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No diagnostic test ordered? Be sure chart includes the reason it wasn't

Plaintiff might decide against pursuing claim

Malpractice suits involving failure to order diagnostic tests resonate well with lay jurors, according to **David P. Sousa**, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh.

"The sad reality is that there are still physicians willing to serve as medical experts in malpractice cases who will almost always be critical of the choice to just not do one more thing that may have prevented the adverse outcome," he says.

Sousa says that he rarely sees any documentation as to why a diagnostic test wasn't ordered. Ideally, the chart would state that a plain chest X-ray was done, and a CT was considered, and give the reasons why the physician and patient decided against it, for example. "That is a note that you never see," Sousa says. "Instead, what happens is the physician uses his or her best clinical judgment, and there is virtually no explanation that appears in the chart that documents the thought process."

Sousa says this absence, in large part, is due to time constraints faced by physicians. "But it is a behavioral adjustment that physicians need to make," he says. "If that's in the chart, it becomes very difficult for the expert witness to take the position that the physician didn't order the test because he never thought about it."

The physician had recommended a colonoscopy three times ... The patient declined the test.

A reasonable explanation of why a diagnostic test wasn't ordered "is a red flag to the plaintiff attorney that this is going to be a hard case to prove," adds Sousa.

Sousa recently successfully defended an internist at trial. The case involved a failure to diagnose rectal cancer in a 44-year-old man who was seen on three occasions over a four-month period with varying complaints of rectal bleeding. The physician had recommended a colonoscopy three times, once in the presence of the patient's wife, and each time, the patient was told of the need for testing, the reason for it, and the risk in not doing it.

The patient declined the test. The physician was meticulous in charting the discussions and the patient's refusal to be tested. A flexible sigmoidoscopy was scheduled, and the patient cancelled the test, which was

INSIDE

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well-documented. "Unfortunately, the plaintiff's attorney still took and fully pursued the case to verdict," says Sousa. "The jury found that all appropriate tests were ordered and recommended, as evidenced by the chart notes, and returned its verdict in less than 30 minutes."

Executive Summary

Physicians can best protect themselves from allegations involving failure to order diagnostic tests by documenting their decision-making process. Consider including the following points in the medical record:

- ✦ the fact that the test was considered;
- ✦ the reason the test was determined to be unnecessary;
- ✦ whether the patient refused a recommended test.

Show test was considered

Keith C. Volpi, JD, an attorney at Polsinelli in Kansas City, MO, has defended several cases in which the allegations included failures to order imaging studies.

In one such case, a man was brought to the emergency department by ambulance after a motor vehicle accident, and he was discharged home without undergoing any imaging studies. The patient returned the following morning with a significant closed-head injury that the family alleged would have been caught on head CT. In another case, a patient underwent a chest CT that showed some scar tissue in the area of a previous surgery. More than a year later, a malignant tumor developed in the area of the previous scar tissue. The patient alleged that a mammogram shortly after the chest CT would have identified the malignant tumor.

"Nothing about the patients' physical examinations or diagnostic studies indicated the need for additional imaging," says Volpi. "In other words, the imaging studies were not clinically indicated."

Volpi says he isn't sure that any amount of documentation would have changed the perception of the family, but believes it would have changed the perception of the jury. "I always want the worst thing that a jury can say about my client to be that he made an incorrect medical decision after appropriate attention and consideration," he says. "The best way to send a jury this message is to document the risk/benefit analysis of a decision." In this case, the physician could have identified the scar tissue as an abnormal finding that would normally warrant further imaging and stated that this patient was different because her medical history made the scar tissue a normal finding. "We don't want a jury to think that the scar tissue was simply never identified or considered," he explains.

These cases underscore the reason many physicians practice defensive medicine: the risk of a poor, unanticipated outcome that leads to a lawsuit. "It's easier for a physician to scan everyone, just so that no one can criticize him for failing to do so," Volpi adds. "It is very difficult to sell to a jury all the reasons for not ordering a CT, when they see it as a relatively effortless procedure."

Contemporaneous charting of rea-

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Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410, (joy.dickinson@ahcmedia.com), Editor: **Stacey Kusterbeck**, Production Editor: **Kristen Ramsey,** Interim Editorial Director: **Lee Landenberger.**

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Editorial Questions

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Call **Joy Daughtery Dickinson** at (229) 551-9195.

soning for not ordering a CT is better than explaining the same reasoning during litigation, says Volpi. "Jurors are smart enough to know that lawyers and doctors can craft a good explanation for most things in the midst of litigation. But if we can hold up a medical record that proves the physician's thought process at the time of the treatment, I think that goes further," he says.

He instructs his physician clients to document all aspects of the clinical picture that led to a decision not to order a diagnostic test. "More often than not, the records are simply silent on this, and a plaintiff's attorney concludes there was lack of attentiveness," Volpi says. "If a physician identifies a test as common under the circumstances but has a good reason for not ordering it, chart that."

If the physician simply makes a progress note stating that the procedure was considered and why it was determined to be unnecessary, "that goes a long way in litigation," he says. "A jury is more willing to accept a regretful decision that was reached after sufficient time and attention than what they view as lack of attentiveness."

Sparse charting hurts defense

Catherine J. Flynn, Esq., an attorney with Weber, Gallagher, Simpson, Stapleton, Fires & Newby in Warren, NJ, has represented physicians in many cases alleging failure to obtain diagnostic tests.

"When you know the outcome is not a good one, it's always easy to look back retrospectively and say, 'You should have ordered a test, and you would have picked up the diagnosis,'" she says.

No documentation or very sparse documentation makes these lawsuits difficult to defend, adds Flynn. For example, a chart might say the patient complained of a lump in her breast, that an evaluation was done and nothing was palpated, but it says nothing about recommendations for diagnostic testing.

"The lawsuit occurs months or years after a test needed to be done, so it's very hard to pull together the facts when time has lapsed," says Flynn.

The plaintiff can show the jury the patient's mammogram, chest film, or CT scan revealing the eventual diagnosis, while the physician defendant is left to explain why a diagnostic test wasn't ordered at a time when the bad outcome could arguably have been prevented. If physicians can show the standard of care for not ordering the test was met, however, the claim will be defensible, says Flynn.

"If it is a gray area, and the physician is asking, 'Should I or shouldn't I order this test?' and it's something someone may question, that's when they have to document why they are not proceeding," says Flynn. *(See related story, below, on what to do if a patient refuses a diagnostic test.)* ✦

Patient refused test? Here's what to chart

"I don't care what my family history is. I'm never going to have that procedure performed."

If a physician recommending a colonoscopy is later sued for failure to order the test, these words in quotes would make the claim very defensible, says **Catherine J. Flynn**, Esq., an attorney with Weber, Gallagher, Simpson, Stapleton, Fires & Newby in Warren, NJ.

"That's the only way anyone will know a year or two down the line why the test wasn't done, or that the test was even recommended," says Flynn.

Flynn has defended physicians in claims alleging failure to order a diagnostic test when the patient was the one who refused the test, but with no documentation of this fact. "Sometimes it's conversational, and the doctor never puts into the chart that the patient refused the test," she adds.

If a patient refuses a recommended colonoscopy and is later diagnosed with colon cancer and sues, the plaintiff can claim it was never discussed. Flynn says an example of good documentation would be, "Had lengthy conversation with patient regarding need for colonoscopy in light of family history. Patient refused test."

David P. Sousa, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh, encourages physicians to use an informed refusal of treatment form. He advises documenting why the physician believes the patient needs a diagnostic test, the patient's understanding of the risks involved in not getting the test, and the fact that the patient decided not to obtain the test.

"The form is dated, witnessed, and signed by the doctor and the patient, and goes into the patient's chart," he says. "There is no way that the doctor will ever lose that case with that form executed and in the file." ✦

Suit over informed consent? Make it easier to defend

Sparse, overly detailed charting both problematic

"If I'd known the risks, I wouldn't have had the procedure." "The physician never told me that."

If a patient made these allegations about your care, would you be able to prove otherwise?

To successfully sue a physician for failure to obtain informed consent, plaintiffs need to prove three things,

says **Samantha L. Prokop**, Esq., an attorney at Brennan, Manna & Diamond in Akron, OH:

• that the physician failed to disclose material and reasonably foreseeable risks of a contemplated course of action to a patient;

• that one or more of the aforementioned undisclosed and foreseeable risk occurred and harmed the patient;

• that a reasonable patient under the circumstances, had the required disclosures been made, would have refused to consent to the course of action that resulted in injury.[1-3]

(See related story on exceptions to the informed consent doctrine, p. 29.)

Even if doctors provide world-class medical care, they still can be held liable under an informed consent theory of liability, says Prokop. "The whole notion of informed consent as a legal cause of action is predicated on protecting the autonomy interests of the patient, rather than holding physicians to an objective standard of care," she explains.[4] Consider these practices to reduce risk of lawsuits involving informed consent:

• Know state requirements.

"The most important thing to note about informed consent is that requirements vary by state," says Prokop. Some jurisdictions explicitly require the discussion of alternative treatments, for example.[5]

• Verbally discuss reasonable foreseeable risks with the patient, and answer any and all questions the patient has about the treatment, including potential alternative treatments.

"Have the patient explain back to you the risks and benefits of treatment, and why he or she has chosen a particular course of recommended treatment, to ensure the patient is truly giving informed consent," says Prokop.

• Use a written consent form that states that informed consent has been given by the patient.

"A written form provides excellent proof that informed consent was given," says Prokop. "In some circumstances, a signed form has even prevented a plaintiff's lawsuit from moving forward."[6]

• Personally obtain informed consent from patients.

"There is some case law that tends to suggest that the duty to obtain informed consent from patients cannot be delegated," says Prokop.

The Supreme Court of South Dakota held that when a surgeon delegated his duty to obtain a patient's informed consent for gastric bypass surgery to hospital staff, that delegation did not relieve the surgeon of his duty to make full disclosure to and obtain informed consent from the patient.[7]

Similarly, a North Carolina court held that when a pregnant hospitalized patient was treated by her own private physician who performed a forceps delivery resulting in severe spinal issues, the hospital had no responsibility to obtain informed consent from the patient.

"The private physician alone was responsible for obtaining informed consent from her patient," says Prokop.[8]

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Executive Summary

Physicians can be held liable under an informed consent theory of liability, regardless of whether the standard of care was met. To reduce risks:

✦ Discuss alternative treatments if required.
✦ Obtain a signed form stating that informed consent was given.
✦ Personally obtain informed consent from patients.

Informed consent not always necessary

Physicians generally must obtain informed consent from their patients, unless an exception to the informed consent doctrine applies.

"There are two types of situations where courts have held doctors are not required to provide informed consent to their patients," says **Samantha L. Prokop**, Esq., an attorney at Brennan, Manna & Diamond in Akron, OH. "The first exception can be broadly characterized as 'implied consent' or 'emergency' cases."

It is generally recognized that in emergency situations in which immediate action is necessary for the protection of life, consent will be implied

when it is impractical to obtain actual consent from a patient or the patient's authorized representative, she explains.[1] "Even in these situations, some courts have required that physicians attempt to obtain the consent of one of the patient's family members, if possible," cautions Prokop.[2] "One must be careful not to push the emergency exception too far."

In one case, an emergency physician intubated an asthmatic over her forceful objections, because in his professional opinion, the patient was subject to a life-threatening situation.[3] "The court held that a competent patient's refusal to consent to medical treatment cannot be overridden, even when the patient faces a life-threatening situation," says Prokop.

Physician's privilege

The second exception, sometimes referred to as a physician's privilege, allows the physician to withhold some material information from the patient if the disclosure would pose an actual threat to the condition of the patient.

"It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient," says Prokop.

Physicians must be careful not to over-reach with the "privilege" exception, cautions Prokop. In a 2002 case, a defendant psychiatrist asserted this privilege and claimed he never told his patients about the risk of neuroleptic malignant syndrome as a side effect of antipsychotic medication because he didn't want to concern them.[4] "The court stated that the exercise of this privilege must be based on specific considerations in the individual patient's case, and the practitioner must be able to identify those considerations," says Prokop.

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Fix EMR issues before med/mal suit

Don't assume you can blame vendor

Just as physicians wouldn't be able to blame the manufacturer of fax thermal paper if hard-to-read information resulted in an error that harmed a patient, they might not be able to blame an electronic medical record (EMR) vendor for a problem with the system that resulted in a malpractice suit.

"It's the practice's responsibility to maintain the medical records, regardless of what the tool is. It makes absolutely no difference," says **Ron Sterling**, author of Keys to EMR/EHR Success (Greenbranch Publishing; Phoenix, MD) and president of Sterling Solutions, a Silver, Spring, MD-based consulting firm advising physicians on EMR implementation.

Sterling adds that every EMR contract he's reviewed states that the vendor is not responsible for its use. Typical language states that "the vendor is not engaged in the practice of medicine. All information entered and displayed by the system is subject to the medical judgment of the user. The vendor is not liable for any damages whatsoever for any use or misuse of the information entered in to the EHR."

"Many physicians rely on techno geeks — EMR vendor staff or hardware support personnel — to make decisions for how to use the system to document patient care," says Sterling. "The problem is, the doctors may not understand the implications of features and workarounds presented by the trainers or technical staff."

For example, if a doctor complains about the difficulty of entering some type of information into the clinical record, the vendor, with the best of intentions, might suggest that the doctor could enter the information as a text note. However, that text note might not be usable by the EMR to warn about drug interactions, clinical care decisions, or reminders for services. In another case, a vendor told a practice to not sign encounter notes in case the doctors wanted to go back and make corrections.

"In either case, a malpractice dis-

Executive Summary

Electronic health records (EHRs) sometimes can complicate the defense of a medical malpractice lawsuit due to inaccurate or incomplete medical records. To avoid problems, physicians should do the following:

- ✦ Perform a daily assessment of EHR documentation.
- ✦ Understand the implications of where information is inserted.
- ✦ Consider how system updates will affect the medical record.

covery process would allow the plaintiff to question whether the patient was properly card for according to the practice's own standards," says Sterling.

Just as physicians ensure payments are properly posted, and appointments have been properly closed or cleared, they need processes to maintain the accuracy of EMR documentation, advises Sterling.

Sterling says physicians should do a risk assessment to determine if EMR documentation demonstrates the practice's due diligence and decision making. "You need to determine what things you need to do daily to keep records in good shape," he says, giving these examples:

• Ensure that encounter notes are signed and completed.

• Determine if outstanding care recommendations are properly communicated to patients and followed up on.

• Ensure that "electronic traffic" of lab orders, prescriptions, and referrals, is going in and out correctly.

Here are three examples of issues with EMRs that could cause problems during malpractice litigation:

• Some EMRs do not include phone messages from patients as part of the medical record.

"That poses a number of serious problems," says Sterling. "It's like throwing out the old phone message booklet in the trash every 30 days."

He says the best solution to the problem is buying an EMR that includes messages as part of the patient record. "If your EMR does not include messages as part of the patient record, then you need to train doctors and staff to document messages as an encounter note or some other feature that is included in the patient record," he says.

Some EMRs allow the user to flag a message to indicate that it is part of the medical record. "In that case, you should make sure that everyone is trained on the messages that should be flagged, and maintain a quality check to ensure that all messages of clinical significance are included in the patient record," says Sterling.

• Alerts on drug interactions aren't always given when medications are entered as free text.

The bottom line is, physicians need to understand how their EMR works.

Physicians need to understand the implications of where information is inserted, says Sterling. A physician might document sample drugs given to the patient in a free text note, for example, instead of the medication list.

"If there is a drug recall or serious interaction, the system won't alert you," says Sterling. "If you are using that note feature, and not the standard medication capability, and end up with a bad situation with a patient, it's going to be very problematic."

• When physicians enter information on a screen, and then print it out as a clinical summary or a referral letter, the EMR might add information to the document or omit information that is displayed on the screen.

"Many EMR products use a separate program with its own document-formatting script print information. For example, the production of a clinical summary, which is a Meaningful Use Measure, may be based on a separate document formatting script," explains Sterling. This situation means that all of the information won't necessarily be included on the clinical screen, unless the physician references the information on the screen. Physicians might add a new finding or field to the clinical screen, but fail to add it to the script.

"Similarly, the script may include information from the patient's record that was not reviewed with the patient or even documented," says Sterling. For example, some EMR products can include advisories or information that is in the script, but not documented in the patient record.

The bottom line is, physicians need to understand how their EMR works, emphasizes Sterling.

"I've seen a number of cases already where the doctor's defense was, 'I didn't know how the EMR works.' You don't want to be in that position," says Sterling. *(See related story, p. 31, on liability risks with EMR updates.)* ✦

EMR update? Assess for problems

Check for unintended effects

An update of one electronic medical record (EMR) included a new checkbox to indicate whether there was an abnormal finding for a certain test.

"The problem was, if you went back and looked at patient visit records from before the EMR was updated, the EMR shows there was not an abnormal finding. In fact, the information was never entered during that previous visit," says **Ron Sterling**, author of Keys to EMR/EHR Success (Greenbranch Publishing; Phoenix, MD) and president of Sterling

Solutions, a Silver, Spring, MD-based consulting firm advising physicians on EMR implementation.

The field was visible in those patient visit records, however. "So it looked like there was not a problem with the patient, when there easily could have been," says Sterling. In this case, the vendor could have displayed a New Field message or even hidden the screen field for old records, he adds.

When EMR systems are updated, this update could have unintended effects on the medical record. To avoid problems, Sterling says to review changes to your EMR before you install the new version, to verify the effect of the new version on your use of the EMR or even your historic data.

"If you have a problem, you need to pursue the issue with your vendor and develop a mitigation strategy," he says. ✦

Not all claims covered by med/mal policies

Don't be blindsided by policy exclusions

Most medical professional liability policies contain exclusions for intentional wrongful acts, fraudulent activity, or sexual misconduct, but physicians often are unaware these claims aren't covered, says **Jeffrey P. Lisenby**, JD, senior vice president, general counsel and secretary at ProAssurance Corp. in Birmingham, AL.

"If physicians are sued for something that's not covered, they may end up paying out of their own pocket for the lawyer to defend the case, even if the allegations are completely frivolous," says Lisenby. He advises confirming whether a malpractice policy provides defense costs for excluded claims, even if the carrier will not indemnify losses for those cases.

"ProAssurance's policy excludes coverage for fraudulent, criminal, malicious, or intentionally wrongful acts, but it also provides that up to $100,000 in defense costs will be paid for such claims," says Lisenby. *(See related story, p. 32, on policy limits.)*

Physicians need to understand that a professional liability policy does not cover everything that happens in the physician's office, emphasizes Lisenby. Generally, the professional liability policy insures liability for the physician's acts or omissions that occur while rendering actual medical treatment to a patient.

"Other sorts of liability, such as employment discrimination claims, worker's compensation claims, liability for damaged or lost property, or accidents such as visitors slipping and falling in the office, simply do not fall within the insuring agreement of a professional liability policy," he says.

Medical malpractice insurance is specifically intended to cover liability for professional services, and physicians therefore might need general or business liability insurance to cover other types of legal risks, says **Mike Merlo**, JD, managing director of casualty legal and claims at Chicago-based Aon Risk Solutions.

"You want to make sure those two coverages fit together snugly and nothing falls through the cracks," Merlo advises.

A physician's liability for breach of confidentiality is not likely to be covered by medical professional liability insurance, for example, but should be covered by general liability insurance.[1] Here are two things physicians should consider regarding non-coverage of claims:

• Be aware of how the policy defines excluded "intentional acts."

The law on what constitutes "intentional" with regard to an intentional acts exclusion in an insurance policy varies by jurisdiction, says Merlo. In some jurisdictions, the insured has to merely intend to commit the acts in order for the claim to be excluded. In other jurisdictions, the insured has to intend to cause the resulting damage.

"I have seen some policies that included the word 'reckless' in intentional acts exclusions. I would say that is a red flag," says Merlo. "If you come across that in a policy, you would want to get it taken out if possible."

Both types might be included

Occasionally, allegations in malpractice suits include covered and non-covered claims. For example, a lawsuit could allege that the physician was negligent in the way a patient was restrained, and it also could allege battery.

"In this scenario, the insurer might be obligated to cover, or at least defend against, all of the allegations, if they are inextricably intertwined," he says.

Executive Summary

Physicians should be aware of types of claims excluded by their medical professional liability policies, including intentional wrongful acts, fraudulent activity, or sexual misconduct.

✦ Some policies provide defense costs for some excluded claims.

✦ What constitutes an intentional tort varies by jurisdiction.

✦ Physicians might need to dispute the basis for the insurer's reservation of rights to deny a claim.

Generally, the insurer's duty to defend is broader than the duty to indemnify. "So if a lawsuit contains just one covered claim along with one or more claims that are not covered, the carrier will often be obligated to defend the entire case," says Lisenby.

• Understand implications of "reservation of rights" letters.

Reservation of rights letters vary depending on the insurance carrier involved and the facts and circumstance of the claim, but typically include a clear statement that the insurer is reserving its rights to contest coverage in the future when it learns more about the facts of the claim and depending on how the claim develops. "Clients often think this means they are not going to have coverage, but this isn't necessarily the case," says Merlo.

It's fairly common for insureds to receive such letters after giving notice of a claim, he says. Reservation of rights letters are typically just an indication that the insurer is reviewing any issues that could result in denial of coverage and reserving its rights in connection with the same.

"If the insurer actually denies a claim, or issues a 'strong' reservation of rights letter with an adversarial tone indicating it's likely the claim will be denied, the physician might need to dispute the basis for the insurer's denial or reservation of rights," Merlo cautions.

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What are the dangers of too-low policy limits?

Lower premium cost often shortsighted

The only way to eliminate the possibility of personal liability for a jury verdict is to settle a plaintiff's claim within the insurance coverage limit prior to trial, says **Jeffrey P. Lisenby**, JD, senior vice president, general counsel, and secretary at ProAssurance Corp. in Birmingham, AL.

"Unfortunately, settlements can carry their own unpleasant consequences," Lisenby says. These include the required reporting of the payment to the National Practitioner Data Bank, the possibility of required reports to state medical or insurance authorities, and the effect of the payment on the physician's future insurance premiums or insurability.

"Clearly, the risk of a loss in excess of the insurance coverage limit can be reduced by purchasing a higher limit of coverage," says Lisenby. In many states, a $1 million indemnity limit is considered standard and is sufficient to protect against most claims, he adds.

"Some states require carriers to offer lower limits, and many physicians buy those lower limits because the premium cost is less," Lisenby says.

In any lawsuit involving a hospitalized patient, however, the medical costs alone that the patient might claim as damages will often exceed a $250,000 coverage limit. "That does not leave room for payment of other potential damages, like lost wages or pain and suffering," says Lisenby.

It is possible that higher coverage limits could increase a plaintiff's targeted settlement amount, he acknowledges. However, some states don't permit the plaintiff to discover the amount of the physician's coverage limits.

"Moreover, any physician with significant personal assets is a 'deep pocket,' in the sense that those assets can be seized to satisfy a judgment," says Lisenby. When considering how much insurance coverage to purchase, he says, "The question is, would you prefer that a potential judgment be paid out of your own deep pocket or the insurance company's?" ✦

How you can stop risk-prone communication

It's often the sole reason for suit

"The doctor didn't tell me that."

"This is the single biggest grievance I hear from plaintiffs and their counsel after a claim has been made," says **Gary Genovese**, JD, an attorney at Conrad & Scherer in Fort Lauderdale, FL. "It all starts with communication."

One recent lawsuit alleged that a neurologist failed to give a stroke patient tissue plasminogen activator (t-PA), but it was discovered during the litigation that the treatment was contraindicated due to the patient's recent head trauma.

"The physician had good reason not to give the medication but got sued anyway," says Genovese. The patient's wife asserted in her deposition that the physician was "short" with her, never discussed t-PA use, and never explained that he thought it was not safe to give her husband. To make matters worse, there was no documentation in the hospital chart concerning any discussion with the patient's wife on the subject or the rea-

sons the physician believed the drug was contraindicated.

"It was no surprise to me that he was named in the suit. The lack of communication and documentation made my job that much harder," Genovese says.

If the doctor had thoroughly discussed with the patient's wife the use of t-PA, the risks associated with it, and why he thought that it was contra-indicated because of her husband's head injury, preferably with an independent witness present, and documented that all of the patient's wife's questions were answered to her satisfaction, the case would have been far easier to defend, says Genovese.

"Rather, what we were left with was very little documentation, no independent witnesses, and a swearing contest between the doctor and the patient's wife about the 'short' discussion," he says. "It was a much tougher case to defend, particularly with the sympathies of a jury naturally going to the patient and his family."

Evidence continues to grow indicating that physicians who have more patient complaints filed are much more likely to be sued, notes **Bradley A. Sharpe**, MD, assistant clinical professor of clinical medicine at University of California — San Francisco Medical Center.

"A tiny percentage of physicians are responsible for the largest number of patient and family complaints," Sharpe says. For example, in one large U.S. medical group, 9% of the physicians accounted for half of all unsolicited patient complaints, and further analysis showed that this small group was responsible for more than 50% of risk-management expenses.[1,2]

"When the authors analyzed the nature of the complaints, it was clear that physicians who communicate poorly, don't follow-up, are less available — or perceived to be so — and are less compassionate are more likely to be sued," says Sharpe.

A little extra time

Genovese says that spending a little extra time explaining what is going on, asking patients if they understand, and asking whether they have any questions can avoid lawsuits if the outcome isn't as favorable as anticipated. "Never be condescending, short, or brusque with a patient or family member, even if they do not return that courtesy to you," he says.

Genovese says that in his experience, patients won't hesitate to sue a doctor with whom they do not have a good relationship. "In fact, I oftentimes get the impression that this is the only reason that a particular doctor was named in a suit with other defendants," he says.

Communication is the culprit

Overall, the literature supports that malpractice suits often are lodged by patients who are unhappy with the relationships with their doctors, says Levinson.

"In the face of a bad event, patients who are angry that their doctor didn't listen, was rushed, or didn't appear to care, are more likely to seek legal advice," she says.

In a 1997 survey of 227 patients and relatives who took legal action, the decision to take legal action was determined not only by the original injury, but poor communication after the original incident.[3]

A 2002 study audiotaped surgeons speaking to their patients during office visits, then studied the relationship between the a physician's lawsuit claim history and the tone of the physician's voice. Surgeons with more dominance and less concern in their voice tones were much more likely to have previous claims.[4] A gruff, disrespectful physician is likely to antagonize patients and make them more likely to sue in the event of a bad outcome, according to **Martha Swartz**, JD, a Philadelphia-based health care attorney.

"On the other hand, a physician who is an active listener — that is, who looks patients in the eye and asks relevant questions at appropriate points during an exam or history-taking — is more likely to be well-received and, possibly, less likely to be sued," she says. She recommends these communication practices:

• Explain the tests or treatment to be performed and the patient's diagnosis in lay language.

"Physicians who pay attention to the manner in which the convey information, as well as the substance, may be less likely to engender malpractice suits," says Swartz.

• Make eye contact with patient even when utilizing electronic medical records.

Because it is difficult for a physician to maintain eye contact when the physician must type information into a computer, Swartz suggests making a point of doing so when greeting and releasing the patient.

• Avoid interruptions during an exam as much as possible.

• Call the patient about test results directly, or at a minimum, have a qualified staff person call.

"This shows a level of concern that may make the patient less likely to sue," she says.

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2. Hickson GB, Federspiel CF, Blackford J, et al.

Executive Summary

Poor communication is often the precipitating factor in malpractice litigation, according to medical/legal experts interviewed by Physician Risk Management.

- ✦ Never be condescending, short, or brusque with a patient or family member
- ✦ Explain tests or treatment in lay language.
- ✦ Make eye contact with patient when using electronic medical records.

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Patient harmed self after being in your care?

How you can protect yourself legally

If one of your patients commits suicide shortly after being in your care, you are likely to be named in any subsequent malpractice claim, even if your care had nothing to do with behavioral health.

It is frequently the case that any physician who had a recent encounter with a patient will be drawn into a malpractice claim, says **Mary Jean Geroulo**, JD, an attorney at Wilson Elser in Dallas. "But if a patient does not disclose a history of mental illness or suicidal thoughts when asked , and does not have any outward manifestation of such symptoms, then it is not likely that a physician treating the patient for an unrelated issue will be held responsible," she says.

In allegations against behavioral health physicians involving a patient's self-harm, plaintiffs usually claim that psychiatrists failed to recognize that patients were at risk for self-injury and/or failed to manage the risk appropriately, says **Paul S. Appelbaum**, MD, Dollard Professor of Psychiatry, Medicine, & Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University College of Physicians & Surgeons in New York City.

"However, there may be many subcomponents to those claims," says Appelbaum. These include failure to do the following:

- ask the patient about suicidal history and current ideation, including plans of self-harm;
- inquire about the availability of means of self-harm;
- speak with family members or others to obtain additional information;
- obtain past treatment records or review such records if they were obtained;
- speak with previous mental health treaters;
- monitor the patient's suicidal ideation over time;
- implement appropriate treatment for the underlying disorder, including medication and psychotherapy;
- warn family members so that they can take preventive measures;
- hospitalize the patient.

Appelbaum says non-psychiatric physicians are at risk for these allegations:

- that the physician should have known the patient had a mental disorder and/or was likely to injure himself or herself;
- that the physician should have instituted appropriate treatment or referred the patients to a psychiatrist or other mental health professional.

"If patients were already in mental health treatment, plaintiffs may claim that treating physicians failed to communicate information about the risk of self-harm, such as suicide threats, to the treating mental health professionals, thereby precluding preventive action from having been taken," says Appelbaum. *(See related story, below, on the legal standard of care for non-behavioral health physicians caring for psychiatric patients.)* ✦

Executive Summary

Physicians are likely to be named in malpractice lawsuits involving a patient's self-harm, even if the care had nothing to do with behavioral health. To reduce risks:

- ✦ Inquire about the patient's psychiatric history and symptoms.
- ✦ Follow-up on any affirmative responses.
- ✦ Request a consult or make a referral to a psychiatrist or other mental health professional.

What is legal standard for non-psych MDs?

Dismissal often hinges on documentation

(Editor's Note: This is the first of a two-part series on liability risks involved with psychiatric patients. This month, we give strategies for physicians to protect themselves legally. Next month we'll cover the legal standard of care to which physicians will be held.)

If a family practice physician chooses to treat a patient for depression, he or she will be held to the same standard of care as a psychiatrist, according to **Mary Jean Geroulo**, JD, an attorney at Wilson Elser in Dallas.

There are some circumstances, such as a true emergency, when a physician without the typical specialty skills would not be held to the same standard of care, she acknowledges.

"But in general, if a physician accepts

a patient for treatment, they are held to the same general standard of care as a physician in the specialty," she says. If an emergency physician accepts the responsibility to deliver a baby in a non-emergent situation, he or she is held to the same general standard of care of an obstetrician gynecologist, notes Geroulo, and the same is true for primary care physicians caring for psychiatric patients. "One of the elements that should be addressed in the standard of care is when it is appropriate to refer a patient to a specialist," she says. "Failure to make a referral when indicated can be interpreted as a violation of the standard of care in certain circumstances."

Non-psychiatric physicians generally will be held to the standard of care of their specialty in screening for mental disorders and offering referrals to specialists. However, if they undertake to treat the disorders, they might be held to the higher standard of psychiatric specialists, says **Paul S. Appelbaum**, MD, Dollard Professor of Psychiatry, Medicine, & Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University College of Physicians & Surgeons in New York City. "Since non-psychiatric physicians' obligations are fairly circumscribed, their documentation should reflect that they at least met minimum standards of care," says Appelbaum. "Many offices accomplish this by having patients complete self-report forms."

Documentation of these actions can make it more likely a non-psychiatric physician would be dismissed from a claim involving a patient's self-harm, says Appelbaum:

• inquiring about the patient's psychiatric history and the presence of the major categories of current psychiatric symptoms: anxiety, depression, and cognitive impairment;

• asking about past or current suicidal ideation;

• encouraging regular follow-up if the patient is in mental health treatment;

• offering a referral to a psychiatrist or other mental health professional if a patient with significant mental health symptoms is not in mental health treatment.

Sparse records with no indication of whether a physician inquired about mental health issues or thoughts of self-harm are an invitation for plaintiff attorneys to dig deeper, moving toward deposition and further discovery, says Appelbaum.

"Records indicating that the questions were asked, but without any indication that affirmative responses were followed up by the physician, can be equally problematic," he adds.

The standard of care when treating a patient with a psychiatric history remains the same as in any other medical negligence case, but the specifics might vary greatly depending on the resources available, says **Andrew H. Koslow**, MD, JD, an assistant clinical professor of emergency medicine at Tufts University School of Medicine.

If there is no psychiatrist available to the see a patient being boarded in an emergency department, for example, the physician cannot reasonably be expected to provide the same level of psychiatric care expected of a psychiatrist.

"Regardless of the psychiatry resources, however, provision of a safe environment is a must," adds Koslow. "The cases that stand out the most are those where a patient comes to harm through lack of observation or noncompliance with policy or procedure, such as a restraint policy."[1,2]

References

1. Freeman v. St. Clare's Hospital, 548 N.Y.S. 2d 686, 156 A.D.2d 300 (1989).
2. Pisel v. Stamford Hospital, 430 A.2d 1 (1980). ✦

COMING IN FUTURE MONTHS

✦ Avoid disastrous disclosures of medical mistakes

✦ Prevent suit for failure to act on test results

✦ How metadata is making claims indefensible

✦ Increase your odds of being dismissed from claim

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 of the following practices does Keith C. Volpi, JD, an attorney at Polsinelli, recommend to reduce the risks of claims involving the failure to order a diagnostic test?**
   A. A physician should document a patient's refusal to undergo an indicated and recommended test.
   B. A physician should document any behavior by a patient that makes him or her difficult to treat or diagnose.
   C. If a physician determines that an arguably indicated test is unnecessary, he should document his thought process.
   D. All of the above.

2. **Which of the following does not need to be proven by the plaintiff in order to successfully sue for failure to obtain informed consent, according to Samantha L. Prokop, Esq., an attorney at Brennan, Manna & Diamond?**
   A. That the standard of care was not met.
   B. That the physician failed to disclose material and foreseeable risks of a contemplated course of action.
   C. That one or more of the undisclosed and foreseeable risks occurred.
   D. That a reasonable patient would have refused to consent had the required disclosures been made.

3. **Which is true regarding claims excluded by medical professional liability policies, according to Mike Merlo, JD, managing director of casualty legal and claims at Aon Risk Solutions?**
   A. No malpractice policies provide defense costs for excluded claims.
   B. The law on what constitutes an "intentional" act varies by jurisdiction.
   C. Physicians should never dispute the basis for the insurer's reservation of rights to deny a claim.
   D. "Reservation of rights" letters are always an indication of denial of coverage.

4. **Which is true regarding malpractice lawsuits involving a patient's self-harm, according to Mary Jean Geroulo, JD, an attorney at Wilson Elser?**
   A. Physicians should not routinely inquire about a patient's psychiatric history.
   B. Only non-behavioral health physicians are at risk for allegations of failing to manage the risk of self-injury appropriately.
   C. Failure to make a referral when indicated can be interpreted as a violation of the standard of care.
   D. Non-psychiatric physicians are not at risk for allegations that they should have instituted appropriate treatment.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Failure to diagnose bacterial meningitis causes infant's death and $1.7 million verdict

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

Patrick Dolan, Esq.
Associate
Kaufman Borgeest & Ryan
Garden City, NY

Leilani Kicklighter, RN, ARM
MBA, CHSP, CPHRM, LHRM
The Kicklighter Group
Tamarac, FL

News: A family in Pennsylvania was awarded $1.7 million against an emergency department (ED) doctor who failed to recognize the signs and symptoms of bacterial meningitis resulting in a patient's death. The patient, 3 months old at the time, presented to the doctor in the ED with a 103 degree fever on Dec. 16, 2007. The patient was released the same day with a diagnosis of a middle ear infection and a prescription for amoxicillin. The following day, the patient's parents brought her to her pediatrician, who immediately referred her to another hospital's ED. There she was diagnosed with pneumococcal meningitis. The infection had caused hypoxic brain injury and hydrocephalus. The patient died almost two years later due to complications from the infection.

Background: Parents brought a 3-month-old patient to the ED of a local hospital on Dec. 16, 2007. The doctor recorded the patient's temperature as 103 degrees. It appears that this note was the extent of the doctor's documentation. The doctor diagnosed the patient with a middle ear infection and prescribed amoxicillin and discharged her home two days later on the 18th. The doctor did not indicate in which ear he found the infection, nor did he record any signs or symptoms to support his diagnosis. He released the patient to home with her parents the same day.

It was argued that the doctor should have, at the minimum, ordered blood and urine tests to rule out a bacterial infection.

The next morning, the parents awoke to find the infant cool to the touch, lethargic, and pale, so they brought the child to her pediatrician. The pediatrician immediately transferred her care to a different hospital than the one the patient had been seen at the previous day. She was diagnosed with pneumococcal meningitis resulting in hypoxic brain injury and hydrocephalus. The patient was admitted to the second hospital from Dec.19, 2007, to Jan. 14, 2008.

The patient died from respiratory complications related to the meningitis infection on Sept. 15, 2009. Between Jan. 14, 2008, and Sept. 15, 2009, the patient was seen emergently at various hospitals approximately 10 times. The patient also was seen by other medical specialists with regard to her compromised condition.

The patient's parents sued the ED physician for medical malpractice on behalf of the patient's estate. The damages included loss of enjoyment of life, pain and suffering, brain injury, and death. The patient's attorney argued that the doctor failed to properly assess the patient while she was in the ED. It was argued that the doctor should have, at the minimum, ordered blood and urine tests to rule out a bacterial infection. It was argued that blood and urine tests were indicated even if patient was suffering a middle ear infection. It was argued that if the doctor had performed the blood or urine tests, the results would have been abnormal and prompted further test-

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Leilani Kicklighter, Patrick Dolan** 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.

ing, including a lumbar puncture for meningitis. The patient's attorney also argued that the doctor failed to provide proper discharge instructions. The doctor instructed the patient's parents to return "as needed." It was argued that the standard of care was to have patient return within 24-48 hours. The patient's expert opined that if the doctor had properly evaluated the patient, swift treatment would have prevented the catastrophic injuries she suffered.

The doctor's emergency medicine expert opined that at the time he evaluated the patient, there was no indication that she was suffering from a pneumococcal meningitis infection. He further opined that the middle ear infection posed no substantial risk for the patient to develop a bacterial meningitis infection. In fact, the doctor's pediatric expert opined that the patient began suffering from the infection after the ED doctor's care and that there was no reason for doctor to have foreseen her clinical course.

The jury found the doctor liable for medical malpractice for failing to diagnose the patient with meningitis, which caused hypoxic brain injury and eventually her death. Accordingly, the jury awarded the patient's estate $1.72 million. Her family was awarded $860,000 for future lost earnings and $860,000 for her pain and suffering.

What this means to you: In this case, we have a 3-month-old infant who presents at the ED with a high fever of 103 degrees. In this scenario, we have no description of other presenting signs and symptoms. It was not until the second ED admission, at a different hospital, that the child was diagnosed with pneumococcal bacterial meningitis.

Meningitis in an infant and toddler is difficult to diagnose as the signs and symptoms can be thought to be something else. The information we are given here indicates that the only signs, symptoms, or other information documented by the ED physician who saw this patient was the temperature of 103, his diagnosis of middle ear infection, and the order for amoxicillin. With this sparse information, it is difficult to opine if the infant should have been kept overnight for observation, whether a spinal tap should have been done, or if blood and urine samples should have been obtained. Certainly in all inner ear infections, a spinal tap is not warranted. However, in this case, was the eardrum protruding? Was the infant pulling at the ear? Was the infant fussy and, if so, when did the fussiness begin? Did the infant have signs and symptoms of a cold? All this information might have assisted in making a more definitive diagnosis. This untoward event emphasizes the necessity of a thorough history and physical and thorough documentation, and it shows how lack of such documentation leaves so much to question.

The medical record has many uses, but the first and most important use is for continued or continuity of patient care between caregivers on different shifts and days or in different settings. Backup documentation for billing and defense in a legal matter are secondary to the patient care aspect. The lack of more detailed documentation raises the question of whether this was a matter of missed diagnosis or mis-diagnosis.

The physician's documentation of his physical exam and discussion with the parents as to the onset of signs and symptoms was sorely lacking. Also, the discharge instructions only indicated return "as needed." Infants' signs and symptoms can be unrecognized by new parents or because they often are subtle. There is no documentation that the physician or nurses spent any time with these parents discussing the diagnosed "ear infection" and directed them to return immediately if certain signs or symptoms became evident. Were the parents advised to monitor the infant's temperature during the night? Was the infant given a dose of amoxicillin while in the ED, or was a prescription for oral medication given? The discharge nurses are the last resort as they teach and go over the discharge instructions with the parents. As pediatric nurses, if they think something should be added, it is their role to bring it to the physician's attention.

If a hospital does not have a section or separate designated ED for pediatric patients staffed with pediatric physicians and pediatric nurses, the hospital and emergency medicine department should take steps to provide ongoing in-service and support to all ED staff regarding diagnosis, treatment, and dosages for pediatric patients.

The risk management and patient safety issues raised by this particular untoward event are complicated by the HIPAA privacy issues. In particular how would the first hospital's ED or risk manager be made aware of the infant's admission to the second hospital on a timely basis without breaching the privacy rules? If the first hospital isn't made aware on a timely basis by the second hospital's ED or risk manager, the steps to assess the situation and implement steps to prevent a recurrence cannot be undertaken until the facts are "cold." Unless the infant's pediatrician who referred her to the second hospital notified the hospital, it might have been only with the request for records or first notice of intent to bring a legal action that the first hospital was made aware and could begin its own investigation.

Based on the facts we are given in this scenario, the risk manager should have been notified immediately by whoever first was made aware. The risk manager should have obtained statements and interviews of those nurses, physicians, and other staff members who were involved in the care of this infant. Upon being made aware of this untoward event, the physician should have been notified to advise his malpractice insurance carrier, and likewise, the hospital should have notified its insurance carrier of a potential claim.

The hospital should undertake a review of a sample of medical records of all ED admissions. It should include all ED pediatric admissions under the age of 5 with presenting complaints

of high temperature, if available, and all those with discharge or admitting diagnosis of inner ear infection or meningitis (viral, bacterial, or rule out). The focus of this review is to determine if there is a trend or pattern in the lack of documentation among the nurses and physicians and to determine the acceptability of the overall documentation found in the charts reviewed.

This particular physician should be referred for a medical staff peer review as it relates to this case. Consideration should be given to requiring this particular physician to attend an approved chart documentation course.

A root cause analysis should be undertaken, guided by the risk manager and the ED medical director, to determine if this was a scenario that can be prevented from recurring. Hospitals that do not have a separate pediatric ED should evaluate how a trained pediatrician can be available 24/7 to confer in situations such as this one when staff are faced with signs and symptoms that are known to be difficult to diagnose. In the alternative, and in addition, steps should be taken to hold mandatory in-service sessions with all ED nurses and physicians on aspects of pediatric emergency care and diagnosis and on documentation. The hospital might consider a protocol to require a second opinion from the ED director or supervising physician in cases with certain diagnoses or signs and symptoms before discharge.

The ED quality improvement program should include regular review of physician and nursing documentation on a timely basis. The lack of documentation as reported in this particular situation does not meet the acceptable standard of care.

Reference

C.P. Berks No. 09-9629, June 14, 2013. ✦

Surgeon hit with $5.1 million verdict for botched forehead lift

News: In January 2010, a 53-year-old woman from Ohio agreed to have minor plastic surgery performed on her forehead and on her eyelids. The surgery was to involve only three minimal incisions and the injection of dermal fillers, a synthetic material. The surgeon, however, performed completely different procedures than those he and patient had agreed upon. He used more invasive and dangerous methods than necessary, and the patient suffered postoperative infections, nerve damage, and vision problems. In fact, it was discovered that surgeon did not perform any of the procedures patient wanted and that he failed to inform her of any of the risks, benefits, or alternatives of the procedures he did perform. The jury returned a verdict of $5.1 million for the patient and her husband.

Background: The patient in this case presented to a surgeon in January 2010. She was considering upper eyelid repairs and the removal of wrinkles underneath her eyes. This procedure, a blepharoplasty, involved having dermal filler, a synthetic wrinkle-relieving material, injected into patient's lower eyelids. The surgeon persuaded the patient that she needed additional procedures to obtain the proper look. The procedures the surgeon discussed were an endoscopic forehead lift, laser skin rejuvenation, botox injections, and eyelid repairs. Incidentally, these procedures would cost the patient an additional $5,350 over the $1,975 for the original procedure.

One month later, on Feb. 23, 2010, the patient returned to surgeon and signed an agreement to undergo an endoscopic forehead lift, a blepharoplasty upper, pinch lower lid blepharoplasty and volumizing filler, fractional laser skin rejuvenation, and Botox periorbital. The patient returned on March 12, 2010, to have the surgeries.

When the patient awoke, she discovered the surgeon had performed a traditional forehead lift as opposed to the endoscopic forehead lift. In performing the traditional forehead lift, the surgeon made an ear-to-ear incision across her scalp, which resulted in pain and scarring. The patient also discovered that surgeon did not use the dermal filler, but that he harvested tissue and fat from patient's thigh and injected it into her lower eyelids, which resulted in pain and scarring on her thighs. The surgeon also performed an additional laser eye procedure, which resulted in damage to the patient's vision. The surgeon never discussed performing these surgeries and, therefore, failed to apprise the patient of the risks, benefits, and alternatives available. In addition to not performing the endoscopic forehead lift, the surgeon also failed to perform the blepharoplasty upper, pinch lower lid blepharoplasty and volumizing filler, fractional laser skin rejuvenation, and Botox periorbital.

As a result of surgeon's care, the patient was left with permanent scarring, nerve damage, and damage to her vision. The patient also suffered a postoperative methicillin-resistant *Staphylococcus aureus* (MRSA) infection.

The patient and her husband sued surgeon for medical malpractice, failure to obtain informed consent, medical battery, loss of consortium, and malice. Plaintiff's experts opined that the patient and surgeon had entered a contract for the performance of an endoscopic forehead lift, upper blepha-

roplasty, lower lid blepharoplasty with volumizing filler, and Botox injections. The plaintiff's experts further opined that the surgeon failed to perform any of the agreed-to operations. Instead, the surgeon performed a much more invasive forehead lift and other completely new procedures such as the excision and injection of thigh tissue and fat into the patient's eyelids and laser eye surgery. The patient testified that she specifically told the surgeon that she did not want the traditional forehead lift due to the ear-to-ear forehead incision.

During discovery, the surgeon refused to release his records to the patient. However, the court granted plaintiff's motion to compel production of the records and ordered the defendant to disclose them The jury returned a verdict finding that the surgeon negligently performed the procedures, the surgeon was liable for medical battery for failing to obtain informed consent, and that the plaintiff would not have gone through with the operation had she been informed. The jury allotted the patient $50,000 for economic damages such as potential earnings or lost earnings, $3 million to compensate the patient for surgeon's negligence, $2 million to compensate the patient for medical battery, and $50,000 for the patient's husband's loss of consortium claim.

What this means to you: What is wrong with this picture? In January 2010, a woman, 53 years young, visits a physician to discuss her desire to have elective minor plastic surgery procedures to reduce minor wrinkles around her eyes. The cost of these desired outpatient procedures was $1,975. As elective cosmetic procedures, they were not covered by insurance and therefore were self-pay. During this visit in January, the surgeon talked the patient into more extensive procedures that increased the cost an additional $5,350. She returned to see the surgeon a month later and agreed to the upgraded procedures, signed the consents, and scheduled the surgery for March. Upon awakening from the surgical procedure, she found that even more aggressive and extensive upgraded procedures has been done that she had explicitly told the surgeon she did not want. As a result, she suffered scars she had not wanted and other complications and expenses.

This surgeon held himself out to be a clinical assistant professor of medicine at Northwestern Ohio Universities College of Medicine who had a practice in a town close to the university. His specialty was otolaryngology, head and neck, but he also did business as a facial plastic and aesthetic laser center. The surgery was done in the surgeon's office. We are not provided with information regarding whether the office surgery was an approved/licensed ambulatory surgery center (ASC), an approved office-based surgery (OBS) facility, or just a room where the surgery is done.

In view of this doctor's main specialty of otolaryngology, head and neck, it is unclear if he had additional training in plastic surgery. It is unclear if this patient did any background checks on this surgeon or others in the area and how she decided on this surgeon. This scenario adds support to the advice given to patients to check out physicians and surgeons and to obtain a second opinion before agreeing to an elective or non-emergent procedure, if time permits.

This case is very disturbing. We are faced with a surgeon who might or might not have had further training in plastic surgery past his otolaryngology, head and neck training who has "hung out his shingle" as a plastic surgeon with a surgery room in his office. We have no information regarding whether his surgery was compliant with applicable state rules and statutes. We have a patient who came to this surgeon for minimal procedures to smooth out the wrinkles around her eyes and was talked into more extensive and aggressive surgical procedures. The patient explicitly told this surgeon that she did not want the more extensive surgical procedures than those to which she had consented and that were more expensive than the ones she agreed to. However, when she awoke from the surgery, she found she had had the surgical procedures she explicitly refused to have. This surgeon disregarded the patient's desires and consented to do surgical procedures that apparently he wanted to do regardless of the patient's desires.

Within seven days of the surgery, the patient developed facial boils that were from MRSA. Was this the result of less than adequate sterilization and aseptic techniques in his surgery room?

This surgical procedure was done in the surgeon's independent office practice surgery. It is not usual practice that a stand-alone office practice engages a risk management consultant to conduct a periodic assessment of the office's compliance with rules and standards of practice. Unless the physician's professional liability insurance provides an on-site assessment or a complaint is made to the state department of health, there generally is no oversight provided to the physician's office practice setting. That being the case, the usual post-event evaluation and full analysis of the facts probably would not have been undertaken. Other than the investigation undertaken by the plaintiff and defense attorneys, there is no process to identify the root cause and to implement preventive actions.

The jury found this surgeon guilty of medical battery and failure to have consents for the procedures he performed. This case is a good example of why the physicians and surgeons should understand the patient's desires and consents. Patients have control over their bodies, and doctors have no right to disregard the patient's consent.

Reference

Case No. 2011-CV-00758, Court of Common Please, Mahoning County, OH. ✦