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Electronic fingerprints are making some malpractice claims indefensible

It's impossible for defense to dispute metadata

Metadata, the electronic fingerprint that is left from all interactions done with electronic medical records (EMRs), is playing a pivotal role in some malpractice suits, but many physicians still don't have any idea what it is, says **Sandeep Mangalmurti**, MD, JD, lecturer in law and fellow in the University of Chicago's Section of Cardiology.

"A lot of physicians don't fully appreciate how pervasive the surveillance of metadata is," Mangalmurti says. "As a rule of thumb, remember that everything is being monitored. Ask yourself, 'Would a jury take a jaundiced view of what I'm doing right now?'"

A plaintiff attorney can use metadata to learn how long the physician looked at patient charts, what part of the chart was looked at, who the physician contacted, and what time the physician made changes to the patient record.

Because metadata is discoverable in a lawsuit or medical board inquiry, all the physician's interactions with the EMR can be accessed by the plaintiff attorney, Mangalmurti explains.

"They are going to know every single thing you did on the computer, what you did, and how long you did it for," he says. "There is no place to hide."

> *"A lot of physicians don't fully appreciate how pervasive the surveillance of metadata is."*

The question, "You're not going to argue with the computer, are you?" is difficult for physicians to answer. "Even if you are doing things exactly right, you look bad and you lose credibility," says Mangalmurti. *(See related stories on how metadata is used during malpractice suits, p. 41, and risk-prone EMR charting practices, p. 39.)*

Plaintiff attorneys are only beginning to understand how metadata can help them to win malpractice lawsuits, but they are learning quickly, according to Mangalmurti.

"Once we get a few lawsuits that hinge upon metadata, routine discovery of metadata will become a part of litigation," he says. "It could be a very powerful technique for the plaintiff."

Currently, plaintiff attorneys don't routinely obtain metadata, mainly because it is a lot of information to sort through and the process is so time-consuming, Mangalmurti explains.

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"I don't think it has reached the point where they can go on vast fishing expeditions looking at reams of metadata to find things to justify a lawsuit," he says.

Instead, lawyers are using specific pieces of metadata to try to answer questions that arise during the lawsuit, such as when a physician looked at a test result. "But once it becomes easier to sift through this data, and people become more facile with it, you could definitely have plaintiff attorneys using metadata to exploit vulnerabilities," says Mangalmurti.

During a deposition in a recent medical malpractice case, a physician at a skilled nursing facility stated that he had instituted neurological checks every 15 minutes on a patient with a head injury.

Ken Zafren, MD, FAAEM, FACEP, FAWM, who reviewed the case, said, "The nursing notes documented neuro checks exactly every 15 minutes, which, in my opinion, was not believable." Zafren is EMS medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center.

In fact, the metadata showed that all the neurological checks were documented after the patient had been taken to the emergency department (ED) by ambulance.

Executive Summary

Metadata is the electronic fingerprint that is left from all interactions done with electronic medical records (EMRs). It is playing a pivotal role in some malpractice suits.

- ✦ Metadata is discoverable in a lawsuit or medical board inquiry.
- ✦ Plaintiff lawyers use specific pieces of metadata answer questions that arise during litigation.
- ✦ Some data might be saved that isn't included in the printout of the medical record.

"By the time this elderly patient who was on warfarin, Plavix, and aspirin presented to the ED, he had a nonsurvivable subdural hematoma," says Zafren.

The ED physician expert at the Level I Trauma Center tried to help the nursing home physician by saying that it would have taken too long in any case to get a CT scan after the patient arrived.

"But the metadata of the EMR showed that virtually all of the delay in obtaining the CT on a busy Saturday night in the ED had to do with the difficult intubation," says Zafren. "The nursing home physician settled, on very favorable terms for the plaintiffs."

Winnable cases must settle

During another malpractice lawsuit, metadata revealed that the physician defendant had "copied and pasted" the patient's history without adding the fact that the patient had an aortic valve replacement, which would have alerted the healthcare team that the patient was taking warfarin.

Kathy Dolan, RN, MSHA, CEN, CPHRM, a senior risk management consultant at ProAssurance Casualty in Okemos, MI, said, "The documentation stayed the same for many months. The patient died from a medication error that was contraindicated with patients on Coumadin." The physician was unable to be defended when the plaintiff exposed months of template charting that did not reveal an aortic valve replacement, Dolan adds.

"The EMR was the type that the physician had to go in and change the template, or it populated as normal values," he says. "He testified that in order to save time, he typically just hit 'enter.'"

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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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The physician filled out the history and physical document in the hospital, and he noted the aortic valve replacement. But when the patient came to the office, he left the template as "normal" under the auto-fill template rather than adding the abnormal findings.

In another malpractice claim, the EMR audit trail was used to determine when the nurse accessed the radiology report relative to a physician's verbal order for a hospitalized patient.

"The patient aspirated during the procedure, causing neurologic injury," says Dolan. "The case turned on when the physician knew the information."

The case was settled after the metadata revealed that the nurse accessed the radiology software, presumably read the radiology report and informed the physician, and entered the physician's order one minute later.

"We were unable to defend the physician since the EMR indicated he was informed of the results but failed to notify other treating physicians prior to a scheduled EDG [esophagogastroduodenoscopy]," says Dolan.

SOURCES

- Kathy Dolan, RN, MSHA, CEN, CPHRM, Senior Risk Management Consultant, ProAssurance Casualty, Okemos, MI. Phone: (608) 824-8308. Fax: (608) 828-1196. Email: kdolan@proassurance.com.
- Sandeep Mangalmurti, MD, JD, Lecturer in Law and Fellow, Section of Cardiology, University of Chicago. Phone: (773) 702-1000. Fax: (773) 702-8875. Email: Sandeep.Mangalmurti@uchospitals.edu.
- Marlene Nazarey, RN, MSN, CPHRM, Risk Control Director, Healthcare Segment, CNA, Chicago. Phone: (424) 206-9840. Email: marlene.nazarey@cna.com.
- Ken Zafren, MD, FAAEM, FACEP, FAWM, Alaska Native Medical Center, Anchorage, AK. Phone: (907) 346-2333. Fax: (907) 346-4445. E-mail: zafren@alaska.com. ✦

Unsure how EMR works? It's legally risky

What you don't know can harm defense

When saved medical record information is deleted, electronic medical records (EMRs) vary as to whether this information is stored. In the event of a malpractice suit, stored information could become very important.

"It is easier to defend an allegation of medical record alteration if every entry is stored," says **Marlene Nazarey**, RN, MSN, CPHRM, risk control director in the Healthcare Segment at CNA, a Chicago-based provider of professional liability insurance. For example, if a physician mistakenly documents a note intended for another patient's record and then deletes the note and writes the correct note, there still should be evidence in the EMR of the original note and the correction made. "When purchasing an EMR, it is important to ask the vendor whether every entry is stored, even error corrections," she says. "In this way, the integrity of the medical record can be demonstrated. No alterations can be made without a record of the entry."

Here are important things for physicians to know regarding metadata:

• The time that the documentation entry is made is recorded in the medical record.

Information might have been obtained from the patient earlier, as when a doctor sees a patient before making the entry.

"Physicians should document as soon as possible after assessing or treating a patient," Nazarey advises. "If this is not possible, such as in an emergency situation, then document the time that the assessment or intervention occurred in the progress notes."

• Specific computer actions trigger data being saved.

In most systems, each subsequent change to the note is recorded to create a time-sequenced record of changes to the chart. "Once the physician has finished documenting a note, there is usually a submit button or other similar type button to click to indicate that the note should be saved," says Nazarey.

If physicians weren't adequately trained on the EMR, they could inadvertently fail to save the note as intended. "Thorough training on the EMR is important for this reason," says Nazarey.

• Some data is saved, which is not included in a medical record printout.

"There may be data saved related to what screens were viewed by the provider and when," she says. "Such data creates a 'footprint' of who viewed what part of the medical record and when." ✦

Paper-based habits risky with EMRs – Physicians should change charting practices

Charting practices used with paper records are not acceptable with electronic medical records (EMRs), warns **Sandeep Mangalmurti**, MD, JD, lecturer in law and fellow in the University of Chicago's Section of Cardiology.

For example, some physicians fill out certain parts of the patient record before they actually occur for the sake of efficiency, such as completing an examination before it's actually performed.

"If there is a bad outcome, everyone

is going to know you filled the information out before you saw the patient," he says. "That doesn't look very good." Mangalmurti recommends these practices:

• Explain any deviation from a clinical pathway included in EMR clinical decision systems.

The problem with EMRs that go beyond electronic ordering of medications or lab tests, and actually help guide clinical decision making, "is that to some extent, the EMRs are trying to substitute for medical judgment," says Mangalmurti. "This can be helpful to clinicians, but may also increase liability risks."

Deviation from these pathways, even if justified, can create an impression that the physician deviated from the standard of care. "Take the extra step to explain why you deviated from a pathway," says Mangalmurti.

• When transitioning to EHRs, move to a truly electronic system that is as complete as possible.

Physicians face increased legal risks when using hybrid systems that are half-paper and half-electronic, according to Mangalmurti.

"Physicians may have illusions that data is being electronically backed up, or that the record is more complete than it actually is," he explains. "There may be data that's falling through the cracks electronically." ✦

Physicians face 'triple threat' with opioids, and many claims are wrongful death cases

(Editor's Note: This is a two-part series on legal risks involving pain management. This month, we report on allegations of overprescribing of opioids. Next month, we report on cases alleging undertreatment of pain.)

Malpractice claims involving prescribing of opioids are increasing, according to healthcare attorneys and state medical board directors interviewed by *Physician Risk Management*.

"Most claims center on ordering too much, or prescribing for known addicts or abusers," reports **Robert J. Conroy**, JD, MPH, an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ. "Usually, they are wrongful death cases."

Physicians who routinely prescribe large doses of opioids could face a "triple threat" if a patient is injured or has an unsatisfactory outcome: a malpractice claim, criminal prosecution, and a disciplinary proceeding by the state medical board for substandard or unprofessional practice, says **Ben A. Rich**, JD, PhD, professor and School of Medicine Alumni Association Endowed Chair of Bioethics at the University of California — Davis Health System's School of Medicine in Sacramento.

The Medical Licensing Board in Indianapolis is seeing a recent influx in the amount of cases that are brought before the board regarding the inappropriate prescribing of narcotics, reports Kristen Kelley, board director for the Indiana Professional Licensing Agency. "If the physician is found to have violated the medical practice act, the board could issue discipline ranging from revocation, suspension, probation, reprimand, censure, and/or administrative fines," she says.

There is growing evidence that the long-term use of high doses of opioids might not be beneficial, and in some instances actually might be detrimental to patients.[1,2] These studies could be used to argue that the standard of care was breached if opioids were prescribed, says Conroy, but much of the time, this allegation isn't necessary for a patient to successfully sue. "Right now there are so many 'easy' cases, that plaintiffs' counsel do not have to work that hard to develop more involved theories," he explains.

Most of the claims handled by Conroy alleged that a physician prescribed opioids to a known addict or a patient with a history of abuse, did not follow-up closely with a patient who is exhibiting drug-seeking behavior such as asking for early refills, or disregarded family concerns or warnings from pharmacists or primary physicians. In one case, a physician neglected to notice in the triage nurse's history that a 16-year old young woman had admitted to prior treatment for substance abuse two years earlier. She initially presented saying she could not get her regular physician to renew her pain medication, and later saw the physician for various problems including management of pain.

Executive Summary

Malpractice claims and wrongful death cases involving prescribing of opioids are increasing, according to attorneys interviewed by PRM. If a patient is injured or has an unsatisfactory outcome, physicians could face a "triple treat" of malpractice litigation, criminal prosecution, and a disciplinary proceeding by the state medical board. Plaintiffs' allegations include:

✦ prescribing of opioids to a known addict or a patient with a history of abuse;

✦ failing to follow-up closely with a patient who is exhibiting drug-seeking behavior;

✦ disregarding family concerns or warnings from other professionals such as pharmacists or primary physicians.

"He prescribed an opioid for the patient's pain, which started a chain of events that led to the patient ultimately taking a fatal overdose," says Conroy. "The case settled, and the physician was disciplined."

Criminal prosecution

"The front on the war on drugs is shifting from the streets to the exam room," says Conroy. "From a prosecutor's perspective, they are just moving up the supply stream."

The exponential increase over the last decade in drug overdose deaths involving prescription opioids puts physicians who overprescribe at risk not only for malpractice, but also prosecutions for violation of the Controlled Substances Act for prescribing controlled substances without a legitimate medical purpose, warns Rich.

"This often involves physicians who treat a very large number of patients reporting chronic pain, with little or no attention to the basics of patient care," he says. This includes medical history, physical exam, diagnostic procedures, assessment of the risk of addiction or diversion, and regular follow-up.

To reduce legal risks, some physicians are obtaining formal treatment agreements or "opioid contracts" from patients and using random urine drug screens. "Both of these are outside of the usual parameters of patient care," he says. Reliance on such agreements might create a false sense of patient adherence on the part of the physician, adds Rich.

"Urine drug screens are subject to misinterpretation, false positives and negatives," he says. "These may sometimes be invoked as grounds for dismissing patients from one's practice precipitously, possibly giving rise to a claim of patient abandonment."

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• **Robert J. Conroy**, JD, MPH, Kern Augustine Conroy & Schoppmann, Bridgewater, NJ. Phone: (908) 704-8585. Fax: (908) 704-8899. Email: conroy@drlaw.com.

• **Ben A. Rich**, JD, PhD, Professor and School of Medicine Alumni Association Endowed Chair of Bioethics, University of California — Davis Health System, Sacramento. Phone: (916) 734-6010. Fax: (916) 734-1531. Email: barich@ucdavis.edu. ✦

Late entries are legal game-changers, and they're devastating for defense

Did a physician make a late entry to the record and knowingly misrepresent the date and time?

"That absolutely will destroy a case, even if it is otherwise defensible," says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland. "In addition, in some states it may be a crime to knowingly falsify medical records," says Tafuri.

Tafuri says that a late entry, generally speaking, tends to make it look like the physician forgot to do something. "When presented to a layperson jury, they might wonder why you waited a day," he says. "Was it because you knew there was a problem?"

Joseph P. McMenamin, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician, says that from the defense perspective, "there is nothing worse than distorting the record. You can take a winnable claim and make it into a loser."

Tafuri has reviewed several claims in which late entries were devastating to the defense. In one case, a patient presented to an emergency department with abdominal pain, and the workup was negative. "The patient was admitted and the next morning, an abdominal aortic aneurysm was detected. The patient died at 7:30 a.m. before the patient could get to surgery," says Tafuri.

The dictation was not typed until 9:31, and included some handwritten notes added by the physician after the patient was known to have died. "Those notes that he documented were to make it look like he had checked for an aneurysm when he saw the patient the day before," says Tafuri. "This destroyed his defense and led to a settlement."

Plaintiff will find out

Altering medical records without others finding out about it is highly unlikely.

"With electronic charting, the time stamp will reveal exactly when infor-

Executive Summary

Late entries can make a case indefensible if the timing is misrepresented, and can raise questions about the physician's credibility even if properly done.

✦ Time-stamped entries or multiple copies of charts will reveal discrepancies.
✦ Late entries should be stated as such, timed and dated.
✦ If a bad outcome occurs before the chart is completed, physicians should consider obtaining legal advice.

mation was added to the chart," says Tafuri.

With paper charting, multiple copies of the patient's chart likely exist. "Doctors sometimes don't realize that lots of folks now have access to medical records, and in fact, have obligations to copy them," adds McMenamin.

The odds are good that during the discovery process, plaintiff counsel will get both versions of the record. "If they see any discrepancy, they will seek explanations for why that might exist," says McMenamin.

Doctors often are unaware of the scope and breadth of information that can be obtained in the discovery process, he adds. A plaintiff attorney could request that opposing counsel produce medical records and also subpoena them from the plaintiff's doctor.

"So now they have two sets, and 99% of the time they are indistinguishable. But once in a while, there are differences," says McMenamin. If attorneys discover that the set from the original provider is more complete or different than the one provided by the physician defendant, they usually can use that difference to their advantage, he adds.

Do it properly

"Sometimes, a mistake is made and you have to fix it," says McMenamin. "There is a proper way to do that. If you do it any other way, even innocently, there can be negative repercussions." *(See related story, below, on what to do if you learn of a bad outcome before the chart is completed.)*

McMenamin advises that if you have to alter the record or add new information, state, "This is a late entry. The information above is incorrect in that [provide reason why information is incorrect]. The correct information is [provide correct information.]"

"You don't need to embellish, elaborate, or even necessarily explain why there is a mistake," says McMenamin. "If you now have corrected the record, dated and timed it, and signed it, no one can suggest that there was anything at all improper."

If there is a critical issue that you need to document, a late entry might be worthwhile. "If a patient signed out against medical advice and the physician didn't put in a narrative about what was explained to the patient, the physician might want to edit it after the fact in a very straightforward way," says Tafuri.

Likewise, a late entry might be called for if the physician learns a critical fact that wasn't known at the time of treatment, such as a positive blood culture. In that case, the physician might make a supplemental entry to chart the result and what he or she is going to do to contact the patient.

"It all depends on the timing. If it is done relatively contemporaneously, it's less of an issue," says Tafuri. "If it's done days after the fact, it starts to look suspicious."

SOURCES

- **Joseph P. McMenamin**, MD, JD, FCLM, Richmond, VA. Phone: (804) 828-5460. Email: joe.mcmenamin@venebio.com.
- **John Tafuri**, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. Fax: (440) 835-3412. E-mail: jotafu@ccf.org. ✦

Learn of problem before chart is done?

A patient presents with a headache and is sent home on medication for migraines, with only the chief complaint documented in the chart. Later that night, the emergency physician calls asking for admit orders, because the patient is being admitted for a brain bleed that the initial treating physician missed.

The physician now knows the bad outcome, and the timing of the note will be memorialized in the chart.

In this situation, a lawsuit is likely, so physicians should consider consulting risk managers, hospital counsel, or even outside counsel, suggests **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician. "Do this by telephone, and seek verbal advice from someone experienced in the handling of claims," he says. "That gives the person an opportunity to weigh whether you can make some limited explanation for why you omitted this particular data in the note you wrote initially hours earlier."

There is no general rule for this situation, says McMenamin, "and it is a delicate call. But the basic rules don't change. You still indicate that your note is late, with a 'just the facts, ma'am' approach."

If there are facts that justify the original decision to send the patient home, McMenamin says "there is nothing remotely wrong with making sure such facts are accurately recorded, as long as you make it clear that it's a late entry."

If a chart is only partially completed and a physician learns of an adverse outcome before going back to finish and finalize the medical record, "that is a bad situation," says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland. "An attorney will impugn the motivation with respect to completing the chart after the fact."

Tafuri advising clearly documenting what was added late, making certain that it is clearly dated. Be certain that the added documentation is consistent with other contemporaneous prior documentation by nurses and other medical personnel, he adds.

"Recognize that what you add will be looked at very critically, and that improper motivation will be alleged," he says.

As for whether the chart should reflect that the physician knew of the bad outcome before completing the note, Tafuri says this is a tough judgment call.

"It is certainly not inappropriate to

do so, but it would be important to be clear and reasonable in what is added," he advises. "Do not document excessively to the known subsequent diagnosis. Otherwise, it would look too self-serving." ✦

Liability for patient's infection hard to prove — Plaintiff attorneys rarely take cases

Plaintiff attorneys are starting to look at hospital-acquired conditions as the basis for a cause of action, and some are even advertising related to hospital-acquired conditions, says **Sarah E. Swank**, JD, a principal at Ober Kaler in Washington, DC.

Plaintiff attorneys are using publicly reported information, such as the Hospital Compare website (http://www.medicare.gov/hospitalcompare/search.html) to show that a hospital knew of its hospital-acquired infection rate and to target specific hospitals, says Swank.

"Claims are typically based on the theory that when physicians follow proper protocols, they are more likely to prevent hospital-acquired conditions," she says.

Difficult to prove

Unless there is an epidemic in the hospital that goes unnoticed and is not timely addressed, resulting in multiple patients being afflicted, most lawyers would decline such a case, says **Robert D. Kreisman**, JD, a Chicago-based attorney.

"Hospital-acquired infections are not usually related to a specific deviation from the standard of care," Kreisman explains.

Difficult issues of negligent and causation make the cases very challenging for plaintiff attorneys to bring, says **Russell X. Pollock**, Esq., an attorney with Bergstresser & Pollock in Boston. "Having spoken with a number of potential clients, I understand that a hospital-acquired infection is one of the most frustrating illnesses a patient can get," says Pollock.

Because it is extremely difficult to pinpoint the treating physician responsible for the patient's infection, this situation offers protection from liability, he says. "We get called on hospital-acquired illness cases quite frequently. We rarely accept such cases, because such illnesses are arguably foreseeable," Pollock says.

Infection is a known risk of surgeries and procedures, he explains, but the firm would consider the case if a particular facility had an abnormally high rate of such illness.

Hospital-acquired infections typically don't have significant damages, notes **Timothy B. Adelman**, JD, an attorney with Adelman, Sheff & Smith in Annapolis, MD. "In reality, the case with big damages are the ones being brought, such as a brain-damaged baby, failure to diagnose an injury causing permanent damage, or surgical injuries. There has to be enough money in the case to pay for experts and lawyers," he says.

Standard of care

Successful cases usually focus on extremely widespread outbreaks of an infection or an outbreak of an unusual pathogen, Pollock says. The institution, not the physician, is typically the target, he says.

However, a successful suit against a physician is possible if the treatment of the patient's infection is below the standard of care, says Kreisman. A physician could be held liable for a hospital-acquired infection if the blood tests show an elevated, abnormal white cell count, but no medical treatment is given, for example.

The best approach is for physicians to be upfront with patients about the hospital-acquired infection and any resulting complications, advises Adelman.

"In our experience, this has helped mitigate any further action by the patient," he says. Hospitals are usually proactive in waiving charges or providing additional services at no cost, and it's important for the physicians to follow suit, even if it's unclear how the infection occurred, adds Adelman.

'If this is done on a hospital/physician/patient level, not at an attorney level, most of the time it will be amicable and less expensive," he says.

The question will become whether the physician should have noticed the infection sooner and whether they followed protocol, says Adelman. Every expert who looks at a case like this will acknowledge that infections occur, he says, but the important question is, "Did the doctor identify it early on, and take appropriate steps to treat it?"

"Or did the [physician assistant]

Executive Summary

Plaintiff attorneys are starting to look at hospital-acquired conditions as the basis for a cause of action. However, liability is difficult to prove, and damages generally aren't significant. Successful claims typically involve one or more of these scenarios:

- ✦ a widespread epidemic that goes unnoticed resulting in multiple patients being afflicted;
- ✦ an abnormally high rate of such illness;
- ✦ treatment of the patient's infection that is below the standard of care

PA round on the patient a day later and didn't see it, and the patient was discharged home and nobody caught it?" asks Adelman. "One concern is whether physicians are getting enough information from their extenders about the patient's condition."

SOURCES

• **Timothy B. Adelman**, JD, Adelman, Sheff & Smith, Annapolis, MD. Phone: (410) 224-3000. Fax: (410) 224-0098. Email: TAdelman@hospitallaw.com.

• **Robert D. Kreisman**, JD, Attorney, Chicago. Phone: (312) 346-0045. Fax: (866) 618-4198. Email: bob@robertkreisman.com.

• **Russell X. Pollock**, Esq., Bergstresser & Pollock, Boston. Phone: (617) 682-9211. Fax: (617) 451-1070. Email: Russ@bergstresser.com

• **Sarah E. Swank**, JD, Principal, Ober Kaler, Washington, DC. Phone: (202) 326-5003. Fax: (202) 336-5302. Email: seswank@ober.com. ✦

Disclose errors, but proceed with caution — Poorly done disclosure could backfire legally

Disclosing mistakes that harmed patients is a moral obligation for physicians, but it also might protect them against liability claims, according to **Peter J. Pronovost**, MD, PhD, senior vice president of JHM Patient Safety and Quality and director of the Armstrong Institute for Patient Safety and Quality in Baltimore, MD.

Pronovost says patients generally file lawsuits only when two things happen: when a bad outcome occurs, and when the patient loses trust in the clinician.

"Anytime that trust is breached and the patient perceives you are trying to hide something, the relationship is done," says Pronovost. "It's really hard to recover from that."

Physician credibility is almost always an issue in litigation, says **Richard C. Boothman**, JD, executive director of clinical safety at University of Michigan Health System in Ann Arbor. Boothman is assistant adjunct professor in the Department of Surgery at University of Michigan Medical School. "Getting caught hiding or obfuscating an error can inflame a jury and exacerbate the verdict," he adds.

There is no data on the percentage of physicians who disclose errors, says Boothman, but some physicians have done this disclosure long before it became a hot topic in healthcare. "When I was in the private practice of law, I was always aware that there were doctors who simply accepted that professionalism and ethics included being honest with their patients, even when things didn't go well," he says.

"We're going to look into it and find what happened and will share that with you. In the meantime, we are going to care for you and your family."

Boothman observed that these physicians were rarely sued. "These physicians did not look to insurance claims people for instructions about their professional obligations to their patients," he says. "They created personal bonds with their patients that survived unexpected clinical outcomes." *(See related story on how to disclose errors, p. 45.)*

Here are ways to avoid pitfalls when disclosing errors to patients:

• Never try to explain before you're reasonably sure what happened.

"Far better to pledge disclosure once the dust settles, than try to do it before you have all the facts and a balanced view of what happened," says Boothman.

Physicians sometimes speculate on why an error happened, when in fact they really don't know the cause of it.

Pronovost recommends physicians state, "We're going to look into it and find what happened and will share that with you. In the meantime, we are going to care for you and your family."

• Obtain training before you disclose.

Many physicians have had no training on disclosing errors to patients, and even if they do, they have no experience in actually doing so.

"Talking to patients about how we harmed them is incredibly threatening," says Pronovost. "There is a huge opportunity for malpractice insurers to train physicians in good disclosures." This should be done not with e-learning, but with simulated role playing that allows physicians to become more comfortable disclosing mistakes, he advises.

• Consider designating someone to disclose errors.

Executive Summary

Disclosing errors that harmed patients is potentially protective against liability claims, but poor disclosure practices can cause problems.

- ✦ Avoid speculating why an error happened.
- ✦ Participate in role-playing exercises to increase comfort with disclosure.
- ✦ Consider designating a risk manager to support physicians in disclosure.

A large group practice could assign a particular individual to support clinicians in disclosing errors, suggests Pronovost. "It might be the group risk manager," he says. "Insurers might consider providing this service." *(See related story, below, on how to disclose errors.)*

SOURCES/RESOURCES

• Richard C. Boothman, JD, Executive Director of Clinical Safety, University of Michigan Health System, Ann Arbor. Phone: (734) 764-4188. Fax: (734) 936-9406. Email: boothman@med.umich.edu.

• Peter J. Pronovost, MD, PhD, Sr. Vice President, JHM Patient Safety and Quality, Director, Armstrong Institute for Patient Safety and Quality, Baltimore, MD. Phone: (410) 502-6127. Email: ppronovo@jhmi.edu. ✦

Take these steps for 'good' disclosure

Fear of malpractice litigation is overblown

Fears about the potential harm to physicians who practice disclosure have been overblown, according to **Richard C. Boothman**, JD, executive director of clinical safety at University of Michigan Health System in Ann Arbor, where an early disclosure and offer program has been in place since 2001.

"It is also important to note that the act of disclosure has not been the focus of litigation," he says. "I've never seen a case in which a physician got sued only for what he said."

Boothman notes that patients still need to show violations of the standard of care with resultant harm to successfully sue for malpractice.

"Still, because you cannot 'un-ring the bell' once an imprudent statement is made, we advocate only intelligent disclosures," says Boothman. "Speculation, unwarranted mea culpas, and temper tantrums in the heat of the moment are not advisable."

Here, Boothman gives recommendations on how to disclose errors, based on the organization's experience:

• Who should be present?

This answer should be determined on a case-by-case basis, says Boothman. Some families and patients do not want to speak with the doctors who they believe made mistakes, while others won't settle for anything less than a face-to-face meeting.

"Some patients and families won't likely be appropriate in that setting, and we feel the need to buffer and protect our staff," Boothman adds. "Others only want to talk with 'someone in charge.'"

• What information should and should not be disclosed?

"Every event is different, but we do draw some lines," says Boothman. "We do not discuss personnel issues and discipline, for instance."

Financial considerations are kept separate from factual disclosure. "We try to adhere to 'intelligent' disclosure. We only disclose facts, not conjecture, speculation, or assumptions," he says. "If we're not sure about a material fact, we say that."

Details of quality reviews aren't routinely disclosed, says Boothman, but this information is shared occasionally depending on the circumstance.

• Should any offers be made along with the disclosure?

Boothman says that it's a bad practice to blend financial and factual discussions, regardless of how clear the facts appear or how limited the compensation might be.

"Before you can speak respectfully about compensation, you must first understand all the implications of an event," he says. "Listening is the first priority for us. So we disconnect those two. We concentrate first on getting the facts straight."

• What if insurance company does not agree with the disclosure?

This is an important point to clarify before starting a disclosure program, advises Boothman.

"Many physicians mistakenly believe that their insurance policies specifically prohibit these kinds of discussions," he says. "I've seen hundreds of policies and have never seen anything like that in an insurance contract."

Most physicians confuse this with the obligation to cooperate with the defense-of-a-claim clause. "Any caregiver considering adopting components of disclosure into their practice would be well-advised to ask their personal lawyer for an opinion first," adds Boothman. ✦

'Catastrophic' payouts for med/mal unlikely

Claims aren't rare, but large payouts are

"Catastrophic" malpractice payouts — those that total more than $1 million — make up just 7.9% of total claims, says a recent study on malpractice payouts.[1]

Researchers reviewed 77,621 nationwide medical malpractice claims reported in the National Practitioner Data Bank from 2004 to 2010. The largest payout was $31 million.

"Physicians have this perception that there are routinely $100 million and $200 million payouts for malpractice, and that's just not true. Claims are not rare, but large payouts are rare," says

Martin A. Makary, MD, MPH, one of the study's authors and an associate professor of surgery and health policy at the Johns Hopkins University School of Medicine. Makary is author of *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* (Bloomsbury Press).

Payouts of more than $1 million are more likely to occur when a patient who is killed or injured is under the age of 1; develops quadriplegia, brain damage, or the need for lifelong care as a result of the malpractice; or when the claim results from a problem related to anesthesia.[1]

A 2011 study in *The New England Journal of Medicine* showed that there is 7% chance of any claim and 1.6% chance of claim leading to payment each year.[2]

Makary expected the total amount paid for malpractice payouts during the study period ($27 billion) to be higher. "The data reveal that the amount of money paid is actually very small, compared to overall Medicare expenditures or any other benchmark of healthcare spending," he notes.

Executive Summary

Payouts of more than $1 million, known as "catastrophic claims," made up 7.9% of total claims, according to a recent study of malpractice payouts from 2004 to 2010. Payouts of more than $1 million are more likely to occur when:

- ✦ a patient who is killed or injured is under the age of 1;
- ✦ a patient develops quadriplegia, brain damage, or the need for lifelong care as a result of the malpractice;
- ✦ the claim results from a problem related to anesthesia.

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1. Bixenstine, PJ, Shore, AD, Mehtsun, WT, et al. Catastrophic medical malpractice payouts in the United States. *J Healthcare Qual* 2013; doi: 10.1111/jhq.12011.
2. Jena AB, Seabury S, Lakdawalla D, et al. Malpractice risk according to physician specialty. *NEJM* 2011; 365(7):629–636. ✦

Named in suit? Increase odds of being dismissed

First, the defense attorney will need the facts

Early dismissal of defendant physicians is always the goal for both sides in medical malpractice litigation, says **Erin L. Muellenberg**, JD, an attorney at Arent Fox in Los Angeles.

"The plaintiff's attorney does not want to waste his time or resources on a defendant physician who will have a strong defense if there are other physicians or a hospital that is a better target," Muellenberg explains.

However, plaintiff attorneys cannot dismiss defendant physicians until they have the facts to do so; to do otherwise could leave them open to claims of legal malpractice, she says.

Often, dismissals will not occur until late in the process after all expert depositions have been taken. "When the expert depositions point to no or minimal liability of a defendant physician, then the physician will generally be dismissed and the case will proceed against the physicians or hospital with more liability exposure," Muellenberg says.

Plaintiff attorneys might keep a physician in a case in order to increase pressure on other defendants to settle, or because other defendants have insufficient professional liability coverage, she adds. If named in a suit, physicians should consider these actions, which could increase the likelihood of dismissal:

• Don't withhold information from your attorney.

"Litigation is about information control," Muellenberg says. "An attorney will use the information selectively to work with opposing counsel for an early dismissal."

For example, a client surgeon could share the fact that he was not in the room at the time of an incident, which isn't apparent from the records, or the fact that another physician gave the order for the wrong medication. "Or maybe there is evidence that a death was not caused by a particular treatment," says Muellenberg. "Knowing these facts early will let the attorney negotiate an early dismissal."

The worst thing the defendant can do is not tell the attorney an important negative fact because the physician is hopeful that it will not come out in the case, according to **John Davenport**, MD, JD, physician risk manager of a California-based HMO.

In one malpractice case, it was revealed that a doctor actually scrubbed

Executive Summary

The plaintiff and defense have a goal of early dismissal of defendant physicians, but this action often doesn't occur until late in the process. To increase the likelihood of dismissal:

- ✦ don't withhold negative information from your attorney;
- ✦ consult with your attorney about offering expert opinions early;
- ✦ cooperate with defense counsel.

out of a surgical case to place a series of bets through his cell phone. "He admitted that he had scrubbed out for a period of time, but told his attorney that it was to attend to a biological urgency," says Davenport.

The plaintiff attorney obtained the physician's cell phone records and was able to document the time and the target of the calls, which resulted in a large settlement. "Only if the attorney knows everything about the case, the good and the bad, can he prepare an effective defense or a reasonable settlement," says Davenport. *(See related story, below, on the need to cooperate with counsel.)*

• State only the facts regarding the cause of an incident.

"Defendants should not voice opinions. That is the job of experts," says Muellenberg. "Their role is to be the percipient witness and talk only about their personal involvement," she says.

• Consult with your attorney about offering expert opinions early to achieve a dismissal.

If an anesthesiologist gives the wrong medication and the patient dies, and the autopsy reveals that the cause of death was a ruptured cerebral aneurysm, an expert's opinion could potentially dismiss the anesthesiologist from the case.

"If the expert opines that the medication had no neurological effect and could not have caused the aneurysm to burst, the plaintiff's attorney would confirm with their own expert and then dismiss the case," says Muellenberg. ✦

Uncooperative MD? You might be kept in case

During recent malpractice case, a supervising physician named in the lawsuit refused to cooperate in providing dates he was available to be deposed and failed to send required discovery responses.

"Although he was not directly involved in the negligent act, he was kept in the case and forced to go through discovery, because he was difficult to deal with. The family had directed the plaintiff's attorney to 'make him suffer,'" says **Erin L. Muellenberg**, JD, an attorney at Arent Fox in Los Angeles.

If physicians are dismissive of the legal process, they might be kept in the case even if they have minimal liability. "Cooperation is essential to dismissal," says Muellenberg.

Lawsuits are public and how you handle any phase might wind up in a public document that is accessible to anyone or any organization, she warns.

Attorneys sometimes keep a physician in a case simply because he or she has dodged service or been rude and abrasive over the phone, says Muellenberg.

"Sometimes physicians think that they can call and talk their way out of the lawsuit," she says. "This is an ill-advised approach. The information that a plaintiff's attorney gains in any such contact will be used against the physician." ✦

COMING IN FUTURE MONTHS

✦ Learn legal risks involving negligent referrals

✦ What to do immediately if lawsuit is likely

✦ Actions to achieve early dismissal from claim

✦ Avoid allegations involving lack of follow-up care

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 is recommended for physicians to reduce legal risks regarding electronic medical record (EMR) charting, according to Sandeep Mangalmurti, MD, JD, lecturer in law and fellow in the University of Chicago's Section of Cardiology?**
   A. Routinely complete certain parts of the patient record before these actually occur for the sake of efficiency.
   B. Explain any deviation from a clinical pathway included in an EMR clinical decision system.
   C. Avoid any explanation in the chart as to why care provided deviated from a clinical pathway.
   D. When transitioning to EMRs, always use hybrid systems for a significant period of time.

2. **In which scenario is a late entry to the patient's medical record advisable, according to John Tafuri, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic?**
   A. If there is a critical issue that the physician needs to document.
   B. If the patient signed out against medical advice and the medical record didn't include a narrative about what was explained to the patient.
   C. If the physician learns a critical fact that wasn't known at the time of treatment, such as a positive blood culture.
   D. Any of the above.

3. **Which is true regarding malpractice suits involving hospital-acquired conditions, according to Russell X. Pollock, Esq., an attorney with Bergstresser & Pollock?**
   A. Liability is generally easy for the plaintiff to prove.
   B. Damages in these cases generally are significant.
   C. Physicians cannot be held liable even if treatment of the patient's infection is below the standard of care.
   D. It is difficult for the plaintiff to pinpoint the treating physician responsible for the patient's infection.

4. **Which is recommended regarding disclosure, according to Richard C. Boothman, JD, executive director of clinical safety at University of Michigan Health System?**
   A. Disclosure should occur immediately, even if the physician is unsure what happened.
   B. It is acceptable for physicians to speculate on why an error happened.
   C. Personnel issues and quality reviews always should be disclosed.
   D. Financial considerations should be separated from factual disclosure.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Patient suffers stroke during elective hair transplant, has $2.7 million verdict reduced due to culpable conduct

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

Steve Auletta, Esq.
Associate
Kaufman Borgeest & Ryan
Valhalla, NY

Bruce Cohn, JD, MPH
Vice President
Risk Management and Legal Affairs
Winthrop-University Hospital
Mineola, NY

News: In February 2010, a 70-year-old male patient underwent an elective hair transplant procedure performed by a general surgeon. The patient claimed that he suffered a stroke during the procedure that caused him to sustain permanent brain damage, severe speech impairment, and other injuries. The patient and his wife sued the surgeon and his practice for negligence, and a jury awarded a total of $2.7 million. However, the award was reduced to $1.2 million due to the jury's finding that the patient and his wife were 55% responsible for the damages due to their comparative negligence.

Background: In February 2010, a 70-year-old male patient presented to a general surgeon at his hair restoration office to undergo an elective hair transplant procedure. The patient's wife was present for the procedure. Before the procedure, the patient reportedly told the surgeon that he was a diabetic and had hypertension. However, the plaintiffs claimed that the surgeon failed to perform a sufficient evaluation before the procedure. Additionally, the patient claimed that the surgeon failed to advise him of the risk of death or serious complications given his age and risk factors. The plaintiffs claimed that during the 10-hour procedure, the patient suffered a stroke, which the defendants failed to detect. The patient also reportedly became hypertensive and convulsed.

... the patient claimed that the surgeon failed to advise him of the risk of death or serious complications given his age and risk factors.

The defendants also allegedly failed to timely administer thrombolytic medication to break up clots, which could have prevented much of the patient's brain damage. The plaintiffs also contended that the defendants negligently discharged the patient after the procedure, even though he was unable to speak or walk without assistance at that time.

Testimony at trial indicated that the plaintiffs spoke to someone at the defendants' office after the procedure, who stated that the patient's continuing symptoms were due to the pain medication that was administered during the procedure and that there was no cause for concern. To support their claims, the plaintiffs called experts in neurology and anesthesiology.

The defendants argued that all of the treatment was provided within the proper standard of care. Additionally, they claimed that the stroke actually occurred several days after the procedure, and that the patient and his wife were negligent for failing to go to seek medical attention sooner and for failing to seek treatment for the patient's chronic medical conditions. The defendants called experts in hair transplantation surgery, neurology, and anesthesiology.

As a result of the alleged malprac-

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Steve Auletta**, **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.

tice, the patient allegedly sustained permanent brain damage, severe speech impairment (including Boca's aphasia and speech apraxia), and right-sided partial hemiplegia. He is allegedly unable to walk without dragging his right leg. Before the surgery, the patient worked as a jeweler in a business he owned with his wife, and he also managed a real estate portfolio they owned. After the procedure, the patient was allegedly unable to return to work or manage the properties he owned with his wife. He also allegedly requires round-the-clock care, is unable to feed himself, and has difficulty with personal hygiene activities.

The jury found for the plaintiffs and awarded a total of $2.7 million in damages. This amount included: $200,000 for past medical expenses; $500,000 for future medical expenses; $120,000 for past lost wages; $400,000 for future lost wages, $900,000 for pain and suffering, and $600,000 for loss of services. The jury assigned 45% liability to the surgeon and his practice, but found contributory negligence on the part of the patient (45%) and his wife (10%).

What this means to you: A 70-year-old man goes in for an elective procedure and comes out seriously impaired from a cerebrovascular accident (CVA). This is the kind of "horror movie" that makes lay jurors become punitive. Six or nine or 12 people with no medical (or legal) experience can sooner forgive a physician and hospital when a patient is really sick and needs surgery that does not go well. Elective surgery that is supposed to be "no big deal" and goes wrong is difficult for them to reconcile.

This older man presented for a hair transplant. According to the testimony of the wife who was present, the patient reported a history of diabetes mellitus and hypertension. This point raises the first question: What kind of evaluation was done prior to clearing the patient? Hair transplant is a surgical procedure. While we don't have access to the medical records, it does not appear from the trial report that the patient's primary care physician cleared the patient prior to the surgery. It would be expected that if there was a separate clearance, that testimony would have been used certainly by the defense to mitigate the allegations.

This point is a major consideration in evaluating the liability. The patient's age and history would have moved him to a higher risk anesthesia class, and it seems more dangerous to operate on this type of patient without a comprehensive evaluation by an internist or cardiologist.

The wife also testified that no discussion was had regarding the risks, benefits, and alternatives to the procedure. We always take this testimony with a bit of skepticism, having seen dozens of plaintiffs testify over the years that the doctor told them essentially "nothing" about the procedure and just "sign here" The proof, such as it is, in these types of situations is the record, and this is another caution.

We remind physicians all the time that the consent is not the piece of paper that the patient signs; the consent is the conversation with the patient. The consent for any invasive procedure should be obtained by the person doing the procedure or at least, someone who is credentialed to perform the procedure. Otherwise, how can questions be appropriately answered? In addition, the details of the conversation must be clearly set out by the practitioner in the record. The entry should not simply say that the risks, benefits, and alternatives have been discussed. Instead, it should say what information was discussed. What specific risks, what benefits, and what questions did the patient and/or family raise?

In the event that something goes wrong, the record must show convincing evidence of the discussion. Did this patient and his wife understand that any surgical procedure, given the patients' age and history, have the risk of death or serious injury?

The operation is said to have taken an inordinate amount of time, and it appears that the procedure was performed not in a hospital but in some type of office-based surgery or in an ambulatory center affiliated with the hair restoration practitioner. Was this office/center the proper place for this type of patient? Many physicians who are comfortable with office-based procedures or working in an ASC on low risk patients will insist on performing the procedure in a hospital if the patient has comorbidities.

The case also has an apparent large component of failure to adequately monitor the patient, or what the medical-legal bar calls "failure to rescue." Should the surgeon or the person doing the intraoperative monitoring (and who was this person?) have noted the patients' symptoms and intervened, which might have required terminating the procedure and transferring the patient to a hospital? We have seen a hesitation among proceduralists of stopping a case, wanting to finish, as long as the patient is there and anesthetized. In an emergency procedure, this might make sense, but less so for a hair transplant procedure.

Finally, the patient appeared to be discharged even with complaints of being unable to walk or speak properly. This is a huge mistake. Intraoperative complications occur especially when the patient has a complex medical history. The occurrence of such a complication might be defensible, but discharging a patient who has not reached his or her pre-procedure status without further work-up will likely not be defensible.

The problem apparently was compounded when the wife called the

center to say that the husband was continuing to have symptoms. These symptoms were ascribed to effects of pain medication, which again was a dangerous assumption.

Patients who undergo procedures who then call with complaints should be taken seriously. Any significant complaints that are not expected should warrant a suggestion to return immediately or to proceed to the nearest emergency department. It is better to create an extra unnecessary trip back for some reassurance than to risk missing a significant complication that could be treated.

In this case, the patient suffered a stroke, and early treatment was essential to lessen the severity of the injury. If the patient had been treated, made a full recovery with little or no sequela, the value of the legal case could have been significantly diminished even in the face of proven malpractice.

Also of interest in this case is that the jury found a greater percentage of negligence leading to the damage on the part of the patient and his wife than on the surgeon. However, the money damages still are significant, and this decision does not absolve the surgeon of liability.

Reference:

Los Angeles Superior Court, Claim No. BC445812. ✦

Mistake in cancer diagnosis leads to seven months of unnecessary chemotherapy, subsequent hospice care

News: In May 2009, the month after she underwent a left breast mastectomy for removal of a cancerous tumor, a patient visited an oncologist, who diagnosed her with Stage IV metastatic cancer of the left breast. Based upon this diagnosis, the patient underwent several courses of chemotherapy and received home hospice care. In April 2011, a further CT revealed that the diagnosis was incorrect, and further work-up indicated the patient had been cancer-free since before May 2009. The patient sued the oncologist for negligence, and a jury awarded her $367,500 for physical pain and mental anguish.

Background: In April 2009, a 50-year-old female patient underwent a left breast mastectomy for removal of a cancerous tumor. The following month, she presented to the oncologist, who diagnosed her with metastatic left breast cancer. She was told that the cancer was Stage IV and terminal. The diagnosis was based on a CT of the chest, which the oncologist indicated showed enlarged mediastinal lymph nodes. The oncologist ordered a PET scan and a bone scan, the results of which were inconclusive. Based upon the oncologist's diagnosis, the patient began chemotherapy in June 2009. The oncologist did not recommend that she seek a second opinion before beginning treatment. She continued to treat with the oncologist and ultimately underwent eight rounds of chemotherapy over seven months.

... as a result of the oncologist's negligence, she underwent eight rounds of chemotherapy and received over a year of home hospice care.

In February 2010, the oncologist referred the patient for a second CT of the chest. The study was interpreted by a radiologist, who noted the patient had "mediastinal lymphadenopathy without change." The radiologist also encouraged correlation by examining tissue from the enlarged lymph nodes. Following the second CT, the oncologist did not order a biopsy or any further diagnostic tests. The oncologist's diagnosis remained unchanged, and he ordered hospice care.

The patient received hospice care from March 2010 until April 2011, when she presented to another doctor to treat her anxiety. This doctor indicated that she might not have cancer, and referred her to a hospital for further testing. She underwent a further chest CT, which was compared to a prior study from February 2008, prior to her original cancer diagnosis. Based upon this comparison, it was determined that what appeared to be enlarged lymph nodes on the newer image was actually sarcoidosis, and not evidence of cancer. Subsequent testing at a hospital specializing in cancer treatment indicated that the patient had been free of cancer since the mastectomy was performed in April 2009.

The patient sued the oncologist for negligence in failing to properly interpret the results of the May 2009 CT. She claimed that as a result of the oncologist's negligence, she underwent eight rounds of chemotherapy and received over a year of home hospice care. As a result of chemotherapy, she complained that her body deteriorated and she lost her hair, eyebrows, and eyelashes. She

claimed that her diagnosis and treatment caused her to lose her job and her health insurance, and to suffer significant anxiety and depression, which were treated with medication. She also claimed that she gave away some of her belongings.

Several months before the case went to trial, the oncologist died. He had previously given a videotaped deposition, which was used during the trial. During the two-day trial, the patient's attorney argued that while chemotherapy is commonly prescribed after a mastectomy to ensure that cancer will not reoccur, the oncologist should have presented the choice of opting out to the patient. The attorney for the oncologist noted that it was "very difficult" to defend his client after he died, but argued that he had relied on radiologists to help him interpret the diagnostic scans. The jury returned a verdict for the patient and awarded her $367,500 for pain and suffering. Pursuant to the law of the jurisdiction where the case was tried, the award will be reduced to $250,000.

What this means to you: The oncologist in this case essentially diagnosed the patient with a more advanced form of disease than she was found to have, resulting in unnecessary and harmful treatments along with tremendous emotional damages.

A 50-year-old woman undergoes surgery to treat breast cancer. One month later, her oncologist reviews a CT of the chest, which reports enlarged mediastinal nodes. Additional testing via bone scan and PET scan are listed by the radiologist as "inconclusive."

On the basis of this testing, the oncologist diagnoses the patient with stage IV metastatic cancer. This diagnosis leads to eight rounds of chemotherapy followed by a referral to hospice. Eventually, almost as a fluke, when the patient consults another physician for anxiety, further testing is done, and it is revealed that the patient was cancer-free after the mastectomy.

There appear to be several failure points in the care and treatment of this patient. The first the lack of a second opinion. It is not clear whether the oncologist simply did not suggest a second opinion or affirmatively dissuaded the patient from seeking another opinion. Either way, with what was a devastating and fatal diagnosis, it would have benefited the patient from confirming the oncologist's opinion.

Secondly and potentially of greater importance, the essence of the diagnosis was in the radiological testing, including the bone scan and PET. An "inconclusive" finding should have resulted in another radiological opinion on the films and possibly a repeat of the testing. The stakes were too high to simply call it without confirmation. The oncologist left himself open to criticism in not going all the way to confirm the diagnosis.

There is also a second CT scan, the report of which has the radiologist calling for correlation by biopsy of the mediastinal tissue. The suggestion was also not followed up by the oncologist, which is a major risk management issue. The oncologist might have thought that the radiologist simply was hedging, but once the suggestion is out there, the oncologist has to be right. This is a classic situation faced by physicians in which a consultant makes a suggestion for further testing that the referring physician feels is not necessary. Once the suggestion is out there, the failure to follow the suggestion and then being wrong creates a high degree of liability in front of a jury for the oncologist.

This particular patient also spent a large amount of time in a hospice program because she believed that she was dying. She gave away possessions and, according to the report, lost her hair, health, job, and insurance due to the chemotherapy and diagnosis. Although the defendant oncologist passed away prior to trial, an argument might have been made by counsel that the patient required the chemotherapy treatment regardless to ensure the cancer did not return. In point of fact, this therapy ultimately might have contributed to the positive outcome. Regardless, the patient spent a long time believing that she had a fatal disease when she did not, which is clearly compensable in the court system.

What mitigates the damages in this case is that juries sometimes look at these fact patterns differently than other cases. In essence, the jury feels that in the end, the patient should be happy to not have the disease as opposed to other cases in which the patient was told they were healthy and actually were suffering from a serious condition. Usually those cases involve patients who wrongly believe that they are sick for a week or a month as opposed to the extended time this patient had that belief.

The defendant's insurance company also was helped by the jurisdiction. In the courts of this particular state, pain and suffering claims are limited to $250,000 by a statutory cap. This amount is not the same as in other places where seven figure damages for pain and suffering are common. It is also somewhat surprising that the whole case revolved around emotional and physical damages. It would be common for plaintiffs in these cases to sue for the money damages of lost income, expenses, etc. The amount of these damages is unusual; in many places, the amount of money would be significantly more.

The bottom line: Be sure or as sure as one can be in the practice of modern medicine. There is a natural tendency, particularly by experienced physicians, to rely on their diagnostic acumen and experience. This case also demonstrates that one can be liable not only for failing to diagnose, but also for over-diagnosing.

Reference:

24th Judicial District Court, Victoria County, TX. Case No. 12-2-72769-A. ✦