PHYSICIAN Risk Management

December 2013 | Vol. 2, No. 6 Pages 61-72

Patient refused care due to cost? Protect yourself from lawsuits

Legal risks stem from incomplete care

A patient might have insurance, but he or she might not be able to afford the high deductible of $5,000, $10,000, or even $20,000. If that patient refuses recommended treatment or leaves a hospital against medical advice (AMA), there could be significant legal risks for physicians.

"Patient non-compliance can be a critical factor in adverse outcomes that lead to malpractice suits," says **James W. Saxton**, Esq., an attorney at Stevens & Lee in Lancaster, PA.

> *"Patient non-compliance can be a critical factor in adverse outcomes that lead to malpractice suits."*

Patients are shouldering more of the cost of insurance, including higher copays through employer-sponsored plans and high-deductible plans purchased on state Health Insurance Exchanges set up under the Affordable Care Act. "Financial considerations play a larger role in determining how patients make healthcare choices," Saxton says.

At the same time, healthcare reform's emphasis on screening and testing is resulting in more follow-up appointments and referrals to specialists.

"As lawyers defending physicians, we recognize that patients need to take an active role in their care," Saxton says. "At the same time, we recognize that the expectation is – still

Next month's issue of *PRM*: claims for failure to diagnose

The January 2014 issue of *Physician Risk Management* will be a special issue on medical malpractice claims alleging failure to diagnose. We'll cover common allegations in lawsuits involving failure to diagnose heart attack, cancer, and sepsis. We'll also report on common claims against primary care physicians, pediatricians, surgeons, and obstetrician/gynecologists.

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— that physicians will make sure that patients take that next step."

Long-term adverse effects

The odds of death within 90 days were two and a half times higher for people who left the hospital AMA, according to a recent study that looked at 1.9 million adult admissions and discharges over almost 20 years.[1]

The most interesting finding is the persistence of the effect of leaving a hospital AMA on hospital readmission and death, according to **Allan Garland**, MD, MA, the study's lead author and associate professor of medicine and community health sciences. "While these rates rose almost immediately after leaving AMA, they remained persistently elevated out to at least six months," says Garland. "The implication of this finding is that at least some of the adverse effects of leaving AMA are not due to incompletely treated acute illness."

The researchers hypothesize that nonadherence to medical recommendations could play a role. **Edward Monico**, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT, says, "A plaintiff's attorney could argue that a patient made an ill-informed decision to leave AMA because the healthcare provider failed to inform the patient of material information regarding that decision."

To protect themselves, physicians should include sufficient information to allow patients to make an informed decision regarding their decision to continue medical care, says Monico. (*See related story, p. 63, on how to document that patients were fully informed.)*

Monico says physicians should make certain that information contained in the medical record is consistent with information in the discharge documentation. "Plaintiff attorneys can build an argument that the provider withheld information that was charted in the medical record but not divulged to the patient, and that this information was material to an informed decision to stay and be treated or leave," he explains.

New areas of exposure

With the expansion of the healthcare team to include care coordinators, specialty hospitals, and advanced practiced providers, patients are being handed off to a wider scope of healthcare professionals.

Saxon says, "We are seeing the development of new areas of exposure, linked to communication gaps, 'splintered' care, and discontinuities in treatment." Increased volume of patients and more testing and screening is also

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With higher out-of-pocket expenses and frequent referral for high-cost specialty care, patients are more likely to refuse necessary care or to leave a hospital against medical advice. These decisions might increase the risk for a bad outcome and also might increase legal risks for physicians.

- ✦ Involve patients in their care with web portals and care coordinators.
- ✦ Document enough information to show that patients were fully informed.
- ✦ Be sure the chart is consistent with the discharge documentation.

Physician Risk Management (ISSN 2166-9015) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry NE, Ste. 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Physician Risk Management· P.O. Box 550669, Atlanta, GA 30355.

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Subscription rates: U.S.A., one year (12 issues), $389. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $55 each. (GST registration number R128870672.)

contributing to more litigation, he adds.

Saxton is seeing more claims alleging failure to advise patients of significant test results requiring follow-up, inadequate documentation of the follow-up plan and discussion with the patient, and missed or delayed diagnosis because the patient didn't see a specialist or get a follow-up test. One claim involved a patient who underwent a chest CT, but did not undergo a repeat CT in three months as recommended by the radiologist. The patient was seen 11 times over the next several months for complaints of a persistent cough. A chest X-ray and biopsy were done five months later, which resulted in a diagnosis of metastatic lung cancer.

"The patient claims that she was not advised of the results of the initial chest CT, or the need to follow up in three months," says Saxton. He says these practices possibly can reduce legal risks for physicians if patients refuse care:

• Engage patients as "partners" in their care by using patient portals to provide access to test results and facilitate scheduling.

• Document care discussions with patients about the recommended next steps and follow-up instructions.

Specialty-specific informed consent and refusal forms, at-risk letters, and disease-specific care contracts can demonstrate that patients have received information and have taken some responsibility for their treatment decisions and their care.

"These can be very helpful evidence, in the event that care ends up as the subject of litigation," says Saxton.

• Use care coordinators or patient navigators to encourage patient compliance.

"Improving compliance can improve outcomes and prevent adverse occurrences," says Saxton.

Care coordinators or patient navigators can encourage patient engagement by facilitating adherence to care and medication instructions and coordinating follow-up appointments and testing.

"Documentation of these interventions can show that information and access was provided, and the nature and extent of a patient's compliance and cooperation with the treatment plan," says Saxton.

Reference

1. Garland A, Ramsey CD, Fransoo R, et al. Rates of readmission and death associated with leaving hospital against medical advice: a population-based study. *Canadian Med Assn J* 2013; 185(14):1207-1214. ✦

Prove AMA patient was fully informed

Plaintiffs in malpractice suits typically refute signed forms stating that they knew the risk of leaving against medical advice (AMA) by claiming they were not informed of the significance of leaving before the evaluation or treatment was completed.

"The issue is not whether the patient's attestation exists on a form, but what the attestation signifies," says **Edward Monico**, MD, JD, assistant professor in the Section of Emergency Medicine at Yale University School of Medicine in New Haven, CT.

In a study performed at Yale University, only 4.8% of providers documented that patients leaving AMA were informed of the risks of terminating their emergency evaluation, and only 5.7% documented alternatives to treatment. About 50% documented they actually informed patients they were leaving AMA.[1]

Monico says these points should be documented for patients leaving AMA:

• that patient has the competence and capacity to make healthcare decisions;

• that the patient was informed of the extent and limitation of the evaluation that occurred;

• that the patient has an understanding of presenting signs and symptoms and the healthcare provider's concern about that presentation;

• that the patient was informed of the foreseeable risks of terminating the medical evaluation or treatment prematurely;

• alternatives to suggested treatment, if any exist;

• an explicit statement that the patient was informed that he or she is leaving AMA.

• that the patient was provided an opportunity to ask any and all questions.

"Explain the specific concern the provider has, like chest pain signifying angina, and the risk posed to the patient by leaving AMA, such as occlusion of a coronary vessel and arrhythmia or sudden death," says Monico.

Reference

1. Monico EP, Schwartz I. Leaving against medical advice: facing the issue in the emergency department. *J HealthCare Risk Management* 2009; 29(2): 6-15. ✦

Claims allege failure to follow guidelines

If physicians fail to follow guidelines, plaintiff attorneys can use this to support their argument that the standard of care was breached.

"Physician who had good documentation explaining the reasons for not following the guidelines have a better chance of defending the care than physicians who do not have

this documentation," says **Anna M. Grizzle**, JD, an attorney at Bass, Berry & Sims in Nashville, TN.

Medical providers often have good reasons for not following guidelines, such as the patient's condition being a contraindication for doing so. However, these reasons often aren't documented, says Grizzle.

"Clear documentation of the provider's thought processes keeps the provider from being second-guessed after the fact," she says.

More physician groups, hospitals, and accountable care organizations (ACOs) will be adopting standardized approaches to delivering care, in which deviation from the accepted standard would be expected to be documented as to why, says **Alice G. Gosfield**, JD, a Philadelphia-based healthcare attorney.

"If physicians are aware of the guideline, they should document why they are deviating from it in this instance," says Gosfield. For example, a physician might chart, "Discussed doing an ultrasound, but the patient does not want it at this time," or "Have prescribed a different drug because the patient has a known intolerance to the recommended drug."

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Plaintiff attorneys often use guidelines to establish the legal standard of care. If physicians don't follow guidelines, their documentation should clearly explain the reason for not doing so.

✦ Good documentation of why the guidelines weren't appropriate can make claims more defensible.
✦ Physicians should tell the patient or family why the guidelines do not apply in this particular instance.
✦ Physicians should be aware that The Joint Commission standards have been cited by plaintiff attorneys to identify an alleged breach of the standard of care.

Explain reasoning

At times, for whatever reason, guidelines are not applicable to every patient situation, says **Franchesca J. Charney**, RN, director of educational programs at the Pennsylvania Patient Safety Authority in Harrisburg.

"In these circumstances, there has to be documentation of awareness of the guideline and why the guideline is not being followed for this patient," says Charney.

The documentation also will serve as a reference for other care providers on what factors made this an acceptable decision for this patient at this time, she says. Charney says good documentation includes: the guideline recommendation, the reason why it is not being followed, and the patient or family's understanding of why the guidelines do not apply in this particular setting.

At times, patients confided to Charney that they filed a claim simply because they wanted to know what happened. "If we, as care providers, communicate to patients and families more effectively, would we see less claims?" she asks. "I believe we would." *(See related stories on Joint Commission standards and malpractice suits, below; and whether Joint Commission survey results are discoverable, p. 66.)* ✦

Joint Commission standards cited by lawyer? Rebut allegations

It is not uncommon for plaintiffs in malpractice cases to cite The Joint Commission (TJC) standards as a source of evidence of the standard of care. However, merely citing the standards is generally not sufficient to establish the standard of care, says **Victoria L. Vance**, JD, an attorney at Tucker Ellis in Cleveland, OH.

"Moreover, The Joint Commission standards are not considered irrefutable evidence," says Vance. "The healthcare provider defendant has several defense strategies to rebut the applicability of The Joint Commission standards."

TJC standards for patient restraints, precautions for equipment and room accommodations in behavioral health units, credentialing standards for members of the medical staff, the proper disposition of pathology specimens, and standards for record retention have been cited in a wide variety of medical malpractice or negligent credentialing cases. "In those cases, some courts have recognized that The Joint Commission standards may be one source of evidence of the standard of care," says Vance. *(See related story, p. 66, on whether The Joint Commission survey results are discoverable.)*

Here are some recent cases which have cited TJC standards:

• In a 2013 case, the plaintiff alleged that an elderly patient was not properly supervised, fell while unattended, and sustained a head injury that ultimately led to her death.[1] The plaintiff's nursing expert submitted an affidavit in which she cited the 2009 TJC hospital national patient safety goals (NPSGs) and elements of performance (EPs) to support her opinion that the defendant hospital violated the applicable standard of care by not using a monitoring device such as a bed alarm.

"The trial court agreed that the expert's affidavit raised a legitimate question of fact as to whether the standard of care requires use of a bed alarm, and thus denied the hospital's motion

for summary judgment," says Vance.

• In a 2012 case, the plaintiff sued for alleged failure of the defendants to treat, protect and care for the patient prior to his suicide.[2] The patient was found hanged from a piece of PVC piping, which was serving as a shower rod in his hospital room. Plaintiffs alleged that the piping was out of compliance with TJC standards and that the defendants' conduct was reckless, which is a higher standard that was required to be established in a case against the state to overcome a statutory immunity for state actors.

"In this case, the court held that the violation of The Joint Commission standard was not sufficiently 'reckless' to support the plaintiff's claim," says Vance.

• In a 2011 case, the patient's mother brought a medical malpractice action against a hospital and several defendants for massive injuries and death sustained by the patient following a bilateral lumbar laminectomy and discectomy on the patient.[3] During the surgery, the orthopedic surgeon transected the patient's internal iliac artery, failed to recognize that he had done so, and thus failed to repair the artery prior to closing. The patient suffered massive internal hemorrhaging that led to cardiac arrest and death.

"The lawsuit alleged that the hospital had a duty to follow Joint Commission standards for credentialing physicians," says Vance.

The plaintiff's expert opined that if the hospital had denied or revoked the surgeon's surgical credentials, in all reasonable medical probability, a more competent surgeon would have operated on the patient, her artery would not have been severed, and she would not have died.

"The hospital challenged the sufficiency of the expert reports and filed a motion to dismiss the case," says Vance. "The trial court ruled that the plaintiff's experts' reports were sufficient to establish that the plaintiffs' claims had merit. It denied the hospital's motion, and allowed the case to proceed."

One court referred to TJC documents as "national standards."[1] Another court stated that the standard of care of a healthcare facility "is generally defined by [The Joint Commission] standards and the hospital's bylaws."[4] "But the standards, alone, are not sufficient or indisputable evidence of the standard of care," says Vance.

She encourages defense attorneys to aggressively challenge and rebut the application of TJC standards in their cases, especially when plaintiffs seek to apply hospital-based standards to a physician defendant. Below are some arguments that can be used to dispute TJC standards in a medical malpractice case:

"The Joint Commission standards are not considered irrefutable evidence ..."

• The standards are merely expressions of a private body and not necessarily binding on the defendant.

"The standards themselves are the expressions of a third-party organization," says Vance. "Thus, they constitute a form of hearsay evidence, which is generally not admissible in a court of law."

• The standards are often too general and subject to interpretation.

"The standards do not speak for themselves," says Vance. "The plaintiff must also offer a witness to explain and apply the standards to the facts of the case."

Defense counsel then has an opportunity to cross examine that expert on his lack of knowledge and familiarity with TJC standards and survey practices. "Some courts have excluded references to The Joint Commission standards if the plaintiff could not effectively relate the standards to the facts of the case," says Vance.[5]

• The standards arguably apply only to hospitals.

Many TJC standards, by their terms, apply only to hospitals. TJC has a voluntary program for accreditation of office-based surgical practices that meet specified criteria.

"But if the practice is ineligible for, or elects not to participate in the accreditation program, those would be additional arguments against the use of, or admissibility of those standards in an office-based medical malpractice case," says Vance.

However, some plaintiffs seek to extend the reach of the hospital-based standards to physician practitioners. "One trial court excluded any evidence of The Joint Commission standards, recognizing that the hospital standards are irrelevant to establishing the standard of care for a physician in an office-based practice," says Vance.[6]

The cited malpractice case involved a plastic surgeon who removed moles from the decedent's back and chest and who discarded the tissue rather than submitting the specimens to a pathologist for histological or pathological examination. Two years later, the mole on the patient's chest recurred, and by the time the patient sought medical attention, the growth was determined to be malignant melanoma, which had metastasized. The patient expired one month later.

The surgeon moved to exclude any reference to TJC standards that stated, at that time, that when tissue is removed from an individual in a hospital setting, the tissue must be sent to pathology for examination.

"The trial court agreed with the surgeon that The Joint Commission standard was irrelevant to determining the appropriate standard of care for a physician performing procedures in his office," says Vance. "This ruling was upheld on appeal."

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2. Davenport v State of Connecticut, 2012 WL 4040348 (Conn. Super. Aug. 21, 2012),
3. Renaissance Healthcare Systems, Inc v Swan, 343 SW3d 571 (Court of Appeals, Texas, June 30, 2011
4. Riply v Lanzer, 152 Wash. App. 296 (2009).
5. Wansley ex. rel. Wansley v. ABC Ins. Co., Inc., 81 So.3d 725 (La.App.4, 2011).
6. Klein v Dietz, 1998 WL 896345 (Ohio App. 7 Dist. 1998). ✦

Joint Commission survey results might not be discoverable

Plaintiff attorneys often seek to discover the results of an accreditation or investigation survey of a healthcare facility, but this action isn't always successful.

"One plaintiff went so far as to issue a subpoena to The Joint Commission, to compel the organization itself to come to court and produce the survey report of a defendant hospital," says **Victoria L. Vance**, JD, an attorney at Tucker Ellis in Cleveland, OH.

In that case, the trial court cited The Joint Commission president for contempt when he refused to turn over the survey results. "But that decision was reversed on appeal, with the appellate court declaring the survey results non-discoverable," says Vance.[1]

In several medical malpractice cases, the defense was able to successfully prevent the plaintiffs from gaining discovery of The Joint Commission's survey report for a hospital. They did so, says Vance, "on the grounds that The Joint Commission survey and findings was the equivalent of a peer review report, intended to be kept strictly confidential."[2,3]

References

1. Niven v. Siqueira, 109 Ill 2d 357 (1985).
2. Hofflander w. St. Catherine's Hospital, Inc., 262 Wis 2d 536 (2003).
3. Variety Children's Hospital v. Mishler, 670 So. 2d 184 Fla App 3 Dist (1996). ✦

Beware of 'captive' med/mal coverage

Physicians often get 'raked over the coals,' source says

"Don't buy malpractice insurance. Let's set up a captive for you instead!" might be a tempting offer coming from a financial planner or accountant.

"Most of the time, physicians will get raked over the coals and set up with something that is not really right for them," warns **Jonathan Katz**, president of Oros Risk Solutions, an Orlando, FL-based insurance and consulting agency specializing in selling medical professional liability insurance.

Often, it turns out that a true captive, which means the physician group is actually forming its own insurance company, is not being offered. Instead, it's a "microcaptive," with physicians paying money to a third party instead of an insurance company. "It is very suspect if they ask you to overfund the captive and make up coverage with premiums that you are not actually paying for," says Katz.

Physicians also are typically charged various fees for administrative costs and reinsurance by the third parties setting up the captive. "It's a way for the people pushing it to make money off doctors," says Katz. "And if the doctor happens to actually have some malpractice claims, it all falls apart."

Misuse is common

Generally, a captive insurance company provides physicians with more control over settlement and ultimate decisions. **Scott Martin**, JD, a partner in the Kansas City, MO office of Husch Blackwell, says, "It also eliminates the risk of bad faith, which can lessen the settlement value of a claim."

Because the elements of bad faith cannot be present when the insurer and insured are controlled by the same decision-makers, a claim for bad faith only makes sense when one entity is making a claim against a separate insurer, Martin says. The possibility of a future bad faith claim can increase the overall settlement value because an insurer might be pressured into paying a higher amount because of the possibility of a verdict in excess of the policy limits.

"The excess verdict exposes the insured to liability which could have been avoided with a settlement within policy limits," says Martin. "No insurer wants to allow the possibility that its exposure is not limited to the actual policy limits."

However, there need to be some corporate elements in place to maximize the protection, such as the captive maintaining its own corporate structure with officers and policies, says Martin. "There are multiple additional legal hurdles to manage [in creating a captive] that would otherwise be done by the insurance company," he says. "This requires more work, but is generally a cost savings if done correctly."

The possibility of making a profit instead of paying premiums to an insurance company is appealing to many physicians. Katz says, "Captives

are often promoted as tax shelters and asset protection vehicles, but this is how we often see them misused."

To decide if a captive is the right choice, Katz says physicians should have an actuarial study done. This study looks at industry data and the premiums paid by the physician practice over years. Next, physicians should have a feasibility study done by an independent consultant. A physician group might pay for the study, only to be told they are better off continuing with their current policy.

"You don't know if a captive is right for you until you do the work," says Katz. "This means a lot of upfront money, which is a barrier of entry for smaller medical groups."

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Some financial planners or accountants offer to set up "captive" insurance companies for physicians, instead of purchasing medical malpractice coverage from a third party carrier. Physicians should be aware of the following:

✦ A true "captive" plan means the physician group is actually forming its own insurance company.
✦ "Microcaptives" involve physicians paying money to a third party instead of an insurance company.
✦ Red flags include being charged administrative and reinsurance fees, and overfunding of the captive

Most often, it's large medical groups paying millions in annual premiums who are best-suited for captives. However, in some cases smaller groups are good candidates. Katz recommended a captive for one anesthesiology group that had virtually no losses in 20 years, for example. "The only reason for going with a captive is that you can do better on your own," he says. "You have to well outperform the average on a consistent basis." ✦

Criticism from other physicians can fuel suit

Critical comments are surprisingly common

When researchers set out to learn how doctors talked about other doctors to a group of 34 seriously ill patients, they found something surprising. More than one-third (38%) of physicians criticized a patient's previous care, despite the fact that the patients didn't ask for their opinion.[1]

Also, the patient's charts showed that the standard of care had been met. "So the fact that the care was criticized meant something different than if there had actually been poor care delivery," says **Susan H. McDaniel,** PhD, the study's lead author and associate chair of the Department of Family Medicine at the University of Rochester (NY) Medical Center.

The researchers initially were looking for comments involving empathy and self-disclosure. "But what popped out at us was a lot of criticism by one physician of another," says McDaniel. "We didn't set out to study this, but we found it, as happens in a qualitative study."

If physicians genuinely are concerned, McDaniel says a better approach would be to advise the patient to get a second opinion or contact the physician to discuss the care directly.

When physicians complain about the care provided by another physician, it causes patients to wonder whether malpractice occurred, she says. "It makes patients very uncomfortable for their physicians to criticize each other," says McDaniel. "It can fuel uncertainty and anxiety, and in some cases, even malpractice suits."

Common reason for suits

Jack H. Olender, JD, a Washington, DC-based plaintiff's malpractice attorney, often is informed by a prospective client that a follow-up treating physician said that the treatment given was improper, not indicated, or negligently administered.

"Sometimes these allegations are borne out by the records and the total picture of what happened, and sometimes they are not," says Olender.

The physician who allegedly made the statement isn't necessarily willing to cooperate with a plaintiff attorney. Some deny ever making the comment. "However, the physician's criticism may indeed be the deciding reason for the patient to seek legal counsel," he says.

Executive Summary

Physicians criticize the care of other physicians with surprising frequency even if the standard of care has been met, according to a recent study. This criticism can fuel malpractice risks. If physicians disagree with previous care, they should do the following:

✦ Advise the patient to get a second opinion.
✦ Contact the patient's previous physician to discuss the care.
✦ Avoid criticism by creating detailed, coherent, and complete records.

If physicians learn another physician criticized their care, Olender says they "should not do anything, other than wait for the other shoe to drop — or, for nothing to happen" and not make matters far worse by altering or deleting existing records. "Such actions can turn a so-so case into a locked case or even criminal prosecution," he warns.

Physicians who make detailed, coherent and complete records are unlikely to encounter criticism from other physicians, Olender says. "It is the sketchy, unclear records that produce the criticism," he says. "The same is true with the quality of the communication with the patient." If physicians explain something clearly, the patient presumably will have fewer questions for follow-up physicians. "Perhaps the single best way to prevent criticism from other physicians is to take the time and effort to render excellent care," says Olender.

Reference

1. McDaniel SH, Morse DS, Reis S, et al. Physicians criticizing physicians to patients. *J Gen Intern Med* 2013; 28(11):1405-1409. ✦

Delayed diagnosis: Poor communication is factor

Poor communication among care team members is one of the primary factors resulting in delayed diagnosis and treatment, according to an analysis of 111 root cause analysis reports submitted to the Veterans Affairs (VA) National Center for Patient Safety in Ann Arbor, MI, from 2005 to 2012.[1]

The researchers took advantage of the comprehensive data available from the VA, which is a very large and integrated health system, says **Hardeep Singh**, MD, MPH, one of the study's authors. Singh is chief of the health policy, quality, and informatics program at the Houston VA Center for Innovations in Quality, Effectiveness, and Safety and associate professor of medicine at Baylor College of Medicine in Houston, TX.

Other healthcare systems might not have access to the same data points, because patients often are traversing through multiple care settings. "We have a much better understanding of the longitudinal care patterns that patients experience," says Singh.

Because the VA uses a comprehensive, integrated electronic health record (EHR), the researchers had access to all patient care progress notes including consultant reports, laboratory, imaging and pathology reports, procedures, and emergency department visits. "When you have access to all that information, you can figure out a lot about what's going on with patient care," says Singh. "This data can really shed light on communication and coordination issues."

Not many systems perform outpatient root cause analyses, which is another reason the data was unique, says Singh. "We are a fairly team-based outpatient care model, but there were still several breakdowns in team level decision-making that were prominent," he says. For example, researchers noted miscommunications related to the degree of urgency of a patient's situation. At times, providers lacked awareness of specific patient information, such as their abnormal test results.

As the U.S. health system moves to a more team-based model of care, "we will continue to see such breakdowns unless specific factors are addressed," adds Singh. Here are some of the findings in the analysis:

• The organization's EHR, though more sophisticated than many other commonly used systems, still needs enhancements.

"The EHRs of today probably don't support the level of teamwork that we need in order to prevent delays in care," says Singh.

• Better policies and procedures are needed to clarify roles and to address the diffusion of responsibility.

"When patients travel between different people and different systems of care, it's often not clear who is responsible for following up abnormal test results or ensuring patients are following up or returning for important appointments," says Singh.

• Teamwork principles need to be better integrated.

This is becoming more important, says Singh, as the "doctor-centric" model of care moves to accountable care organizations (ACOs) and medical homes. "We will need to learn much more about teamwork principles," he says. Singh says that while they are doing teamwork training in the inpatient and operating room settings, "these programs need to be adapted and exported to the outpatient setting as well."

Physicians Insurance in Seattle is seeing more claims involving

Executive Summary

Poor communication among care team members is one of the primary factors resulting in delayed diagnosis and treatment, according to a recent analysis.

- ✦ Policies and procedures need to clarify who is responsible for following up.
- ✦ Teamwork training should be considered for the outpatient setting
- ✦ Electronic health records might need enhancements to support teamwork.

handoffs of patients from provider to provider, in the hospital to out of the hospital, and from primary care physicians to specialists, reports **Dennis R. Olson**, vice president of risk management."The complexity of medical care is a major factor in our malpractice cases," Olson says.

Singh says that to address the contributors of delays in diagnosis and treatment, "we need multiple solutions."

Reference

1. Giardina TD, King BJ, Ignaczak AP, et al. Root cause analysis reports help identify common factors in delayed diagnosis and treatment of outpatients. *Health Aff* 2013; 32(8):1368-1375. ✦

New HIPAA regs: Proper privacy notices needed

If physicians don't provide an updated privacy notice as required by new regulations, physicians could be accused of violating the Health Insurance Portability and Accountability Act (HIPAA) by the government or the state attorney general.

"If you or your office has a Notice of Privacy Practices that has not been updated since Jan. 25, 2013, you need to update it," says **Nicole E. Stratton**, JD, an attorney at Foster Swift Collins & Smith in Lansing, MI.

Physicians are required to distribute these new Notices of Privacy Practices only to new patients. "However, many are distributing their new Notices of Privacy Practices to current patients as well, so every patient has the latest information about their privacy rights," says Stratton.

Everything in prior Notice of Privacy Practices still is required, along with these additional items:

- information related to an individual's right to notification after a breach;
- descriptions of uses and disclosures requiring authorization (such as psychotherapy notes, marketing, and sale of medical information);
- a statement indicating that individuals have a right to restrict certain disclosures of medical information to a health plan where the individual pays for the service entirely out of pocket;
- a statement that individuals have a right to opt out of fundraising communications.

The final regulations made penalties steeper, with the potential of fines of up to $1.5 million for all violations of the same HIPAA requirement or prohibition.

"Additionally, there is no maximum limit on the amount of fines per year. It all depends on how many different kinds of violations are found," says Stratton. *(For examples of the notices of privacy practices that must be furnished to patients, go to http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html.)* ✦

Countersuit is rarely good option for MDs

It can quickly backfire on physician defendant

When physicians feel they're wrongly accused of malpractice, they sometimes think of countersuing the patient or plaintiff attorney.

This option is rarely a good one, according to **Leonard Berlin**, MD, FACR, professor of radiology at Rush University and University of Illinois, both in Chicago, and author of Malpractice Issues in Radiology.

"Your insurance company will appoint a defense lawyer and review the case. After investigating all aspects of the medical care rendered to the plaintiff-patient, if they feel there are no grounds for a suit, they will probably wind up having the suit dismissed," he says.

In 1975, Berlin was one of the first physicians to countersue, after being named in a suit involving a patient with an injured finger. "It was an absolutely absurd case, and the patient was looking for a fast settlement," he says. He sued the patient and the patient's lawyer for filing a frivolous malpractice suit without any objective basis, which harmed Berlin's reputation and increased his insurance premiums.[1]

After the case received national publicity, the plaintiff offered to drop the case if Berlin would do likewise, but he refused. The suit progressed to a jury trial with a verdict in Berlin's favor. "Over the next year or two, about 100 countersuits were filed [by physicians sued for malpractice], in

Executive Summary

Physicians often wish to countersue a patient or plaintiff attorney if they think a frivolous lawsuit is filed, but this action is rarely a good option.

- ✦ Countersuits are unlikely to be successful.
- ✦ In rare cases, the court will penalize the plaintiff for filing a frivolous case.
- ✦ Attorneys typically take cases only with a strong likelihood of return on investment.

over a dozen states," says Berlin. His and virtually all other similar countersuits eventually were reversed on appeal.

"Countersuits today are extremely rare," says Berlin. One reason is that attorneys face significant expenses in taking on a malpractice lawsuit, says Berlin.

"Even on a minor malpractice case, they may pay over $50,000 out of their pocket, and if it goes to a jury trial it might be well over $200,000," he notes. "Plaintiff attorneys won't take a case unless they really see a strong likelihood of ROI."

Because countersuits are unlikely to be successful and costly, it is better to allow the legal system to take its course, advises Berlin.

"If you are sued and you really feel that there is absolutely no basis, on rare, egregious situations, the court will penalize the plaintiff for filing a frivolous case," says Berlin. "But that is very rare. Also, the courts won't even take a look at a countersuit until after the malpractice case is resolved, one way or another." *(See related story, below, on scenarios where countersuit is an option.)*

Mark L. Rosen, Esq, a partner at Lubell Rosen in Fort Lauderdale, FL, says there are several downsides to suing your own patient. "First of all, you have a lot more at risk than your patient. Any misstep can lead to disaster," he says. "One mad patient can create a public relations nightmare online." *(For more information on this topic, see "Negative online review of MD? Keep legal risks top of mind,"* Physician Risk Management*, May 2013, p. 121.)*

An angry patient might retaliate by filing a complaint with the board of medicine. "It is very easy for a patient to do and will be expensive for the physician to respond," he says. "If the board of medicine agrees with your patient, you will be worse off."

The best step is to remove your emotions from the lawsuit and remember that lawsuits are business, not personal, says Rosen.

"If you are wrongfully accused, then vindicate yourself in court and move on," he says. "If the case is frivolous, it will be apparent during the underlying case, and the judge will knock the case out of court." ✦

These situations might call for countersuit

Although **Mark L. Rosen**, Esq, a partner at Lubell Rosen in Fort Lauderdale, FL, almost never recommends countersuit to a physician client, he says there are a few exceptions. Here are some circumstances in which a physician can successfully countersue a patient and/or attorney:

• When the attorney is not following the rules.

"The physician's attorney should be aware of circumstances where a plaintiff attorney has crossed the line," says Rosen. For example, the attorney is not allowed to talk directly to a represented physician instead of defense counsel.

"If the attorney stops by your office to intimidate you, then that attorney has broken the rules and may be sanctioned," says Rosen.

• When the lawsuit contains intentional factual inaccuracies.

"In most states, if a lawsuit is found to be frivolous, the patient and the attorney could be liable to reimburse your attorneys' fees," says Rosen.

• If the patient or family engages in inappropriate conduct.

Rosen was involved in a case in which a patient died during surgery performed by one of his physician clients. The family of the deceased hired an attorney to investigate a potential negligence claim.

"In the interim, the family appeared at our client's medical office and began to create a ruckus," says Rosen. "The family had a video camera and was warning patients in the waiting room of the 'dangers' of our doctor."

Rosen's firm sued the family to prevent them from trespassing in the physician's office. "Later, when the case was being filed in court, our client was not included in the case," he says. "There was too much baggage created by the trespass case, and the plaintiff's attorney wanted no part of it." ✦

Notify carrier, or risk loss of coverage

Physicians often unaware of requirements

Physicians might choose to ignore papers indicating there is a lawsuit at hand, rather than immediately notify their medical malpractice insurance carrier. Ignoring papers is a mistake, says **Michael R. Tamucci Jr.**, vice president of claims at MagMutual, a provider of medical professional liability insurance based in Atlanta.

"We've heard of physicians simply putting the papers away in their desk drawer, hoping the lawsuit would simply go away," says Tamucci. "Physicians should always reach out if an issue arises."

Tamucci says physicians should immediately notify their insurance carrier in these instances:

• if the physician is served with lawsuit papers;

• if the physician receives a records request or demand letter from an attorney or patient;

• if there is any suggestion of a

potential lawsuit or pursuit of a claim, such as a patient appearing uncharacteristically angry or if there is an unexpected outcome with which the physician is just not comfortable.

Physicians might be unaware of the notice requirements in their medical malpractice policies, says **Mike Merlo**, Esq., managing director of casualty legal and claims at Aon Risk Solutions in Chicago. "It's important for physicians to be aware of insurance technicalities. You don't want to put your coverage in jeopardy," says Merlo.

Some policies specify certain information that needs to be provided when a claim is noticed, such as a copy of the lawsuit or demand letter documenting the claim. MagMutual, for example, asks that physicians provide:

- details of what happened;
- names and addresses of any injured people and witnesses;
- specific dates of treatment;
- all lawsuit documents received;
- all medical records.

Tamucci advises physicians to keep a copy of all documents sent and use registered or certified mail to confirm receipt.

Physicians who don't strictly comply won't necessarily lose coverage.

"There are some cases where courts have found that the insurer cannot be hypertechnical in denying a claim due to a policyholder's failure to strictly comply with notice requirements," says Merlo.

Timely response needed

A delayed response could complicate the defense in these ways, says Tamucci:

- A delay could mean that the plaintiff's attorney is able to review the case first and might begin raising issues that compromise the defense.
- A communications lag might interfere with the insurer's ability to negotiate directly with the patient or coordinate efforts with other potential defendants.
- Physicians might run the risk of a lapse in coverage if there is a delay in reporting the claim.

Once reported, the insurance carrier will confirm coverage and begin an investigation.

"Physicians should contact the insurer by phone, then follow up with an email. They must be prepared to supply all associated records," says Tamucci.

Physicians should not share any facts or speculation with anyone outside the claims defense team, he emphasizes. MagMutual offers a doctor-to-doctor support program that pairs a defendant physician with a colleague who already has been sued.

"This peer support provides emotional insight and guidance about the rigors and stress of being named in a lawsuit, but does not involve discussion of case facts," says Tamucci. ✦

Executive Summary

Physicians should immediately notify their medical malpractice insurance carrier if they believe a lawsuit is likely.

✦ Some policies specify that certain information needs to be provided.

✦ Physicians should report even a potential claim.

✦ Some insurers offer support programs for defendant physicians.

COMING IN FUTURE MONTHS

✦ Avoid claims for failure to diagnose sepsis

✦ Common allegations in missed heart attack cases

✦ Learn from successful postop peritonitis lawsuits

✦ How communication can prevent missed cancer suit

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 to reduce legal risks of patients refusing care, according to James W. Saxton, Esq., an attorney at Stevens & Lee?**
   A. Physicians should avoid using patient portals to facilitate scheduling.
   B. Physicians should not use care coordinators to encourage compliance.
   C. Physicians should use forms, such as specialty-specific informed consents, to show patients have taken some responsibility for their care.
   D. Physicians should not ensure that information in the medical record is consistent with information in the discharge documentation.

2. **Which is true regarding use of guidelines to establish the legal standard of care, says Franchesca J. Charney, RN, director of educational programs at the Pennsylvania Patient Safety Authority?**
   A. Physicians should document the guideline recommendation, the reason it is not being followed, and the patient or family's understanding of why the guidelines do not apply.
   B. Physicians should not acknowledge failure to follow guidelines in the chart under any circumstances.
   C. If physicians are choosing not to follow guidelines for a particular patient, they should not specify they are aware of the guidelines.
   D. It is not advisable for physicians to document the patient's understanding of why the guidelines do not apply in a particular instance.

3. **Which is true regarding physicians countersuing patients or plaintiff attorneys, according to Mark L. Rosen, Esq, a partner at Lubell Rosen?**
   A. Countersuits against plaintiff attorneys often are successful.
   B. Plaintiff attorneys can be sanctioned if they talk directly to a represented physician instead of defense counsel.
   C. Even when a lawsuit contains intentional factual inaccuracies, courts cannot deem the lawsuit frivolous.
   D. The patient and attorney cannot be held liable for the physician's attorneys' fees even if a lawsuit is found to be frivolous.

4. **Which is recommended regarding notification of insurance carriers, according to Michael R. Tamucci Jr., vice president of claims at MagMutual?**
   A. Physicians should immediately notify their insurance carrier only if they are served with lawsuit papers.
   B. Upon receiving a record request from an attorney, physicians should wait to learn if a lawsuit will be filed before notifying the carrier.
   C. Physicians should notify carriers even if there is a suggestion of a potential lawsuit.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICIAN RISK MANAGEMENT

Man who suffers stroke due to his physician's failure to monitor heart condition awarded $6.4 million

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News: In 1996, A 42-year-old male patient was diagnosed by his physician with mitral valve prolapse. Although the condition must be monitored regularly because it can lead to heart valve infections, after 2001 there are no notations of the condition in the physician's records, and he failed to order any follow-up testing. When the patient began to exhibit symptoms of fatigue and weight loss in 2007, the physician ordered several tests but failed to refer him to a cardiologist or recommend any heart related testing. Just a couple of months later, the patient suffered a stroke, significantly impairing his motor skills and short-term memory. The patient and his wife sued and alleged that the physician failed to properly monitor and treat the condition, thereby causing the patient's stroke. The jury agreed and awarded the plaintiffs $6.4 million in damages.

The patient and his wife sued and alleged that the physician failed to properly monitor and treat the condition ...

Background: In 1996, the 42-year-old male patient's physician sent him for an echocardiogram and diagnosed him with mitral valve prolapse, a condition in which a valve of the heart does not close tightly and allows blood to flow backward into the heart. Significantly, the condition can lead to endocarditis, an infection of the heart valve, and therefore must be monitored regularly. The condition was confirmed in 2001 after a follow-up echocardiogram, but no subsequent echocardiograms were ordered. In fact, there is no record of the patient even having the condition following March 2002.

In April 2007, the patient became very ill and complained of fatigue, weight loss, appetite loss, and abdominal pain. The patient scheduled an appointment with the physician and complained that he felt "like I am dying." In order to diagnose his condition, the physician referred him for blood work, a panendoscopy/upper endoscopy, a colonoscopy, and bone marrow tests, but he was never referred to a cardiologist and no heart tests were ordered.

While still awaiting the test results, about a month later, the patient's wife called the physician and implored him to admit her husband to the hospital as his condition continued to deteriorate. However, the physician advised against admitting the patient at that time. The physician informed the wife that they should wait until the tests results from the hematologist arrived.

Another month later, the patient,

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Justin V. Buscher**, **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.

at the age of 53, developed a bacterial infection on his heart valve and suffered an acute stroke. The stroke caused paralysis of the right side of his body and short-term memory loss, and it limited his ability to process words. It has been a process for him to relearn how to use his right hand and foot. The patient had previously been employed as a bank examiner and information technology specialist for the Federal Reserve Bank in Missouri, but he has not been able to work since the stroke.

In 2011, the patient and his wife sued the physician and his medical group. They alleged that the physician was negligent in failing to refer the patient to a cardiologist or admit him to the hospital after he became ill in 2007. The plaintiffs further argued that the physician was negligent in that he failed to monitor the patient's heart condition and order follow-up testing, or even note the condition in the patient's charts. The plaintiffs contended that had it not been for the physician's negligence, the infection would have been diagnosed and treated, thereby preventing the stroke. The defendants argued that the injuries were the result of unknown medical conditions peculiar to the patient and that were not foreseeable to the physician. They contended that the patient's own "allergies, sensitivities, medical conditions, reactions and/or idiosyncrasies" were the cause of his death and not the negligence of defendants.

After a jury trial, the couple was awarded $5.8 million in damages to compensate for pain and suffering, economic losses, and medical expenses. Another $610,000 was awarded for the wife's loss of consortium claim. The verdict is one of the largest awards ever in the state of Missouri.

What this means to you: This case is troubling for a number of reasons; perhaps the most significant is that the condition was diagnosed and then not followed. In 1996, the patient's physician appropriately sent him for an echocardiogram, which diagnosed the mitral valve prolapse (MVP). This condition has the potential to lead to serious complications and is generally followed closely at regular intervals. The condition was confirmed five years later, although it is unclear what was done in the interim. There is no indication that the patient was sent to a cardiologist or that there is further mention of the condition in the physician's office records.

Perhaps the failure to refer or do further testing resulted in the physician forgetting that the condition was there.

In 2007, the patient became ill with a combination of symptoms. The treating physician went everywhere except to the MVP as an answer to the patient's complaints. Again no cardiologist is consulted and no heart-related testing is done in spite of the fact that the patient's MVP is known to this physician.

One month later, the patient's wife calls and asks the doctor to admit her husband as the condition has only gotten worse. The doctor declines and suggests waiting for the results of hematological testing. The patient eventually develops a bacterial infection on the heart valves, which led to a stroke and significant neurological defects.

This case presents a number of issues, most of which revolve around the treating physician's failure to follow up. It is also what some lawyers call a "failure-to-rescue" case. At various times during the patient's long interaction with the physician, there was the opportunity to diagnose the patient and prevent the negative result. In 2001, after confirmation of the heart condition, the physician does not monitor the patient closely. More to the point, the physician fails to refer the patient to a cardiologist. When the patient becomes ill in 2007, the doctor, knowing the patient's has a pre-existing condition of MVP, does not do anything with this knowledge. Perhaps the failure to refer or do further testing resulted in the physician forgetting that the condition was there. It is unlikely that as the patient came in periodically, the physician went all the way back years into his notes.

The call from the wife was the last clear opportunity that the treating physician had to diagnose the actual condition. Whether the doctor was aware of the MVP at this point and eliminated it from his differential diagnosis or simply did not have the condition on his radar is unknown. What is clear to a jury of his peers is that the failure to refer and failure to follow up on a condition that has the potential to cause significant injury has no excuse and therefore appears to be a direct cause and effect of what a layperson will consider sloppy care and the patient's injuries.

In this situation, the patient also was clearly an intelligent, relatively high-earning individual. Along with the lack of demonstrated standard of care and the squandering of multiple opportunities to make the diagnosis, this situation, not surprisingly, led to a large verdict.

Reference

11SL-CC02366 (Miss. St. Louis County Cir. Ct. July 5, 2013). ✦

Woman who dies from pneumonia as result of misdiagnosis awarded nearly $2 million

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News: In 2009, a 25-year-old female who was 28 weeks pregnant presented to the emergency department of a hospital in Philadelphia with complaints of fever, cough, and shortness of breath. The treating obstetrician diagnosed her with bronchitis, and she was discharged on antibiotics. Just two days later, she presented to the hospital again. A chest X-ray was ordered revealing pneumonia. The plaintiff was admitted and treated for the pneumonia, but her lung condition continued to worsen. She slipped into a coma and died about two weeks later. An emergency caesarian section was performed, and the baby survived. The patient's estate sued the obstetrician and alleged that a chest X-ray should have been ordered upon her initial presentation because she had the signs and symptoms of pneumonia at that time and the condition can be particularly harmful to a pregnant woman. The jury concluded that the patient would have had a substantially increased chance of survival if she had been timely diagnosed and awarded the estate nearly $2 million in damages.

Background: In 2009, a 25-year-old female who was 28 weeks pregnant presented to the emergency department of a hospital with complaints of fever, cough, dehydration, inability to eat, diarrhea, shortness of breath, and difficulty breathing. She was seen by an emergency medicine resident and an obstetrician, who performed a physical examination and diagnosed the patient with a viral syndrome, possibly bronchitis. She was treated with IV fluids and discharged on antibiotics.

... pregnant women are more susceptible to pneumonia and at greater risk of suffering related complications.

The patient's condition failed to improve, and she returned to the hospital just two days later. A chest X-ray was performed that revealed pneumonia in both of the patient's lungs. Although she was treated with IV fluids and antibiotics, her lung condition continued to deteriorate. She was intubated and put on a ventilator. She eventually slipped into a coma, and an emergency caesarian section had to be performed. The doctors successfully delivered a healthy baby girl, weighing just two and one-half pounds. However, the mother went on to suffer a collapsed lung and was treated for acute respiratory distress syndrome and a whole body infection: sepsis. She died of bilateral pneumonia about two weeks later.

The patient's estate sued the treating emergency medicine resident, the obstetrician, and the hospital, and the lawyers argued that a chest X-ray should have been ordered during the initial visit to the emergency department and the patient should have been admitted for observation. Plaintiff's counsel contended that had a chest X-ray been performed and had the plaintiff admitted upon the initial presentation, the patient's pneumonia would have been diagnosed and timely treated, thereby preventing the patient's death. The case was dismissed against the hospital, as well as the first-year emergency medicine resident because he did not have authority to order an X-ray or admit a patient.

Plaintiff's experts testified that pregnant women are more susceptible to pneumonia and at greater risk of suffering related complications. Therefore, they contended, that timely diagnosis and treatment is critical. The experts opined that the obstetrician should have ordered a chest X-ray and admitted the patient during the initial emergency department visit because she was exhibiting the signs and symptoms of pneumonia. Indeed, the obstetrician had a differential diagnosis of bronchitis, the flu,

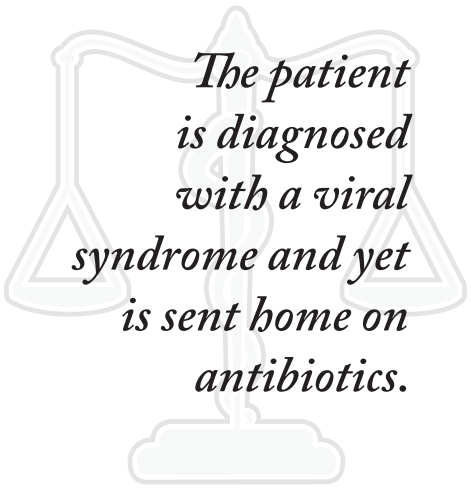
and pneumonia upon the initial presentation. Therefore, sending the patient home on antibiotics did not conform to the standard of care for treating a pregnant woman with pneumonia. The experts concluded that had the doctor ordered appropriate testing at that time, her opportunity for survival would have substantially increased.

The defendant's expert, on the other hand, argued that the patient did not have all the signs of pneumonia and therefore sending the patient home on antibiotics was an appropriate medical recommendation. The expert further opined that even had the obstetrician ordered an X-ray and treated the patient for pneumonia upon her initial presentation, she would have died anyway due to the severity of her condition. The defense also presented an infection diseases expert who suggested that the patient may have died on H1N1, but this argument was refuted because repeated tests for the disease were negative.

The jury agreed with the plaintiff's position and awarded the estate $1.8 million in damages for her two days of pain and suffering, future lost earnings capacity, and loss of household and parental services. An additional $121,000 was awarded for past medical expenses. Although the patient's work history was limited and she was not employed at the time of her death, her counsel presented evidence that she was in the process of earning her GED and had plans on working at a daycare center. The defense maintained that the loss of economic loss was speculative based upon the limited evidence and work history. Ultimately, a basis of $1.5 million to $1.7 million was presented to the jury for the patient's economic loss, including past and future lost earnings and loss of household and parental services. The patient is survived by her two children, ages 4 and 7 at the time of trial.

What this means to you: This case is similar to many others involving evaluation of patients in an emergency department. Under the best of circumstances, the emergency encounter is limited in scope and time. Even with a thorough workup in a physician's office, things get missed.

This 28-year-old woman was 28 weeks pregnant and presented with complaints of fever, cough, dehydration, loss of appetite, etc. This is a long litany of symptoms that might have triggered a higher index of suspicion on the part of the providers. What is also interesting about the case is that an emergency medicine resident and an obstetrician saw the patient. An emergency medicine attending would likely have ordered an X-ray given the extent of the patient's symptoms.



The patient is diagnosed with a viral syndrome and yet is sent home on antibiotics.

The plaintiff's expert made a logically attractive point that will resonate with a jury: The pregnant patient is more susceptible than the average patient. This point is accentuated by the fact that the patient comes back just two days later, is properly diagnosed, and becomes really sick really fast

The patient is diagnosed with a viral syndrome and yet is sent home on antibiotics. If it is viral, why were antibiotics administered? The treating obstetrician might have thought that it was appropriate to give antibiotics "just in case" or to "cover" the patient. Medico-legally, it creates an issue of fact as to what the doctor was thinking.

Another problem, which works against the defense, is the inert nature of an X-ray. It is not an invasive procedure and occurs multiple times all day long in an emergency department. If the jury accepts the argument that having had the X-ray would have saved the patient, it is an easy thing to have done.

In his differential diagnoses, the obstetrician had pneumonia as well as flu and bronchitis. In that situation, the doctor had an obligation to eliminate the most dangerous or potentially life-threatening cause.

The defense also avails itself of the "it-wouldn't-have-mattered" defense. If they had ordered the X-ray, the patient would have succumbed anyway due to the severity of the illness. This defense has two primary problems. Juries don't like to hear that what you did not do did not matter. A better argument is that a test is not warranted rather than it did not matter.

The other issue is that the patient was entitled to an opportunity at being saved. Even if ordering the chest X-ray would have created only a 10-30% opportunity of recovery, even a small percentage is worth money that the jury was ready to award.

Reference

31 Pa. J.V.R.A. 8:C4, 2013 WL 4081988 (Pa. Com. Pl. July 3, 2013). ✦

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