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Claims involving outpatient care increasing: MDs often unaware of actual legal risks

Failure to diagnose is common allegation

"Did you know that primary care physicians are at pretty much the same level of risk for malpractice suits as neurosurgeons, orthopedists, and obstetric-gynecologists?" When **Luke Sato,** MD, asks physicians this question, "they all look surprised and say, 'I wouldn't have known that.'"

Outpatient

The number of paid malpractice claims reported in 2009 to the National Practitioner Data Bank for events in the outpatient setting was similar to the number in the inpatient setting.[1]

One issue contributing to malpractice claims is that primary care physicians are put into the "quarterback" position of coordinating all of the care a patient is receiving, says Sato, assistant professor of medicine at Harvard Medical School in Boston and senior vice president and chief medical officer at CRICO, the Cambridge-MA based patient safety and medical professional liability company serving the Harvard medical community.

"The other element that people may not appreciate from a liability perspective is that the primary care physicians are responsible for anything in the medical record — any abnormal test or study," says Sato. "You can imagine the potential risk there."

CRICO has seen a trend of missed lung cancer claims arising from failure to follow up on incidental findings, missed prostate cancer claims involving failure to follow up

Physician Risk Management focuses on 'failure-to-diagnose' claims

This month's issue of *Physician Risk Management* is a special issue on medical malpractice risks involving failure to diagnose. Inside, we interview leading risk management, patient safety, and legal experts to report on current trends in these claims. We cover common allegations in lawsuits involving failure to diagnose heart attack, cancer, and sepsis. We also report on common claims against primary care physicians, pediatricians, surgeons, and obstetrician/gynecologists. We tell you about frequent allegations in failure to diagnose claims, including lack of follow up, anchoring bias, and failure to order testing.

INSIDE

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on an abnormal test result, and missed colorectal cancer claims from failure to address colorectal bleeding. "Physicians need to be on the alert with patients who come in with symptoms of lumps or rectal bleeding," says Sato.

Diagnostic errors are the most common allegations in claims involving outpatient care, in contrast to claims involving inpatient care that typically involve procedure-related errors, says **Tara F. Bishop**, MD, MPH, assistant professor of public health and medicine at Weill Cornell Medical College. Outpatient malpractice claims "include missed or delayed diagnoses, often for cancer or heart disease," says Bishop.

Nan Gallagher-Auferio, Esq., an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ, is seeing increasing numbers of malpractice claims and state medical board investigations stemming from adverse events in ambulatory care settings. Many involve diagnostic errors. "We are hearing about more and more patients who are dying from preventable medical errors in the ambulatory setting," she says.

Executive Summary

Physicians often are unaware that malpractice claims for events in the outpatient setting are equivalent to those in the inpatient setting. These practices can potentially reduce legal risks:

- ✦ having electronic medical records flag abnormal findings that the physicians needs to act on;
- ✦ standardizing the way patients are informed of lab results;
- ✦ enabling patients to access test results from patient portals.

Patients as safety nets

There is a growing trend of misdiagnoses of heart attacks at urgent care centers, reports Gallagher-Auferio.

"More and more internists and advanced practice nurses who are manning these urgent care centers aren't treating the presenting symptoms with the level of urgency that the facility marquis advertises to passers-by," she says.

Gallagher-Auferio has seen several claims involving the misdiagnosis of myocardial infarctions at urgent care centers. "Failing to appreciate subtle EKG changes and elevated cardiac enzymes is quite common," she says.

Physicians often try to protect themselves legally by discharging patients with the instruction, "If your symptoms don't improve in X days, come back or go to the ER," says Gallagher-Auferio, "but by the time the patient knows any better, it's far too late."

EMRs fall short

Most electronic medical records (EMRs) fall short when it comes to reducing malpractice risks, Sato says. An EMR could flag abnormal find-

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ings that the physicians needs to act on without the physician having to look for these specifically, for example, but most EMRs aren't set up to do so.

"That would be tremendously help in mitigating risk, but vendors are not thinking about it this way," says Sato. Patients themselves also can act as safety nets, if they are able to access test results from patient portals set up by physician offices.

"We highly encourage any means to engage the patient," says Sato. "If you can avoid missing the expectation of patients, you are definitely that much farther ahead of mitigating any malpractice claims down the road."

CRICO's recent analysis of malpractice claims involving EMRs identified two factors contributing to claims involving missed or delayed diagnosis:

• failure to order the appropriate lab test;

• failure to "close the loop" once a test is done or a referral is made.

"You can address these things by creating protocols, but we have found that there are gaps within the EMRs themselves," says Sato.

CRICO identified these steps as a best practice: A referral is ordered, an appointment is made to schedule the referral, and the physician is alerted if the patient misses or cancels the appointment.

Most EMRs omit the last step, says Sato. "There needs to be some mechanism to inform the referring doctor that the patient didn't make it to the appointment," he says.

Is claim defensible?

When considering whether a malpractice claim is defensible, a significant bad outcome such as death or major disability might matter more than the type of error that occurred.

"In general, outcomes matter a lot," says **Tara F. Bishop**, MD, MPH, assistant professor of public health and medicine at Weill Cornell Medical College in New York, NY. Bishop adds that for most diagnostic errors, negligence is very hard to ascertain.

"Most malpractice decisions are based on opinion," she explains. "Diagnosis is a particular area where experts might disagree."

For example, it might be difficult to determine whether diagnostic error caused one doctor to correctly diagnose a condition while another misdiagnosed the same condition. Bishop also notes that not all errors rise to the level of medical malpractice. "If there was a [diagnostic] error, was it a negligent error?" she asks.

Bishop says that standardized systems might help deter lawsuits. For example, an office could standardize the way it informs patients of lab results so that no patient falls through the cracks.

"There is no work that shows that doing more tests or practicing defensively lowers malpractice risk, although this is a wide perception by doctors," adds Bishop.

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• CRICO has produced a video on how electronic medical records can be embedded into the physician workflow in a manner that would improve health care, with a dramatization based on real malpractice cases. To view the video, go to www.rmf.harvard.edu/EMR. ✦

Misdiagnosis is the most common reason for malpractice claims in primary care practices

Primary care ambulatory claims appear more difficult to defend compared with other settings

Failure to diagnose or delayed diagnosis are the most common allegations in malpractice claims involving primary care practices, according to an analysis of 7,224 closed malpractice claims of two medical liability insurers in Massachusetts between 2005 and 2009.[1]

Primary Care

Researchers identified 551 claims arising from primary care practices. Of these cases, 72.1% were related to diagnosis. Cancer, heart disease, blood vessel diseases, and infections topped the list of diagnoses.

"We were surprised at the extent to which diagnoses errors dominated the cases," says **Gordon Schiff**, MD, the study's lead author and associate director of the Center for Patient Safety Research and Practice at Harvard Medical School in Boston.

The researchers also expected to find more cases of "dropped balls" with abnormal test follow-up, such as failing to follow up on an abnormal pulmonary nodule or elevated prostate specific antigen, Schiff says. "While there were a significant number of cases such as

this, we are surprised that these represented only a minority of malpractice suits related to cancers," he says.

The study points to a need to tighten up systems for evaluation, follow-up, and documentation and referral management, according to Schiff. "It also means that if we are going to prevent malpractice suits, we have to prevent malpractice in the first place. There is no getting around it," he says.

Executive Summary

Delayed diagnosis of cancer, heart disease, blood vessel diseases, and infections were the most common malpractice allegations against primary care practices, according to a just-published study.

- ✦ Primary care ambulatory claims were far more likely to be settled or lost in a jury trial compared with non-general medical claims.
- ✦ Patients often contribute to delays in diagnosis by failing to follow up.
- ✦ Improved systems for evaluation, follow-up, and documentation and referral management are needed.

More difficult to defend

Primary care ambulatory claims appear more difficult to defend compared with other settings, based on the study's findings. While primary care practices account for fewer than one in 10 malpractice cases, those cases were far more likely to be either or lost in a jury trial, compared with non–general medical claims.

Urmimala Sarkar, MD, MPH, assistant professor of medicine in residence in the Division of Internal Medicine at University of California, San Francisco, says, "In the hospital, patients are under constant observation. Documentation is voluminous. In contrast, 15-minute ambulatory visits are often sparsely documented. This introduces significant ambiguity."

In a 2012 study that surveyed 848 primary care physicians, a variety of reasons for diagnostic difficulties were reported.[2] Half of the physicians reported that more than 5% of their patients were difficult to diagnose, and inadequate knowledge was the most commonly reported cognitive factor. "I think the fact that we asked folks about cognitive barriers to diagnosis and they responded with a lot of concerns about health systems reflects the multi-level challenges of making timely and accurate diagnoses in the outpatient setting," says Sarkar.

Another issue contributing to primary care claims is that longer timeframes involved with the ambulatory diagnosis process lend themselves to the label of "delayed" diagnosis, says Sarkar. An important strategy in reducing "delayed diagnosis" claims is "emphasizing the importance of timely follow-up and adherence to diagnostic testing, and documenting this discussion," she says.

Patient contributions to delays in diagnosis are present in many successful malpractice claims, such as when patient-plaintiffs failed to obtain a follow-up visit or recommended test, notes Sarkar. In these cases, patients often claim that they didn't realize the importance of following up.

"Explicit documentation of the need for follow-up — a written notification about the diagnostic work-up and its importance — is helpful," says Sarkar.

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Causation: A problem for all in missed cancer cases

Cancer

At Gair, Gair, Conason, Steigman, Mackauf, Bloom, & Rubinowitz in New York, NY, many potential clients ask whether their cancer should have been diagnosed earlier and, if so, whether that failure rose to the level of medical malpractice, says **Stephen H. Mackauf**, JD, an attorney with the firm.

"The types of cancer cases we see probably reflect the incidence of cancer types in general," says Mackauf. "For example, we see a lot of claims involving breast cancer."

The typical breast cancer case involves a young woman who saw her doctor because of a breast lump and is sent her for a mammogram, which is negative. "The doctor tells her it's just fibrocystic breast disease and that she should return in one year," says Mackauf. "When she returns in a year, she has advanced breast cancer."

Other frequent cases involve an abnormal test result, such as a suspicious X-ray or a suspicious biopsy, that somehow just gets filed away in the patient's chart. "The patient

returns in a year or so because they were never advised of the abnormal result, and now they have advanced cancer," says Mackauf. *(See related story, below, on studies showing underlying causes of missed cancer claims.)*

A retrospective review of 307 closed ambulatory care malpractice claims showed that 59% of claims for missed or delayed diagnosis involved cancer patients, most often breast or colorectal cancer.[1]

Saul Weingart, MD, MPP, PhD, chief medical officer at Tufts Medical Center in Boston, says, "Malpractice claims have shifted from the inpatient setting to the primary care office," where missed cancer diagnosis claims, especially colon, lung, prostate, and breast cancer, are prevalent.

Is claim defensible?

Missed cancer claims typically revolve around "issues of fact," such as a patient claiming she reported a lump and the physician says she didn't, or a physician saying a surgical consult was recommended and the patient says there was no such recommendation, says Mackauf.

"It is because of such factual disputes or 'truth-telling contests' that good record-keeping is vital," he says. For example, if a patient refuses a test or a treatment, physicians should document this fact clearly, stating that they explained the significance of the refusal to the patient. "Write 'Follow up in X days or weeks' in the chart. Each time the patient returns, the physician should document the repeated refusal again," says Mackauf.

In cases alleging failure to diagnose cancer, causation is often the most vexing problem for both sides, he says. "In other words, how much better would the patient's prognosis have been if the cancer had been diagnosed when the patient says it should have been diagnosed?" Mackauf asks.

If the alleged failure was actually a failure to diagnose a distant metastasis, it would be almost impossible for the patient to be able to prove significant harm as a result of the delay, for example. "At the other extreme, if despite the delay, the plaintiff's cancer was diagnosed at Stage I, what harm was there from the delay?" he asks.

The defense might argue that although the cancer should have been diagnosed sooner, a short delay didn't make any difference in the patient's outcome. "The longer the delay, the stronger the patient's case," says Mackauf.

Executive Summary

Malpractice claims alleging missed or delayed diagnosis of cancer typically focus around these factors:

- ✦ issues of fact, such as whether a referral was made;
- ✦ whether a patient's refusal of a test or treatment was documented;
- ✦ whether a patient is able to prove significant harm caused by the delay in diagnosis.

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The underlying reasons for missed cancer claims uncovered

Delays stemmed from patients and providers

"I told the patient to follow up in three months and she didn't." "I told the patient to call for the results if he doesn't hear from me."

Cancer

Physicians might believe these responses would be an effective defense in the event of a malpractice suit, but "it's unclear, with respect to the courts, whether that is good enough," says **Saul Weingart**, MD, MPP, PhD, chief medical officer at Tufts Medical Center in Boston.

"At this point in time, it's incumbent on physicians and their practices to make sure there are mechanisms in place to follow up on test and specialist referrals as well as test results. It is important that clinicians don't drop the ball and are sure to send multiple reminders," he says.

A 2009 study of 102 breast cancer patients found that clinicians and patients contributed to breakdowns in the diagnostic process.[1] " It turned out that in a significant number of these potentially missed and delayed diagnoses, that the patient's behavior was important," says Weingart, the study's lead author.

Patients might fail to obtain care because they don't understand the importance of a screening or diagnostic test, or they have difficulty getting access to care.

"The implication is that clinicians should work very, very hard on improving access," says Weingart. He recommends these practices:

• making sure that patients are evaluated quickly if they report concerning symptoms;

• educating patients about signs and symptoms that merit a quick workup, such as breast lumps, blood in stool, new difficulty urinating, and persistent cough;

• "closing the loop" on referrals, with electronic systems that alert the referring provider if the patient missed a test or failed to schedule an appointment. The provider could then send a reminder or contact the patient.

Where is the vulnerability?

Weingart says that while most practices have good systems to follow up on ordered test results, "the thing that's been a real vulnerability is when the patient is sent for a test and never shows up. There are a number of organizations that have been innovating in this area and driving down their malpractice claims." In most of these interventions, the electronic order entry system sends a notification to the ordering provider that the patient has not completed a test that was ordered.

Facilitate communication

In a 2012 analysis of 56 cases alleging delayed diagnosis of breast or colon cancer, researchers found that virtually all of the cases involved one or more cognitive errors, such as a provider making the wrong decision about what test to order or what to do about the results.[2]

"The typical mistake that we see involves the incorrect assumption that since a single test was normal, no additional follow-up is needed," says **Eric Poon**, MD, MPH, the study's lead author and vice president and chief medical information officer at Boston Medical Center. Poon is associate professor of medicine at Boston University School of Medicine.

About half of the cases involved logistical errors. "The clinician knew what the right plan was, but somehow the execution of the plan fell through the cracks," says Poon. The researchers recommend the following:

• Improvement of the effectiveness and use of clinical guidelines in the selection of diagnostic strategy, both during office visits and when interpreting test results.

"If guidelines can be made available as a point of care when clinicians are making decisions, they are less likely to make these errors," says Poon.

• Tools to facilitate communication and to ensure that follow-up visits occur.

"Making test results and the treatment plan available to patients online may be helpful. But we should caution ourselves to make sure we don't rely on that as a failsafe," says Poon.

The best approach is for providers to communicate the treatment plan to the best of their ability when the patient is sitting in front of them, he says, and confirm the patient's understanding of the plan. "We need to document those plans as much as we can in the medical record, so if the patient comes back at another time, another provider might have the opportunity to remind them," he adds.

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Claims allege failure to diagnose and treat post-surgical peritonitis

Patients are sent home without having a proper evaluation

Surgery

The surgical complication of a perforation of the bowel is not necessarily malpractice, says **Kathleen Flynn Peterson**, JD, a partner at Robins, Kaplan, Miller, & Ciresi in Minneapolis. Rather, it's the failure to diagnose and treat that complication that results in a successful claim.

"These are strong cases that get a strong reaction from juries. The majority of them settle," she says.

Peterson is seeing many more claims involving patients who are sent home without proper evaluation and experiencing complications such as compartment syndrome, bowel perforation, peritonitis, and wound infections. "At any given moment, we have half a dozen cases where a disaster has occurred because a bowel perforation with resultant peritonitis was not recognized," she reports.

In some cases, the perforation in the bowel leading to peritonitis is discovered only at autopsy. "We have patients that become septic, slide into acute respiratory and renal failure, and end up on a ventilator and on dialysis. And still, no one recognizes the source of all this misery," says Peterson.

Here are some of the root cause

of these malpractice cases involving missed peritonitis:

• Too much reliance on imaging studies and inadequate clinical bedside examinations.

Phyllis Miller, RN, a legal nurse analyst in the Minneapolis office of Robins, Kaplan, Miller, & Ciresi, says, "We often see entries in the record where the physical exam is documented as being WNL [within normal limits]," and the nurses have documented 'distended, uncomfortable, hard, round, painful. That tells me that somebody is not doing a very good exam."

• Failure to take into account that peritonitis might be obscured if the surgeon placed mesh at the time of the surgery.

• Discounting the finding of persistent free air in the postoperative setting as a potential cause for concern.

• Failure to see tachycardia as the first potential sign of peritonitis.

"Tachycardia is usually symptom number one for patients with a bowel perforation," Miller says. However, surgeons tend to assume tachycardia is due to fever, heart disease, or pain, and never consider a potential intra-abdominal cause.

Executive Summary

Successful malpractice claims alleging failure to diagnose the post-surgical complication of peritonitis are occurring because patients are sent home without proper evaluation, according to plaintiff attorneys.

✦ Recognize the finding of persistent free air in the postoperative setting as a potential cause of concern.

✦ Recognize tachycardia as a first potential sign of peritonitis

✦ Consider infection or inflammation as a potential cause of postoperative ileus.

"The bariatric community has begun to recognize tachycardia as a first potential sign of peritonitis, and lo and behold, they are seeing far fewer cases of unrecognized or delayed treatment of peritonitis," she says. "But general surgeons doing other types of abdominal surgery have not made that leap."

Many patients have ended up with multisystem organ failure as a result, Miller adds. "A lot of surgeons believe that when they closed, everything was fine, so they just don't seem to believe there could be a perforation" she says.

Even if none of their patients have ever developed postoperative peritonitis, Miller notes that surgeons "need to watch for it all the same."

• Failure to consider infection or inflammation as a potential cause of postoperative ileus.

When an abdominal CT scan is read to include a diagnosis of ileus, many surgeons assume it is essentially benign and due to anesthesia, bowel manipulation, and narcotics.

"However, inflammation or infection can cause ileus too," says Miller. "Surgeons need to look at the whole clinical picture, including abdominal exam and vitals and fluid status, before deciding if the ileus is benign or not."

SOURCES

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Patient's lack of follow-up coming up in missed MI claims

There is a 'whole new level of burden' on healthcare providers

"The physician needs to do absolutely everything possible to be sure the patient follows up. If you can't reach the patient, you need to send the police."

Myocardial Infarction

This statement was the general content of an expert witness who testified during a successful medical malpractice trial alleging missed myocardial infarction (MI), reports **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD.

"That is the type of testimony physicians are faced with in court," she says. "There is a whole new level of burden being put on the provider to ensure the patient follows up."

Cerniglia-Lowensen has seen several successful malpractice claims alleging missed MI that involved lack of follow-up on the part of patients.

"Plaintiff attorneys are pretty successful in getting experts to say that physicians are responsible for making sure there is adequate follow up and that this is the standard of care," she says.

Several missed MI suits recently were settled even though the care was appropriate. These settlements were due to bad outcomes and "the sympathy factor that could result in a verdict against the physician," she says.

Cerniglia-Lowensen says good documentation by physicians of what information they were told by the patient, what testing they recommended, and their thought process makes claims alleging missed MI more defensible. "Many MIs present in an atypical fashion. If the patient says,

'I've had this problem before, and it was determined to be gastroesophageal reflux, and I have a confirmed diagnosis of that — all of that makes the case significantly more defensible," she says.

One of Cerniglia-Lowensen's clients, an urgent care center, has a system in which every patient with follow-up recommended is called the next day by a nurse or medical assistant. If the patient can't be reached after several calls, a certified letter is sent stating, "You were evaluated at Center X, and we referred you on to Y. Please call us and let us know the outcome of your visit."

"It doesn't always insulate them [from liability], but it's probably the best system I've seen for that," says Cerniglia-Lowensen.

Previous "normal" workups

Consider the case of a female in her 50s with multiple cardiac risk factor who presents with recurrent syncope, but has no chest pain or other exertional symptoms. A stress test is equivocal, with a mild inferior wall defect that is thought to be artifact.

No angiogram is thought to be indicated, but four months later, the patient has cardiac arrest and is found to have 90% blockage. The cardiologist is sued for failure to perform angiogram, and the case is settled.

This case includes several common allegations in successful malpractice claims alleging failure to diagnose heart attack, says **Sandeep Mangalmurti**, MD, JD, a cardiologist at Bassett Heart Care Institute in Cooperstown, NY, and a member of the American College of Cardiology Board of Trustees Work Group on Medical Professional Liability Insurance.

"Another example of a similar lawsuit was failure to prevent MI due to [3-vessel coronary artery] disease," says Mangalmurti. "There was a 'normal' stress echo after chest pain several months earlier."

Mangalmurti is aware of multiple malpractice cases involving patients with moderate risk factors and a recent mildly abnormal ischemic workup. "The patient presents with new onset chest pain and is found to have plaque rupture," he says. "The cardiologist is then sued for an 'improperly performed' or 'incorrectly read' angiogram or stress test."

Mangalmurti recommends that physicians:

• Be careful with patients with atypical symptoms, such as syncope, as this area can have increased liability exposure.

• Bear in mind that previous ischemic workups that are reportedly "normal" might create a false sense of security that there is no cardiovascular disease.

• Remember that patients with negative ischemic workups might not understand the continued risk of plaque rupture.

"A normal stress test or angiogram does not mean you will not have a future myocardial infarction," says Mangalmurti. "This fact should be explained clearly to patients." ✦

Executive Summary

Successful malpractice cases often allege that physicians failed to ensure that patients followed up. Another common issue in claims is the patient's recent normal or equivocal workups.

✦ Call patients the next day to ensure they obtained follow-up.
✦ Send a certified letter if patients can't be reached by phone.
✦ Explain clearly to patients that a normal stress test or angiogram doesn't mean they will not have a future myocardial infarction.

Failure to diagnose sepsis cases becoming more common

Malpractice cases involving sepsis have been "on the upswing" for several years, says **Kathleen M. Roman**, MS, a Greenfield, IN-based risk management consultant. This increase is primarily because of the increased severity and variety of infectious agents and the diminished number of effective treatments available, she says.

Infection

"It is especially important to identify the septic patient as quickly as possible," says Roman. "Some of them may also pose risk for members of the healthcare team."

Failure to diagnose sepsis cases are likely to become more common due to growing evidence about the need for early recognition and intervention, says **Bradley A. Sharpe**, MD, professor of clinical medicine at the University of California, San Francisco.

To avoid suits, Sharpe says the key is for physicians to "recognize, recognize, recognize!" systemic inflammatory response syndrome [SIRS]; and that seemingly minor vital sign changes, such as new tachypnea, might mean impending sepsis. Also, providers need to realize that patients can have severe sepsis and septic shock without a fever or hypothermia, he adds.

Physicians also should work with nursing staff on recognition of sepsis, as nurses are on the front lines, Sharpe advises. "At our hospital, we have a standard screening tool the nurses use," he says. If it is positive, they call a "code sepsis" which helps to make sure the patient gets what he or she needs quickly. *[The sepsis screening tool is included with the online version of this month's* Physician Risk Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Plaintiff attorneys are unlikely to pursue a missed sepsis claim if there is clear documentation that sepsis was considered and that appropriate interventions were not done for specific reasons, says Sharpe. For example, a physician might document that "a fluid bolus was deferred with concerns for volume overload," or "hold on antibiotics for now, as suspicion for sepsis is low–new tachycardia is likely related to ongoing severe pain."

If a missed sepsis case goes to trial, plaintiff attorneys are likely to show graphs of mortality related to time of antibiotics. In one study, each hour delay increased mortality by 7.6%, and mortality was 21.1% if antibiotics were given in the first hour compared with 58% if delayed by more than six hours.[1] "Mortality goes up quite a bit for each hour that is delayed," Sharpe explains. "A graph that shows this [increase], and then shows that antibiotics were delayed for many hours, could be very powerful for a jury."

Common allegations

Missed sepsis claims typically allege failure to diagnosis sepsis, failure to treat sepsis, and/or delay of diagnosis and/or treatment of sepsis, says Roman. She suggests these practices to reduce risk of missed sepsis claims:

• Use a protocol for assessing patients.

"There should be a requirement that specific assessments are implemented and that all staff follow the same protocols," says Roman.

• Act on the results of these assessments and tests.

• Because time is of the essence for this type of patient, written ED protocols also should include anticipated timeframes for test results and communication among members of the healthcare team who must take necessary steps to ensure that it is promptly implemented, says Roman.

"Documentation is critical to ensuring progress in the patient's care and in protecting the doctor, staff, and hospital from allegations of negligence," she says.

Poor communication, as well as poorly implemented processes for sepsis, can increase patient risk and provider liability, warns Roman. For example, someone needs to act as a "quarterback," especially when the patient needs to be transferred from the ED to the hospital, and track lost/delayed lab results, pharmacy delays, and shortages of intensive care unit beds.

"Resources should be available to ensure that staff actually can abide by the plan," she says. "Lack of equipment or supplies, staffing shortages, and poorly trained staff also contribute to delayed or disorganized care in our stressed-out healthcare system."

Roman says the consequences are higher in the ED, where doctors are treating patients they don't know and who often are very ill. "In addition, the doctor may have little or no access to previous medical records," she says. "Together, these elements comprise a perfect recipe for catastrophe."

Executive Summary

Malpractice claims involving severe infection/sepsis have been on the upswing for several years, according to risk management experts, due in part to growing evidence about the need for early recognition and intervention.

✦ Recognize that vital sign changes might mean impending sepsis.
✦ Realize that patients can have severe sepsis and septic shock without a fever or hypothermia.
✦ Work with nursing staff on recognition of sepsis.

Reference

1. Kumar A, Roberts D, Wood KE, et al. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. *Crit Care Med* 2006; 34:1589–1596. ✦

These malpractice allegations are common in 'failure to diagnose' claims against OB/GYNS

An elderly patient receives two breast exams in the year prior to her cancer diagnosis, but there is no record of a mammogram or ultrasound being ordered or performed in that year or the two preceding ones.

OB/GYN

Then, "when a routine mammogram is finally performed, it shows a mass, which is found to be cancerous," says **Stella M. Dantas**, MD, chair of the American Congress of Obstetricians and Gynecologists (ACOG) Committee on Professional Liability. In this case, the plaintiff alleged that the appropriate diagnostic test was not ordered.

Another malpractice case involved a patient with an abnormal mammogram who was referred to a breast surgeon by her obstetrician/gynecologist (OB/GYN) A biopsy was scheduled, but the patient cancelled. "The allegation with this case was the provider did not set up appropriate follow-up plans," Dantas says.

Failure to perform an adequate physical exam, failure to find the tumor of concern during an exam, and failure to recommend a referral are common in claims naming OB/GYNs, she says.

In the 2012 ACOG Survey on Professional Liability, delay in or failure

to diagnose was the second most frequent primary allegation, after "patient injury-major" claims. Failure to diagnose cancer was most common (41.8%). The most frequent types of cancer involved in these claims were breast cancer (39.1%), ovarian cancer (14.5%), and cervical cancer (10.9%).

Dantas says that a common characteristic of plaintiffs in claims alleging delayed diagnosis of breast cancer is that they are often young, with a self-discovered breast mass and a negative mammogram. Sometimes doctors can be skeptical when considering the possibility of breast cancer in young women, especially when relying on negative mammograms and not recognizing that mammograms can be falsely negative, she says.

To avoid failure to diagnose suits, Dantas says OB/GYNs should:

• Follow national guidelines.

• Strongly encourage patients to follow up and obtain recommended tests.

• Not hesitate to make referrals for consultations and imaging studies.

• Set up tracking system for results and follow-up, to make sure recommended care is obtained.

"Most jurors would consider it the physician's responsibility to make a reasonable effort to ensure that a patient receives the care that was recommended," says Dantas.

• If a test is not ordered for any given reason, this situation needs to be documented in detail. The documentation should show that the patient understands the reasoning behind why a test is not ordered.

Dantas says OB/GYNs should remember two important things about their patients: Not all tests are always accurate, and not all patients will do the tests that are ordered.

"Patients and doctors want to make sure nothing is missed. If doctors are diligent and thorough, they are not only providing good care; they are also decreasing their liability, says Dantas. ✦

Executive Summary

Delay in or failure to diagnose was the second most frequent primary allegation in malpractice suits against obstetrician/gynecologists, according to a 2012 survey. Claims typically include these allegations:

✦ failure to perform an adequate physical examination;
✦ failure to find the tumor of concern during an examination;
✦ failure to recommend a referral.

Meningitis has highest payout of 'failure-to-diagnose' claims

Aggressive evaluation, careful documentation help prevent allegations against pediatrician

Pediatrics

Errors in diagnosis remain the most common claim against pediatricians, with 40% of all actions falling into this category, says **James Scibilia**, MD, a Beaver Falls, PA-based pediatrician and member of the American Academy of Pediatrics' Committee on Medical Liability and Risk Management.

"[Diagnostic errors] also represent almost 50% of all claims paid with an average indemnity over $630,000 in 2011," he adds.

Of 404 claims against pediatricians analyzed in a 2013 study, 83 resulted in an indemnity payment and 15 resulted in a payment exceeding $1 million. The annual percentage of pediatricians facing a malpractice claim was 3.1%, compared with 7.4% among other physicians.[1]

Scibilia notes that the five most common conditions in pediatric "failure-to-diagnose" cases are meningitis (38%), appendicitis (20%), congenital anomalies (15%), pneumonia (13%), and brain-damaged infant (12%). Meningitis has the highest average payout: more than $450,000. "Aggressively evaluate patients you believe may have one of these conditions," advises Scibilia. "Careful documentation of your process of these evaluations will be important if an action is brought against you."

One malpractice suit was filed after an 8-year-old's appendix ruptured when he was misdiagnosed with viral gastroenteritis. The claim alleged that earlier diagnosis and surgery would have prevented the resulting peritonitis. **Jonathan M. Fanaroff**, MD, JD, says, "As a result, the suit alleges, the boy had to have multiple surgeries and suffered permanent injury with loss of a portion of his intestines." Fanaroff is associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

Another lawsuit involved a physician who initially diagnosed bacterial meningitis as an ear infection. "The suit

Executive Summary

Common failure to diagnose claims involving pediatricians include meningitis, appendicitis, pneumonia, and brain-damaged newborns.

✦ Recognize that conditions such as meningitis and appendicitis often don't present in classic fashion.
✦ Follow up with patients in a timely manner.
✦ Continually reassess diagnostic reasoning.

alleges that the delay in performance of a spinal tap and timely initiation of intravenous antibiotics would have prevented the 7-year-old patient from becoming blind," says Fanaroff.

Payments significantly higher

Average indemnity for pediatric malpractice is significantly higher than for adults. For example, from 2004-2005, the average child-related malpractice payment was significantly greater than an adult-related malpractice payment ($422,000 vs $247,000).[2]

"Looking at meningitis data, it is clear that there are some trends in that group," says Scibilia. Many patients did not have typical signs and symptoms of meningitis, and 25% had no fever.

"Generally these children are very young, with a mean age of only two years," he adds. "Frequently, there was an absence of mental status changes or neck stiffness, probably because of the young age."

To avoid missed diagnoses lawsuits, Fanaroff says physicians should do the following:

• Recognize that conditions such as meningitis and appendicitis are difficult to diagnose and often don't present in classic fashion.

• Avoid the cognitive error known as "'anchoring," which occurs when a physician latches on to the first diagnosis; such as viral gastroenteritis when the patient actually has appendicitis, or flu or migraine when the patient actually has meningitis. Anchoring may cause a physician to discount physical or lab findings that do not fit with the original diagnosis.

• Follow up with patients in a timely manner, and continually reassess diagnostic reasoning.

The initial contact of a parent by phone or with a nurse triage system was related to higher average payouts. "Litigation related to improper advice, or not recognizing symptoms which should have prompted office or hospital assessment, is at issue," says Scibilia. He recommends these practices:

• Have telephone protocols that are current and followed by staff.

• Recommend that the family be alert to worsening condition or unusual symptoms.

• Have good communication with the caretaker and good documentation of the encounters in the records.

"About 12% of cases were poorly defensible because of poor records or inadequate documentation, particularly of negative findings," says Scibilia.

• Bear in mind that meningitis, appendicitis, and pneumonia are among the most commonly claimed missed conditions and present in a wide variety of ways.

"Your best defense, should a claim be filed, is to have good documentation of negative, pertinent findings as well as positive findings," says Scibilia.

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1. Jena AB, Chandra A, Seabury SA, et al. Malpractice risk among U.S. pediatricians. *Pediatrics* 2013; 131(6):1148 -1154.
2. Kain ZN, Caldwell-Andrews AA. What pediatricians should know about child-related malpractice payments in the United States. *Pediatrics* 2006; 118(2):464-468. ✦

COMING IN FUTURE MONTHS

✦ Allegations in missed deep venous thrombosis claims

✦ What CMS inpatient rules mean for med/mal suits

✦ Why some physicians really need "tail" coverage

✦ More handoffs are increasing malpractice risks

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.

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CME Questions

1. **Which is true regarding claims alleging failure to diagnose claims occurring in the outpatient setting, according to Tara F. Bishop, MD, MPH, assistant professor of public health and medicine at Weill Cornell Medical College?**
   A. Standardizing the way patients are informed of lab results is an unsafe practice.
   B. Enabling patients to access test results from patient portals increases legal risks.
   C. Instructing patients to return if their symptoms don't improve provides a complete legal defense.
   D. The patient's outcome often matters more than the type of error that occurred, in terms of whether the case is defensible.

2. **Which is true regarding claims alleging failure to diagnose cancer, according to Stephen H. Mackauf, JD, an attorney at Gair, Gair, Conason, Steigman, Mackauf, Bloom, & Rubinowitz?**
   A. If a patient's previous refusal of a test or treatment was documented, additional documentation of subsequent refusals is not advisable.
   B. Issues of fact, such as what the physician recommended, are not relevant.
   C. Causation is never a factor in the outcome of a claim.
   D. Patients must be able to prove significant harm as a result of the delay.

3. **Which is recommended to prevent malpractice claims alleging failure to diagnose peritonitis, according to Phyllis Miller, RN, a legal nurse consultant at Robins, Kaplan, Miller, & Ciresi?**
   A. Surgeons should not view the finding of free air in the postoperative setting as a potential cause of concern.
   B. Surgeons should recognize tachycardia as a first potential sign of peritonitis.
   C. Surgeons should never consider infection or inflammation as a potential cause of postoperative ileus.

4. **Which is true regarding claims alleging failure to diagnose myocardial infarction, according to Sandeep Mangalmurti, MD, JD, a cardiologist at Bassett Heart Care Institute?**
   A. Providers have no legal obligation to ensure patients obtain follow-up care.
   B. Providers should clarify to patients that a normal stress test or angiogram does not mean they will not have a future myocardial infarction.
   C. Sending certified letters to remind patients of follow-up care does not meet the legal standard of care.
   D. Physicians cannot be held liable under any circumstances for a bad outcome resulting from the patient's failure to follow up, as long as the non-compliance is documented.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICIAN RISK MANAGEMENT

Misdiagnosis results in $4.2 million verdict for widow

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News: The patient, a 46-year-old man, was admitted to emergency care at a medical center where emergency department (ED) doctors properly diagnosed hydrocephalus, a potentially fatal condition. However, the subsequent treating physician rejected this diagnosis and took substantially less cautious measures. The patient suffered complications and died due to the subsequent treating physician's incorrect diagnosis treatment of the underlying medical condition. His widow brought suit alleging that the subsequent treating physician failed to provide the standard treatment necessitated by the original diagnosis. The defendant physician denied liability. The jury assessed $4.2 million in damages.

Background: In this matter, the patient received emergency care and was correctly diagnosed with hydrocephalus, a buildup of cerebrospinal fluid in the brain. Four doctors, including one neurologist, based this diagnosis upon an MRI and a CT scan, which clearly revealed hydrocephalus. Hydrocephalus is easily treated by insertion of an implanted drainage tube, which removes the excess fluid and prevents ensuing injury. The condition, as evidenced in this case, can be fatal if left untreated.

... the treating physician ignored the opinions of his fellow physicians and failed to properly read the MRI and CT scans.

After this diagnosis, however, the patient went to his subsequent treating physician who rejected the diagnosis. The patient visited the medical center in February 2010 with typical symptoms consistent with the original diagnosis of hydrocephalus: headache, slurred speech, and confusion. These symptoms were not a lone occurrence; the patient suffered multiple previous episodes within the few months prior. Nonetheless, the treating physician opted to merely monitor the patient for a 24-hour period. After this monitoring, the treating physician decided the patient did not have hydrocephalus that required immediate treatment, and he released the patient to his family.

The patient visited this same physician several times in an eight-month period with the same severe symptoms, consistent with those for hydrocephalus, but the physician continually failed to treat the condition with the standard, known treatment applicable for hydrocephalus cases. Instead, the treating physician ordered tests unrelated to the condition and attempted to reach a new diagnosis. Unfortunately, this lack of treatment ultimately led to the patient's death in May 2010.

The plaintiff, the patient's widow, brought suit. She claimed that the treating physician significantly deviated from the standard level of care and that this deviation led to her husband's death. Evidence during the trial revealed that the treating physician ignored the opinions of his fellow physicians and failed to properly read the MRI and CT scans. The defendant physician alleged that the patient was noncompliant and the cause of death was unknown, while the plaintiff's attorney commented that the physician was "breathtakingly

Financial Disclosure: Co-Authors **Damian Capazzola**, **Jamie Terrence**, **Tim Laquer** 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.

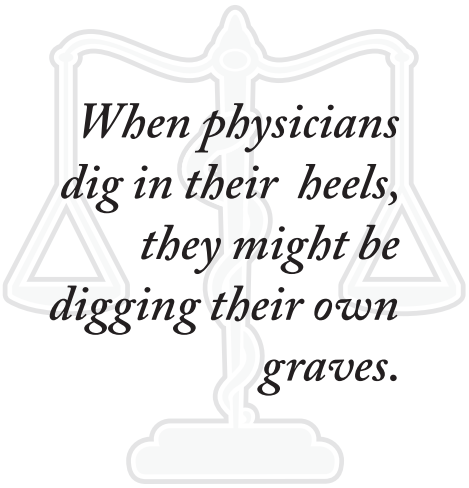
negligent" and made a "fundamental mistake" based on a misunderstanding of the medical condition. The jury clearly agreed. In a unanimous verdict on liability, it found the treating physician 80% liable and the original neurologist 20% liable for failing to follow up based on the original correct diagnosis. It awarded $4.2 million to the widow and her three minor children.

What this means to you: The primary issue for the physician here was to what degree, if any, he was negligent from the failure to diagnose the hydrocephalus condition. Failure to diagnose an illness or condition during the critical period of time where it might be treatable might be the basis for a medical malpractice suit. This is particularly probable when the diagnosis is common or known in the medical community, and diagnosis would be standard among competent physicians. In this case, the condition actually was diagnosed by four prior physicians, which should have led the treating physician to exercise additional care and devote further time to considering the validity of this diagnosis.

Physicians should also follow up with patients when there is an obvious diagnosis that requires urgent treatment. As apparently happened here, allowing a subsequent physician to risk the health of the patient might give rise to liability. Perhaps there is not as much liability as the subsequently negligent physician, but it still is the original physician's responsibility to protect the patient's well-being.

Note also that misdiagnosis is a surprisingly common occurrence, and it is the leading source of successful malpractice claims. An analysis of 25 years of data from the National Practitioner Data Bank revealed that diagnostic errors were the most common type (28.6%) and resulted in the highest proportion of payments (35.2%) in medical malpractice suits. Studies claim that delayed, missed, and incorrect diagnosis may affect 10-20% of cases. The results can be devastating and potentially cause serious harm or death. A 2009 report funded by the federal Agency for Healthcare Research and Quality found that 28% of 583 physician-reported diagnostic errors were life-threatening or resulted in death or permanent disability, while only 31% were minor or insignificant.

The physician is not necessarily negligent because of an error in judgment or because their efforts proved unsuccessful. Radiologists often differ in opinion when reading films. However, in this case the physician was negligent because his error in judgment was due to a failure to perform in accordance with similar professionals acting under the same or similar circumstances, i.e. the original physicians who made the initial diagnosis. This is malpractice. The physician had a duty owed to the patient by his professional license. That duty was breached, and that breach caused injury to the patient.



When physicians dig in their heels, they might be digging their own graves. Saving face and other such ego-driven behaviors are also risk-laden. Allowing the life of your patient to depend on your opinion only, especially when the patient continues to fail, is tantamount to professional suicide. If you second-guess a prior diagnosis, it might be better to err on the side of caution. Subsequent physicians must at least follow up and order tests related to that diagnosis to ensure that it was improper before moving on and ignoring treatment, especially when neglecting treatment can lead to severe injuries or death.

This point does not mean that a past diagnosis needs to be given complete deference. It is still within the treating physician's discretion to follow or reject a previous diagnosis. However, a past diagnosis should be seriously considered and strongly disproven before it is rejected. Consulting other physicians might help to protect a physician against liability in cases such as this one. Additional consultation can give second or third opinions which the treating physician might take into account to better fully and accurately diagnose a patient. Particularly in the case of questioning a prior diagnosis, the physician will be well-served by getting a third opinion that can evaluate the two prior and give input as to the correct course of treatment.

Timeliness of treatment is critical. Questioning or rejection of a diagnosis might be the proper course, but when it is not, misdiagnosis might cause the condition to deteriorate beyond repair. In cases in which death occurs, there is no way to remedy the misdiagnosis, and the physician's liability might significantly increase. Subsequent remedy might help alleviate prior negligent conduct. Given the chance to ameliorate any past misdiagnosis, a physician should take the opportunity, without admitting fault, and properly treat the condition when the correct course of treatment comes to light. The symptoms here displayed over months, and the treating physician failed to order relevant tests. Instead, the physician ordered tests unrelated to the past diagnosis. Again, this is not what a similarly trained physician under similar circumstances would do. The plaintiff's expert witnesses will be severely critical of a physician who deviates from standard practice.

Reference

District Court of Harris County, Houston, TX. Case No. 201207156. Oct. 11, 2013. ✦

30-minute delay of surgery patient results in cardiac arrest, paraplegia, and $2.85M verdict

News: The plaintiff was admitted to a hospital following an automobile accident and scheduled for surgery. An orthopedic surgeon ordered a CT scan of the patient, despite the patient having dangerously low blood pressure. The patient suffered cardiac and respiratory arrest during the delay caused by the CT scan. The plaintiff alleged that the surgeon was negligent because the patient should not have been delayed while in such a fragile state. The defendant surgeon denied liability. The jury awarded $2.85 million in damages.

Background: In this matter, the plaintiff suffered severe injuries caused by an automobile accident and was rushed to a hospital for urgent treatment. His injuries included severed arteries in his forearm and knee damage. However, doctors alleged that the forearm injuries were far more serious and life-threatening than the knee injury, which could have been tended to once the severed arteries were addressed.

The patient was in the preoperative holding area awaiting surgery. His vital signs were dangerously unstable; his blood pressure was 72 over 56. Medical experts testified at the trial that this reading indicated that the patient was on the verge of a cardiac arrest. Nevertheless, an orthopedic surgeon did not recognize this warning sign and ordered the patient to be moved from the holding area to have a CT scan. This order caused a 30-minute delay before his arm could be tended to.

The unnecessary delay caused the patient to suffer cardiac and respiratory arrest. Luckily, he was able to be resuscitated by an emergency department physician and an anesthesiologist, but the damage already was done. The patient had zero blood pressure and pulse, and he was completely without blood flow to his body for between eight and 27 minutes, according to differing witness reports. Serious injuries resulted from this blood flow deprivation: a portion of the patient's spinal cord died, which caused permanent paralysis from the waist down.

The plaintiff alleged that he should not have been moved from the preoperative area to have the CT scan because his vitals were unstable. According to an attorney for the plaintiff, even doctors who testified for the defendant surgeon conceded that the patient's vital signs indicated that he should not have been moved. Nevertheless, the defendant surgeon denied liability and fault for the injuries sustained by the plaintiff. The jury awarded $2.3 million to the plaintiff and $550,000 to the plaintiff's wife, who serves as the sole caregiver to her paraplegic husband. Prior to trial, the plaintiff entered into a settlement agreement with the hospital where the malpractice occurred, and the details of that settlement are confidential.

The patient had zero blood pressure and pulse, and he was completely without blood flow to his body for between eight and 27 minutes ...

What this means to you: Physician liability easily might rise solely from one's decision regarding a patient's treatment, and negligence might be claimed when a physician chooses to pursue one avenue of treatment while delaying another. Emergency situations that necessitate quick decisions must be considered thoroughly, as these situations are ripe for judgment calls that may be second-guessed by patients after the heat-of-the moment decision.

The circumstances of this case raise a question as to who was in charge. In trauma cases, when the patient arrives in the emergency department, the trauma surgeon first on the scene is generally in control. If the hospital is not a designated trauma center, then the ED physician assigned to the patient usually has the helm. That physician or trauma surgeon makes decisions based on the most life-threatening issue, in this case, the bleeding from the severed arteries. The orthopedic surgeon typically should not have been called in until after those were repaired. Consultants called in on trauma cases cannot override the medical plan of care determined by the primary physician. In addition, patients with severed arteries and life-threatening blood pressure readings should not go to a preoperative holding area. They should go immediately to the operating room, where a skilled vascular surgeon can quickly repair the damage and maintain critical blood flow and pressure.

Physicians must be especially cautious when dealing with unstable patients: a patient's vital signs act as potent warnings of impending danger. The utmost care should be given to stabilize a patient's cardiovascular system before other actions are taken that might jeopardize it. When movement might risk a patient's health, it should be minimized and eliminated if possible. Additional tests that might interrupt necessary care should be avoided.

Prioritizing patient care plays a critical role in a physician's work. Treating injuries that might be life-threatening must be done first, while treating non-serious injuries can be

delayed. The physician's focus must be on the most urgent conditions. The surgeon's decision in this case to treat a non-emergent knee condition created the negligence liability/emergency situations, including serious bleeding caused by severed arteries, must be given priority. Damages in a negligence case are directly related to the injuries suffered by the patient, so in a situation in which damages are inevitable, the choice should be made to eliminate or reduce the largest amount of damages possible. More serious injuries lead to higher damage awards from juries. This situation might be prevented by focusing treatment on those injuries deemed more serious. If a plaintiff brings a negligence action for non-treatment of minor injuries, the damages against the physician likely will be insignificant in comparison.

An interesting note from this case relates to case management and settlement. Here, the hospital where the malpractice occurred negotiated a settlement with the patient before trial, while the individual surgeon did not negotiate a settlement. This situation likely greatly reduced the overall amount of money and negative publicity that the hospital received as a result of the case. Settling prevents numerous expenses, including high attorney's fees for months or years of litigation, which might result even if the defendant is found not liable. Keeping the case out of trial also prevents negative headlines that publicize such large jury verdict amounts. Cases resulting in multimillion dollar verdicts grab the media's attention and give physicians and hospitals negative treatment and damaged reputations.

In certain cases, plaintiffs might not be willing to settle because they have a strong case and anticipate a large jury verdict in their favor. Nevertheless, in these cases, physicians and hospitals should strongly seek settlements when the facts are against them. A sympathetic plaintiff, such as a paraplegic plaintiff, can result in large, multimillion dollar verdicts against defendants. Thus, when faced with this potential, physicians should consider pre-empting the jury and avoiding the possibility of huge verdicts by settling the case beforehand when able.

Defendants in such cases also can try to posture the case as a bench trial before a judge, in which case the judge not only makes rulings on legal issues but also acts as the finder of fact in determining liability and the amount of damages to award, if any. The traditional line of thinking is that judges are less likely to award large damages than juries. For this reason, plaintiffs (and the counsel who typically represent them) usually are unwilling to waive their right to a jury trial. However, bench trials typically proceed much more efficiently than jury trials, with the impact of saving the parties the time and money of trying the case. At least some plaintiffs (or their lawyers) might be interested in saving money and time on the front end, so making the request might be a reasonable strategy. Also, experienced legal minds might reasonably disagree on whether judges presiding over bench cases are less likely to award large damages. The advantage to a jury trial is that a number of people, whether it be six or nine or 12, need to be convinced and come to an agreement. At least in theory, the various members of a jury act as a check on one another. In a trial in which a single judge determines everything, even though that judge has years or decades of legal training or experience, that judge is still human being. The judge, for whatever reason (of which he or she might not even be conscious), might seize upon one particular fact or case theme and hammer the defendants with a larger award than a jury would have rendered. Thus, it is important for defendants and their counsel to know the history and idiosyncrasies of the judge in deciding whether to pursue a bench trial.

There might be circumstances in which liability seems clear-cut and public airing of the facts likely will create a public (and permanent) record of ugly facts that led to an adverse outcome. In those situations, defendants can consider suggesting a private dispute resolution mechanism such as "high-low arbitration," in which the parties agree to a streamlined and potentially confidential arbitration process. Another advantage of such a process would be eliminating the significant costs of pretrial discovery for both sides. However, involving a paid arbitrator will impose a cost of dispute resolution not associated with staying in the court system.

In high-low arbitration, the parties contract with an arbitrator to receive evidence about the circumstances of the case and render an award. The arbitrator might or might not know about the "high-low" aspect of the parties' agreement, but either way, the effect of "high-low" arbitration is to guarantee the plaintiff a minimum recovery and to limit the defendants to a maximum exposure. If the arbitrator's award lands in the middle of the range, then that award stands. If the award is outside the range one way or the other, then the parties agree to pay or accept the minimum or the maximum. Such a process also might be further adjusted to refine the amounts of the awards against multiple physicians, which might become an issue in jurisdictions where medical boards attribute the full amount of the award to each physician named in a malpractice action unless the settlement or judgment or arbitration award specifically apportions an amount to each particular physician named in the action. More generally, it is also necessary to consult with qualified counsel about the laws and court rules that apply in his or her jurisdiction of practice, as reporting requirements, discovery rules, or other statutes or regulations might limit or eliminate the ability to keep awards or the underlying facts confidential.

Reference

Circuit Court of Horry County, SC. Case No. 2011CP2607403. Sept. 16, 2013. ✦

PATIENT LABEL

❶ **INFECTION**	**NEW SIGNS OF INFECTION (✓ = yes)**		**A / P**	**PRN**
	NEW suspected infection?			
	NEW worsening current infection?			
❷ **SEPSIS** = 2 or more signs of SIRS + Infection	**TWO OR MORE NEW SIGNS OF SIRS (✓ = yes)**		**A / P**	**PRN**
	Temperature > 38° C or < 36° C			
	Heart rate > 90 beats/minute			
	Respiratory rate > 20 breaths/minute			
	WBC count over 12,000/mm^3 or under 4,000/mm^3			
❸ **SEVERE SEPSIS** = Organ Dysfunction + Infection	**NEW SIGNS OF ORGAN DYSFUNCTION (✓ = yes)**		**A / P**	**PRN**
	Worsening mental status			
	SpO2 < 90% on RA or requires more O2 to maintain SpO2 > 90%			
	Decrease in urine output			
	SBP < 90 mmHg or < 40 mmHg below baseline			
	MAP ≤ 65 mmHg			
SCREEN RESULTS	❶ + ❷ OR ❶ + ❸ = **(+)** ★ Complete (+) Screen Form ★	Time/ Initials	+	+
	Does not meet criteria for Sepsis Screen = **(-)**	Time/ Initials	-	-

MD called for (+) screen:_____

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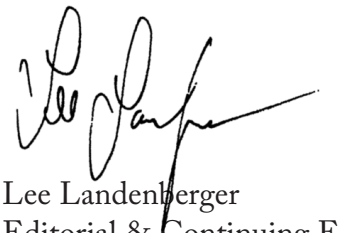

Lee Landenberger
Editorial & Continuing Education Director