued to suffer abdomen pain and went to his primary care physician. His primary care physician conducted blood tests and a CT scan. The blood tests indicated that the patient was suffering from an infection, and the patient was directed to the hospital. At the hospital it was determined that his appendix had ruptured and he was suffering from sepsis.

The jury found that the hospital doctor had departed from the accepted standard of medical care.

The patient's mother sued the hospital doctor. She argued that her son was suffering from appendicitis when he originally was examined and that the doctor had failed to diagnose his condition. The plaintiff further alleged that the doctor's failure to diagnose constituted medical malpractice. She said the doctor had failed to recognize the significance of the blood tests, which suggested elevated levels of leukocytes and neutrophil. Plaintiff's expert opined that the hospital doctor should have performed a CT, which would have revealed that the plaintiff was suffering from appendicitis. Plaintiff's expert also said that the X-rays did not demonstrate an intestinal blockage and, therefore, did not support a diagnosis of constipation.

Defendant argued that she had properly treated the patient. She said that he was not suffering from appendicitis on the day she examined him, because the abdomen pain was in the wrong area and blood

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Aisling Jumper**, **Bruce Cohn** 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.

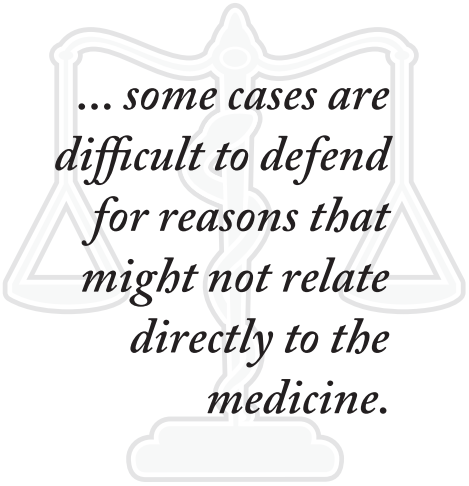
tests did not indicate appendicitis. The defense expert opined that the patient's leukocyte was not high enough to be concerning. That expert said that the pain was not related to appendicitis because the appendix typically will burst 24 to 48 hours after developing appendicitis, and the patient's appendix did not burst until six days later.

The jury found that the hospital doctor had departed from the accepted standard of medical care. The jury awarded the plaintiff $450,000: $200,000 for past pain and suffering and $250,000 for future pain and suffering.

What this means to you: This relates a common scenario, a misdiagnosis or failure to arrive at a diagnosis in an emergency department, which highlights the difficulties experienced by physicians in emergency department encounters. Abdominal pain is a common and sometimes vexing diagnosis that can be simple epigastric distress from overeating or a significant condition such as appendicitis. The emergency department physician in this case did blood work, performed an examination, and diagnosed constipation. The patient was treated for this condition and properly advised to see their primary physician if the pain continued.

Some six days later, the patient's primary physician conducted additional blood tests and ordered a CT scan, which ultimately made the diagnosis of perforated appendix and sepsis. The plaintiff's expert with the benefit of 20-20 hindsight opined that the blood test results were suggestive of an infection, but it appears that they were not that clear, as often is true of lab results. Our physician colleagues often cite a maxim from medical school or residency about treating the patient, not the lab results.

Plaintiff's expert also declared that the emergency department physician should have performed a CT scan that would have revealed the diagnosis. A CT scan of the abdomen with contrast is said to be highly specific for the diagnosis of appendicitis. A CT scan also produces radiation, and a significant amount of it directed at the body of a 16-year-old. The medical and lay presses are filled with articles about the overuse of radiological tests and the resultant exposure to radiation after being subjected to multiple tests. There is also the reality of the time, effort, and resources of CT scans and other advanced testing. Physicians make educated assessments based on the information then available and, based on their differential diagnoses, decide to scan or not. It would simply not be possible in a busy emergency department for every patient with a pain in the head, chest, or abdomen to receive a CT scan.



Our physician and her experts in this case took the position that the leukocytosis was not high enough to be concerning and that burst appendix generally will show itself in 24-48 hours, not six days, a seemingly reasonable statement. Unfortunately what might appear reasonable to a trained physician might not seem reasonable to members of a lay jury. The argument that the pain was "in the wrong area for appendicitis" is difficult to sell when the patient ultimately was diagnosed with that malady. The timing element has scientific merit. Perhaps the teen-ager did not have appendicitis upon the emergency department presentation, perhaps this case was an unusual one, or perhaps the appendix burst earlier than six days after the emergency department visit. Members of the jury viewing a case such as this one start out with the knowledge that the patient ultimately did have appendicitis. They, too, have the benefit of hindsight, and they typically find it difficult to reconcile the facts with the physician's thought process.

What this means to you is, essentially, some cases are difficult to defend for reasons that might not relate directly to the medicine. Most emergency department physicians with substantial experience will be able to relate cases such as this one over their careers. Sometimes the differential or final diagnosis that appeared reasonable at the time might turn out to be wrong. Unlike the doctor at the time of the encounter, the jury knows how the story turned out, and it simply might not be possible to dissuade them from believing the doctor should have made the diagnosis. It is tempting to blame the child or the parents by questioning why it took them six days to meet with another doctor.

Regardless, this case is one of those situations in which nothing was done wrong, but solely the outcome will dictate the result of the litigation.

Reference

Case No. 350597/08, Supreme Court of New York, Bronx County, NY. ✦

$38.6 million awarded for botched procedure that resulted in permanent brain injury

Case involved controversial procedure: manipulation under anesthesia

News: A man and his two daughters were awarded $38.6 million against two doctors for their negligence in conducting a controversial procedure under anesthesia on the patient. The controversial procedure, manipulation under anesthesia, caused a loss of oxygen to the brain, which resulted in permanent brain injury to the plaintiff.

Background: The patient's diabetes doctor and a facility anesthesiologist performed the controversial procedure of manipulation under anesthesia on the patient. Manipulation under anesthesia is claimed to improve articular and soft tissue movement using a controlled release, pressure point manipulation, and mobilization while the patient is under moderate to deep sedation. The doctors connected the patient to a heart monitor and began to manipulate his feet. Eleven minutes into the operation, for unknown reasons, the patient lost oxygen and his heart rate slowed. When the paramedics arrived, the patient had no pulse. At the hospital, the doctors were able to restart his heart, but his brain had been deprived of oxygen. The patient is now in a vegetative state.

Plaintiffs, the patient and his two infant daughters, asserted that the heart monitor's alarm sounded during the procedure, but the anesthesiologist twice ignored the monitor and turned it off. The Department of Health also investigated and found that the records from the operation were incomplete. According to plaintiffs' attorneys, the patient's diabetes doctor admitted during trial that the procedure should not have been performed on the patient.

The anesthesiologist argued that the original cardiac arrest was not from anesthesia or oxygen, and once the patient's heart stopped, his chances of full recovery became remote, regardless of the emergency response. The doctors also attempted to shift blame onto a third doctor; however, the jury found that this doctor was not responsible.

Eleven minutes into the operation, for unknown reasons, the patient lost oxygen and his heart rate slowed.

After a monthlong trial, the jury found the doctors negligent, not only by a "greater weight of the evidence" standard, but also by "clear and convincing evidence." The jury awarded $23.6 million to the patient to cover medical expenses and another $5 million for pain and suffering. His two daughters, now 6 and 9, were awarded $5 million each for the loss of their father's companionship.

Finally, the jury's finding that the doctors were guilty of medical malpractice under the "clear and convincing standard," triggered the "Three Strikes" Florida constitution amendment, which strips medical licenses of doctors who lose three medical malpractice cases under this higher standard.

What this means to you: This case has multiple issues with the physicians, the procedure, and the explanation of what happened and why. It is a sympathetic case. A young patient who is a parent and who went in for a supposedly simple (yet controversial) procedure suffered brain damage. Given the facts of this case, it is not surprising that a large verdict was rendered.

Again we are faced with jury members who will use their own sense of reasonableness and fact analysis to come to a conclusion as to the liability of the defendants. The first issue is the procedure itself. This procedure was not cardiac surgery or neurosurgery that can be risky but lifesaving. This procedure was manipulation under anesthesia, which is said to improve intra-articular and soft tissue movement. Clearly the patient is an adult who consented to the procedure, but the jury is less likely to be forgiving of a physician with a bad outcome if the surgery was necessary as opposed

to an elective procedure. It is simply human nature to feel worse about a bad result in a procedure in which the patient should not have been at risk.

The anesthesiologist argued that the cardiac arrest suffered by the patient was not due to anesthesia or lack of oxygen. This argument is what some trial lawyers call the "stuff-happens" defense. We don't know why the patient suffered the complication, but things just happen. Jurors don't like this argument, as it goes against their common-sense demand for logic. If the doctor who is a trained professional and was in the room can't tell them why something happened, it becomes difficult to for a lay person to accept the complication.

There also is an expectation that the anesthesiologist should have been able to do something to get the patient's heart started after the arrest. This task is what we assume the anesthesiologist is there for: to monitor the patient and to intervene if something goes wrong. Upon the arrival of emergency medical services, the patient had no pulse, and the patient's heart was not able to re-start until arrival at a hospital.

This case has a number of complicating factors. The patient's diabetes physician apparently admitted under oath at trial that the procedure should not have been performed. It becomes difficult if not impossible to defend the care during a procedure that was not indicated.

Even worse, the family raised an allegation that the patient's monitor alarm sounded during the procedure, but the alarm was twice silenced by the anesthesiologist. How they learned of this silencing is unclear from the case report, but it might have been from the testimony of other people present or inferred from the record. Unfortunately, the record that had the potential to support the anesthesiologist did the opposite. The state Department of Health investigated and found that the records were incomplete. The anesthesiologist testified that due to the emergency, he did not have time to complete the record and upon returning to the surgical center, the staff would not allow him to finish his entries.

An incomplete medical record or one in which it appears that the entries might have been modified after the fact is a red flag to the jury or judge sitting in judgment of the facts of the case. It calls into question the veracity of the physician who wrote the record and, by extension, anyone involved with the case.

The patient's diabetes physician apparently admitted under oath at trial that the procedure should not have been performed.

Finally, there is the added credentialing issue that might have not been raised in front of the jury, but it is meaningful from a risk management perspective. The anesthesia physician had prior instances of questionable medical care including two other patients who died while being monitored by this same anesthesiologist. This background clearly calls into question the amount of due diligence done by the surgery center in allowing the physician to administer anesthesia to this patient.

There is an unusual provision in Florida law known as the "three strikes" rule that has the potential to strip a physician of his or her license after three adverse medical malpractice findings. It is notable that for this provision of law to apply, the jury must find the physician not just liable under a preponderance of the evidence theory, which is common, but by clear and convincing evidence. It is difficult to say whether a jury understands the difference between these two. The counsel for the plaintiff had to prove only the lesser standard in order to win the case and obtain a rather larger verdict, but the family was apparently intent on a finding using the higher standard that would trigger the three strikes rule.

Consider the details of this case: The procedure is controversial under the best of circumstances, and elective under all circumstances. It was performed on a patient whose own physician concedes should not have had it. The practitioner had a questionable record. You add in a record that is incomplete, combined with a highly sympathetic patient. When something goes wrong, providers are likely to lose in a significant way.

This case is difficult for all of the reasons stated, and it also makes it clear that as the defense issues mount, the likelihood of success plummets.

Reference

Case No. CACE09007837, 17th Judicial Circuit, Broward County, FL. ✦