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'Anchoring' errors lead to misdiagnoses and many successful malpractice claims

Patients harmed by incorrect assumptions

The most dramatic case that **Steven M. Levin**, JD, founder and senior partner at Levin & Perconti in Chicago, ever handled involving the tragic consequences of "anchoring" when a pediatrician failed to diagnose a young child with cystic fibrosis. Anchoring is a cognitive error that occurs when a physician latches on to the first diagnosis that comes to mind.

"The doctor sent the child for a test that, at best, was 50% accurate at diagnosing cystic fibrosis," says Levin. "When the test came up negative, the doctor incorrectly assumed the child did not have cystic fibrosis."

The physician then spent years trying to interpret the facts of this child's clinical condition into little-known illnesses, and never retested the child because he "anchored" on the negative result of the previous test. "Even in his deposition, he would not acknowledge that his incorrect diagnosis was based on the faulty test," says Levin.

Wachter also advises physicians to ask, "If I'm wrong, what is the worst diagnosis that I could be missing here?"

Robert M. Wachter, MD, professor and associate chairman of the Department of Medicine at University of California — San Francisco, has reviewed many malpractice claims whose root cause was anchoring. "I'm seeing such anchoring occur more and more often in training settings because of the house staff duty hour reductions," he reports.

About one-third of the patients on a typical ward team now will be admitted by a different set of physicians on night shift and then handed to the team that will have primary responsibility at 8 a.m. "Even with very smart residents, the night doctor will get something wrong about one time in five," says Wachter.

It is terribly hard for the day team, who are busy accepting several handoffs, to "rethink things and ask, 'Does this all really make sense?'" says Wachter. "Heart failure with a [brain natriuretic peptide level] of less than 100? Low blood pressure from sepsis with no fever or elevated [white blood cell count] ... Really?"

INSIDE

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Mental tricks needed

It is not uncommon for physicians to accept their own diagnosis or that of a trusted colleague, even in the face of evidence pointing to an alternative.

"We need to create mental tricks to push ourselves to not take the 'easy' way out, but to really question things," says Wachter.

Wachter teaches physicians to question everything; taking the view that their predecessor hasn't made any diagnoses, but rather, has developed some hypotheses. He advises physicians to ask the question, "What would I expect to find on the physical exam?" after hearing the patient's history and a similar question before viewing laboratory or X-ray results.

"This allows physicians to retain the capacity for surprise," he says, such as recognizing that they would have expected crackles at the base and a fever with a diagnosis of pneumonia. The fact that the patient's lungs are clear then would lead the physician to suspect pulmonary embolism.

Wachter also advises physicians to ask, "If I'm wrong, what is the worst diagnosis that I could be missing here?"

Shortcuts lead to errors

"Heuristics" are shortcuts that physicians use to make complex situations easier to tackle, but these shortcuts can lead to cognitive errors, warns **Alexis Ogdie-Beatty**, MD, assistant professor of medicine and epidemiology in the Division of Rheumatology at the University of Pennsylvania in Philadelphia.

"There are several cognitive errors that physicians need to be aware of," she says. These include:

• **framing bias** — letting what others tell you about a patient influence your thought process without thinking through the process on your own;

• **diagnostic momentum** — assuming a previously noted diagnosis is correct without rethinking the diagnosis;

• **visceral bias** — allowing negative or positive feelings about a patient to influence the diagnosis made.[1] *(For more information on cognitive errors that can lead to malpractice suits, see related story, p. 87.)*

Ogdie-Beatty and colleagues teach workshops to resident physicians in which she suggests asking these four questions to avoid cognitive bias after arriving at a potential diagnosis: What else can it be? Is there anything that doesn't fit? Is it possible that there's

Executive Summary

Successful malpractice suits are resulting from "anchoring," which is a cognitive error that occurs when a physician latches on to the first diagnosis that comes to mind. Physicians should consider these practices:

✦ Ask "What would I expect to find on the physical exam?" after hearing the patient's history.

✦ Consider the worst diagnoses that could be missed.

✦ Seek contrary evidence, instead of just confirmatory evidence.

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Editorial Questions

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more than one thing going on? Is this a case in which I need to slow down?[2]

"Physicians should also reflect on their thinking process," says Ogdie-Beatty. "They should consider times when they may be most at risk for these errors, such as when they are unusually busy or distracted."

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Cognitive errors: They're the 'new frontier' in safety

Understanding how cognitive errors and biases can result in misdiagnoses and patient harm is the "new frontier" in patient safety, says **Luke A. Perkocha**, MD, MBA, a pathologist at Kaiser Permanente Medical Center in San Rafael, CA.

During the last decade, the focus on reducing patient harm has been largely on correctable "systematic" causes of error such as medication errors and wrong-site surgery, says Perkocha. Solutions such as checklists, improved medication labeling, and computerized physician order entry (CPOE) have reduced the likelihood of these errors.

"Now that these 'low-hanging fruit' have been picked, focus is shifting to the cognitive processes of physicians and how predictable pitfalls or biases might lead to erroneous or missed diagnoses, thus cascading into wrong treatment and patient harm," says Perkocha. He gives two examples of recent malpractice claims involving cognitive errors:

• Two specimens were obtained from the same organ on each of two patients on the same day, but they were mixed up in the laboratory. The pathologists looking at the specimens each received one specimen on the correct patient and one on the incorrect patient.

Both pathologists, each unaware of the existence of another similar case, arrived at a diagnostic conclusion based on the first specimen they viewed. "When faced with discordant features of the second specimen, they viewed it through the prism of a diagnosis to which they were anchored," says Perkocha. Both physicians concluded that the second biopsy supported their initial conclusion.

"Both exerted great intellectual effort to explain away the discordant clues, by making allowances for artifact, different preparations, different parts of tumor sampled," says Perkocha.

Neither considered the possibility that there had been a lab error and that the diagnoses represented by the two samples they each viewed were different. They both missed the opportunity to discover the laboratory error; instead, they compounded it. "This case was a natural experiment that elegantly demonstrated the effect of anchoring bias," says Perkocha.

• When a patient presented with low back pain, the primary care physician anchored on his initial working diagnoses of musculoskeletal and disk disease and scheduled the patient for physical therapy.

"He missed the fact that the patient had a mild fever recorded by the nurse checking vital signs," says Perkocha. The possibility of a spinal epidural abscess was not considered, and the patient progressed to serious complications.

The data supporting the effectiveness of any specific approach to avoiding cognitive errors still are scarce, says Perkocha. These strategies have been suggested in the growing literature on diagnostic error to help physicians avoid cognitive errors and malpractice claims:

• Be aware of overconfidence.

"Cognitive psychology studies show that we all underestimate the odds we could be wrong; physicians are particularly prone to this," says Perkocha. Some studies have even correlated a higher degree of confidence with a greater likelihood of being wrong, he adds.

"Recognizing that the odds of being wrong are not negligible, even when we feel confident, can help us act accordingly," says Perkocha.

• Actively challenge your assumptions.

Perkocha suggests that physicians throw out a key early piece of evidence that led themselves or others to the diagnosis, and see if the diagnosis still fits all the other data.

• Consider important potential misses.

Physicians should ask themselves, "Is there a catastrophic diagnosis I should consider?" and focus on diagnostic errors that lead to greatest harm, such as unsuspected vascular events, infections, and cancer.

• Actively counter "confirmation bias" by seeking contrary evidence instead of just confirmatory evidence.

Perkocha says a good question for physicians to ask is, "What evidence, if sought, would disprove my diagnosis?"

• Shift your perspective.

Physicians can ask, for example, "What if I looked at this case as if I were a cardiologist instead of a gastroenterologist? What would I think of?"

"It is often helpful to take stock of one's own state of mind, level of fatigue, and distraction at the point of making a consequential diagnosis or dismissing a symptom/compliant as trivial," says Perkocha. "This is the personal equivalent of a preoperative time-out." ✦

Claims alleging patient wasn't told of radiology study findings

In one malpractice case, a 71-year-old female had an angiogram of her chest in February 2012 to rule out a pulmonary embolism (PE). The PE was ruled out, but an incidental finding of a 3.4 cm left axillary mass was noted on the report.

"The primary care physician documented his review of the report but failed to notify the patient of the mass," says **Nancy Meyers**, JD, an attorney at Ward Black Law in Greensboro, NC. Six months later, the patient palpated the mass and sought treatment that revealed that she had Stage 4 metastatic breast cancer.

In a similar case involving an 82-year-old man, a CT of the chest revealed an opacity within the anterior right lower lobe with somewhat nodular appearance. Follow-up evaluation was recommended in the report, which was received by the primary care physician. However, no report was made to the patient regarding the nodular opacity and no follow-up evaluations were conducted.

"Almost three years later, the patient developed pulmonary symptoms. A CT of the chest confirmed lung cancer in the right lower lobe. The patient expired later that year," says Meyers.

In both of these cases, the physicians documented that they received the report, signed off on the report as having been reviewed, yet failed to take action as recommended in the report. "This made the cases very difficult to defend," says Meyers.

Systems errors can harm

Often, there is an appropriate read on a study, but a systems error leads to harm of the patient due to delayed treatment or diagnosis, says **Jennifer L'Hommedieu Stankus**, MD, JD, an attending physician at Group Health Physicians, a Seattle-based multispecialty group practice and former medical malpractice defense attorney.

"Missed diagnosis on radiologic studies is a common area of liability, and it is one that will continue to be, especially if safeguards are not put in place," she says.

L'Hommedieu Stankus recommends these practices:

• It should be standard operating procedure to get a call back on all radiology studies with a positive finding, including over reads that might be done the following day.

• There should be mechanisms in place for specific diagnoses, such as lung nodules, so that follow-up on the patient is set in motion and so that the patient is made aware of the abnormal finding.

As a standard practice, physicians always should read their own studies, read the radiologist's interpretation, and speak with the radiologist if there are any questions, advises L'Hommedieu Stankus.

"If the radiologist is not available, and you still have concerns or questions about the study, run it by another physician such as a general surgeon or a neurologist, depending upon what it is you are looking for," she says.

Liability for a "missed read" might fall solely on the radiologist or both the radiologist and the physician, depending upon the situation, says L'Hommedieu Stankus.

"The truth is, that even when a radiologist, a specialist in reading studies, misses a diagnosis, the physician caring for the patient will also be named," she says.

Once a radiologist notifies a physician about an abnormal finding, it becomes the responsibility of that physician to get the information to the patient, adds L'Hommedieu Stankus.

"How liability is apportioned will depend, in part, on what state the physician is in," she adds. "State law on liability varies, even on joint and several liability issues." ✦

Executive Summary

Missed diagnosis on radiologic studies is a common area of liability, with claims often alleging the patient wasn't informed of positive findings. Physicians should consider these practices:

✦ It should be standard operating procedure to get a call back on any radiologist study with a positive finding.

✦ There should be mechanisms in place for specific diagnoses to ensure follow up.

✦ Physicians should always read their own studies and the radiologist's interpretation.

Med/mal claims costs are surprisingly stable for 2014 — Claims against internal medicine doctors rising

Malpractice claims against internal medicine physicians are increasing, according to the 2013 PIAA Data Sharing Project Risk Management Review, a database that captures medical malpractice claims data.

"When we talk about medical liability, the focus is on obstetrics, general surgery, orthopedic surgery,

and anesthesiology. But we are starting to find that internal medicine is being reported more and more," says **P. Divya Parikh**, director of research and risk management at PIAA, an insurance trade association.

If an acute myocardial infarction is missed after the patient goes to the emergency department, for example, the patient's primary care physician is also likely to be named in a resulting malpractice claim.

Parikh attributes this situation, in part, to patients' higher expectations for medical encounters. "Ten years ago, people wouldn't necessarily sue if the internal medicine doctor didn't pick something up. People are now asking, 'Who is the person in charge of the care?'" she says. "This is an area we are keeping our eye on."

Costs are stable

The cost of medical malpractice is growing at the slowest rate in 14 years, according to Aon Risk Solutions' 2013 Hospital and Physician Professional Liability Benchmark Analysis. The analysis looked at claims paying out a maximum of $2 million because that amount is typical of hospitals' retained insurance layer. Here are key projections for 2014:

• The projected loss rate for hospital professional liability is an estimated $2,940 per bed. The frequency of claims is projected to be 1.67% per occupied bed equivalent, and the severity of each claim is projected to be $176,000.

• The loss rate for physician professional liability is projected to be $6,030 for each class 1 physician, with a frequency of 2.97% per class 1 physician. The severity of these claims is expected to be $203,000.

• The projected loss rate for hospital general liability is expected to be $119 per occupied bed equivalent. The average general liability claim is expected to be $36,000.

• Obstetrics (OB), the most costly specialty in terms of malpractice claims in 2013, is expected to again be one of the costliest in 2014. Projected loss rate for hospital obstetrics claims in 2014 is expected to be $171 per birth.

Erik Johnson, FCAS, MAAA, Aon Global Risk Consulting's assistant director and actuary, says, "While OB comprises only about 10% of overall claims, in looking at 'catastrophic' claims, the share that comes from OB continues to grow." Of claims resulting in payouts of more than $5 million, 43% involved hospital OB units.

• Projected loss rates vary greatly across the country. Florida ($7,440) and Pennsylvania ($4,720) have projected loss rates significantly higher than states such as Indiana ($800) and Minnesota ($810).

Severity of claims rising

Historically, malpractice costs tend to be cyclical and have trended sharply in positive and negative directions in the past, says Johnson. However, the number of claims projected for 2014 is "absolutely flat," he says, and the severity is rising at 2.5% a year.

"That is the lowest trend rate that we've ever reported on," Johnson says. "In fact, we don't even believe that rate is driven by claim payments, but by the expenses associated with defending a claim." *(See related story, below, on the trend of physicians' malpractice insurance being covered by hospitals.)* ✦

Executive Summary

Malpractice claims against internal medicine physicians are increasing, according to a recent report. Another analysis found that costs are surprisingly stable.

✦ A significant percentage of "catastrophic" claims come from obstetrics.
✦ Projected loss rates vary greatly across the country.
✦ Physicians are increasingly being insured by hospitals.

More MDs insured by hospital programs — Risk management practices being standardized

Aon Risk Solutions' Hospital and Physician Professional Liability Benchmark Analysis, which has been reported for 14 years, is generally aimed at a hospital risk management audience. However, the data has become much more relevant for physicians in recent years, says **Erik Johnson**, FCAS, MAAA, Aon Global Risk Consulting's assistant director and actuary.

One reason is that many physicians are moving out of the individual malpractice insurance market because they're being covered by the hospital's plan instead. According to Aon's 2013 analysis, 70% of hospitals employ a large number of physicians and use their own self-insurance vehicles to insure them.

"When physicians move into the hospital's insurance, the hospitals try to improve the uniformity of their risk management practices across their organization, including physician offices, to improve claim results," says Johnson.

Increasingly, risk management approaches used by physicians are being influenced by hospitals, due to

the physicians being insured by the hospital's program. "Therefore, they have a very direct link in the claim outcomes of their employed doctor," says Johnson.

Hospitals are hoping to save costs by jointly defending malpractice claims, instead of having separate opposing counsel for the physician defendants and the hospital. That approach might save on defense costs and also might improve outcomes because there is no "infighting" among defendants, says Johnson.

"There is some evidence that the cost of risk does seem to be lower for the combined group," he notes. "In general, the costs related to named physicians are decreasing; and in some cases, we believe, shifting to the hospitals." ✦

Med/mal claims are alleging failure to prevent or treat DVT

Robert J. Conroy, JD, MPH, an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ, has handled multiple claims alleging that physicians ordered insufficient prophylaxis or otherwise failed to prevent deep vein thrombosis (DVT).

"Many times, the prophylaxis was sufficient but not fully recorded and documented," says Conroy." Also, many times a different course of treatment was considered and ruled out, but with no supporting documentation."

One case involved a young woman with no contributory history who had minor same-day surgery. "She died from a DVT that developed shortly after discharge," says Conroy. "The decision making was not adequately documented, and the case was settled."

Internists and surgeons need to communicate about the patient's condition following surgery and the particulars about DVT prophylaxis, emphasizes **Peter Espey**, JD, an associate at Sharp & Mahoney in Cedar Knolls, NJ. Espey's firm has defended several physicians named in lawsuits alleging that DVT prophylaxis should have been prescribed after a surgery or that the patient should have been kept on the prophylaxis longer.

The cases involved patients who were put on blood thinner to prevent DVT after surgery. "Either there is a disagreement for clinical reasons about how long to keep the patient on the blood thinner, or there is a mistake and the patient is taken off too soon," says Espey. Other cases have alleged failure to diagnose or suspect DVT after examination. These are typical issues in claims involving DVT:

- Whether ultrasonography was ordered for patients when DVT is suspected.
- When, what type, and for how long DVT prophylaxis was prescribed.

"There does appear to be differences of opinion between specialists as to which medication should be used and how long to use it," Espey says. This disagreement means the jury has to evaluate whether it was a reasonable exercise of medical judgment for the physician to discontinue the medication at a certain point in time.

"There may have been good reasons to have discontinued the blood thinner," says Espey. "Thorough and clear documentation is helpful."

The idea that a blood thinner should have been used to prevent a blood clot can be appealing from a plaintiff's perspective. "This type of allegation can be easier to present to a jury through expert testimony than other more complex alleged deviations from the standard of care," Espey explains.

- The time and method of communication and what was communicated.

Documentation of the communication between physicians in the different specialties can prove crucial, says Espey, as well as communication between the physician and the patient.

"This includes the nurses and people working for the physicians," says Espey. "Without the documentation, it is hard for them to remember what happened, or they may not have been told." *(See related stories on practices that increase legal risks, below; and documentation that can help to defend a missed pulmonary embolism claim, p. 91.).* ✦

Executive Summary

Claims involving deep vein thrombosis typically allege that physicians ordered insufficient prophylaxis or otherwise failed to prevent the condition.

- Expert witnesses might disagree over which medication should be used and how long to use it.
- Physicians should document reasons for discontinuing blood thinners.
- Patients with large blood clots should be referred to an interventional radiology specialist.

These practices put MDs at risks for missed DVT claims

The most important short-term risk of deep vein thrombosis (DVT) is the development of pulmonary embolism (PE), notes **Suresh Vedantham**, MD, professor of radiology and surgery at Mallinckrodt Institute of Radiology and Washington University School of Medicine in St. Louis, MO.

"PE is a leading cause of unexpected

in-hospital death," he says. "A significant number of DVT and PE cases are preventable by use of blood-thinning drugs and leg compression devices in patients who are at risk." Here are practices that put physicians at risk legally:

• Failure to administer DVT prophylaxis.

Many major risk factors for DVT are well known. These risk factors include recent surgery, recent trauma with bony fractures, cancer, immobilization from medical illness, pregnancy, and use of hormonal agents such as birth control pills.

"Within the context of a hospital admission, patients with these conditions are at significant risk of developing DVT and/or PE," says Vedantham. Studies show that less than half of patients who are at risk actually receive the preventive measures, however.[1-3] "Failure to administer DVT prophylaxis is common and certainly puts physicians at medicolegal risk," says Vedantham. "Many strategies have been employed to try to get physicians to do a better job of this, but the results have been patchy."

One approach is to make routine assessment of every patient for their risk of DVT/PE a standard procedure upon hospital admission. "Overall, greater awareness of the risk of DVT/PE among physicians would be helpful," says Vedantham.

• Late diagnosis of DVT.

DVT should be considered in any patient with pain, swelling, or cramping in the legs, especially if it is in just one leg, underscores Vedantham. The combination of clinical indicators, blood test, and ultrasound is effective in diagnosing DVT, he says.

"But the key is that the physician needs to think of it in the first place," Vedantham says. "Failure to consider the diagnosis and initiate treatment in a symptomatic patient can be fatal and is another potential medicolegal risk."

• Lack of close follow-up care.

"The quality and rigor of post-discharge care in the U.S. varies widely," says Vedantham. DVT patients put on blood-thinners are often readmitted with recurrent or progressive DVT or PE due to simple failure to take the drugs. This situation occurs due to a combination of poor instructions to patients, problems with accessing the drugs due to insurance barriers, and lack of close follow-up during the initial weeks to ensure that patients are taking the drugs and that their drug levels are appropriate, says Vedantham.

"Also, drug levels fluctuate a lot, so patients' blood can get too 'thin,' making them prone to bleeding," Vedantham says. "The occurrence of recurrent DVT, PE, or a bleeding complication could be attributed to a physician's failure to put in place a suitable monitoring plan."

• Failure to refer patients to a specialist.

About 40% of patients with a DVT will develop a late complication called post-thrombotic syndrome (PTS), which can permanently impair walking, says Vedantham.[4]

"Proper treatment of the DVT with blood thinners probably helps to prevent PTS, but it is not sufficient in many cases," explains Vedantham. He says patients with large blood clots should be referred to an interventional radiology specialist for consideration for more aggressive clot removal procedures to optimally preserve leg function and prevent PTS.

"It is likely that failure to do this will carry medicolegal risk to a physician, since PTS can be a permanent disabling condition," says Vedantham.

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This documentation made missed PE claim very defensible

A primary care physician sued for failure to diagnose a pulmonary embolism (PE) was able to successfully defend the case, despite the fact that the patient died 30 minutes after leaving the physician's office.

"It was a very sympathetic case, as the man died in front of his young children at a park," says **Tammi J. Lees**, Esq., an attorney with Roetzel in Cleveland, OH.

The physician was able to show that he spent a considerable amount of time with the patient. "Although he had a differential diagnosis that included PE, he was able to adequately explain why PE was low on the list and why lung cancer and pneumonia were highest on his list," says Lees. Here are the facts of the case:

The 44-year-old patient presented to his family practice physician with a principle complaint of shortness of breath with exertion. The patient related a two-week history of rib pain after lifting heavy steel plates at work, blood in his sputum, and shortness of breath.

The physical exam was unremarkable with normal lower extremities, and only mild tachypnea and exertional dyspnea. "Our physician noted that the resting pulse oximetry was 93%. The pulse oximetry on exertion was 78%, but recovered quickly back to 93%," says Lees.

The physician explained to the patient that although PE was on his differential, the most likely cause of his symptoms was resistant pneumonia or lung cancer. A complete blood count was ordered, and blood was drawn at the physician's office, but results were not available that day. The physician arranged for a chest CT scan at the hospital two days later and prescribed an antibiotic.

"The patient passed out at a park 30 minutes after leaving our physician's office," says Lees. "After being transported to the hospital, he became unresponsive and died." An autopsy confirmed that the patient died from a PE.

The resulting malpractice suit alleged that the physician failed to diagnose the PE and failed to send the patient immediately to the hospital to rule out a PE. This documentation allowed him to successfully defend the case:

• The physician clearly documented his differential diagnoses: (1) resistant pneumonia; (2) lung cancer; (3) PE.

• His documentation also corroborated his explanation as to why he had PE lowest on the list and why it was reasonable for him not to send the patient to the hospital for an urgent CT of the chest or ultrasound of the legs to rule out the imminent life-threatening condition.

• The history of present illness was documented. The patient was seen by two physicians within the previous two weeks and was diagnosed with pneumonia.

• Family, social, and medical history was discussed with the patient and relevant history was documented: that the patient's father died from lung cancer and the patient was a 25-pack a year smoker with no family history of clotting disorders.

• The physician documented his physical findings and assessment.

Notably, he documented that his exam of the lower extremities was normal and unremarkable, with no edema or swelling, which would not be consistent with DVT.

"Although the absence of this finding does not mean there is no DVT, its presence would have increased the possibility of DVT," says Lees.

During his deposition, the physician admitted that the decrease in the pulse oximetry on exertion and history of blood in the sputum were consistent with a PE. "However, he further explained that each of these findings is more consistent with the established diagnosis of pneumonia," says Lees. ✦

Incomplete care linked to failure-to-diagnose claims

Surge of volume under ACA could increase risks

Routine blood test results are reported to a primary care physician following a patient's annual physical examination, and they show significantly elevated prostate specific antigen (PSA). The results inadvertently are placed into the office chart, without physician review. The patient is not notified of the results or advised to make a follow-up appointment.

"The patient assumes that 'no news is good news' and fails to call the practice, despite having been instructed to do so at the time of his physical examination," says **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company, a Napa, CA-based medical malpractice insurer.

When the results are discovered two years later, the patient has developed an advanced stage of prostate cancer. "The prognosis for a favorable outcome are now severely diminished," says Cahill. This scenario is a common one in many malpractice claims seen recently at The Doctors Company.

Changes resulting from the Affordable Care Act (ACA) make it especially important for physicians to ensure patients receive continuity of care for acute and chronic conditions, Cahill emphasizes. "Millions of additional individuals will be seeking care from a fixed pool of providers, stressing an already-burdened system," he says. "Incomplete follow-up evaluation and care promote greater risks for poor clinical outcomes."

Data goes unaddressed

Too often, an "ad-hoc" process is used to communicate at handoffs, such as when patients go from a rehabilitation facility to outpatient care, says **Tejal Gandhi**, MD, MPH, CPPS, president of the National Patient Safety Foundation and associate professor of medicine at Harvard Medical School in Boston.

She recommends physicians use a

Executive Summary

Changes resulting from the Affordable Care Act (ACA) make it especially important for physicians to ensure patients receive continuity of care for acute and chronic conditions. Physicians should consider these practices:

✦ requiring patients to sign an agreement for "conditions of treatment" at the outset of care;

✦ having procedures in place to reconnect with patients who fail to keep scheduled appointments or obtain requested laboratory testing;

✦ counseling patients in the event of continued non-adherence.

template to ensure key pieces of information are communicated and use "warm" handoffs such as a person-to-person phone call instead of just sending the patient with paperwork.

Gandhi says malpractice suits often result because providers are unable to "close the loop" with test results and referrals. "If you order something, make sure that if it doesn't get done, you know it," she advises. "Breakdowns in that process can lead to missed or delayed diagnosis."

Electronic medical records vary as to their ability to do this well, notes Gandhi, who adds that if a practice uses a manual process, it can in some cases be offloaded to others in the practice so the burden isn't solely on the physician.

Plaintiffs' attorneys frequently attempt to prove that systems errors, breakdowns in communication, or lack of attentiveness by healthcare providers were the cause of the patient's injuries, says Cahill.

"Important patient history or critical laboratory data that is not properly addressed, and that eventually leads to harm, can ultimately result in a jury finding that the care in question was substandard," he warns. *(See related story, below, on reducing legal risks.)* ✦

Avoid suits by involving patients in their care

To reduce liability risks, physicians should require patients to sign an agreement for "conditions of treatment" at the outset of care, in which individuals are advised of the expectations of the practice, advises **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company, a Napa, CA-based medical malpractice insurer.

The exact language of the agreement depends upon the nature of the practice and the patient population, says Cahill, but physicians generally should require that individuals agree to do the following things, as a pre-condition of being accepted as patients:

- Keep all scheduled appointments.
- Follow up as recommended with specialty referrals.
- Complete all prescribed courses of medication and therapy.
- Promptly notify the practice of any significant changes in their condition.
- Pay for professional services, including all insurance copays, at the time of each visit.

Cahill also recommends that physicians use these approaches to reduce legal risks:

- Draft policies to ensure that test results are timely reviewed by the ordering provider, with prompt patient notification as indicated.
- Have procedures in place to reconnect with patients who have failed to keep scheduled appointments or obtain requested laboratory testing.
- Counsel patients in the event of continued non-adherence.

"As a last resort, termination of the individual from the practice may be needed," says Cahill.

- If patients refuse care, have them sign an acknowledgement that they were offered a specific type of treatment or therapy, and that after an explanation of the options as well as the risks and benefits associated with each, the patient voluntarily declined further treatment.

The form should be dated and witnessed by the physician or a nurse, says Cahill. If the patient refuses to sign the informed refusal, the physician should document the discussion in the chart, including the patient's refusal to sign the acknowledgment.

"Lawsuits are less likely to be filed where the records demonstrate that the clinicians undertook all reasonable measures, consistent with the community standard, to provide the patient with good medical care," he says. ✦

Compliance with billing rules likely to come up in suits — Newly required documentation can help defense

New Centers for Medicare & Medicaid Services (CMS) rules for justifying assigning inpatient status to a patient are a hot topic in the reimbursement world, but these rules also will become an issue in malpractice litigation.

"Physicians needn't become Medicare experts, but they do need to understand how the new rule works. There is now even heavier emphasis on documentation," says **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician.

The hospital has to be prepared to show why inpatient admission is necessary and that the patient's problems are sufficiently severe that a stay of two consecutive midnights or longer is reasonably anticipated. It will need to depend heavily on the documentation of the admitting physician to do so. *(The 2014 Inpatient Prospective Payment System Final Rule is available at http://1.usa.gov/J386Do.)*

"There will certainly be fights over whether the documentation was adequate in a given case," McMenamin

says. "Since documentation is often the key in medical malpractice as well, admitting physicians now have even more compelling reasons to dot their I's and cross their T's."

Document reason for admission

Physicians need to be aware of complexities that could arise because of the differences between CMS' "two midnight" rule and state law, says **Cori Casey Turner**, JD, a partner at Husch Blackwell in Kansas City, MO.

For example, under the MO HealthNet rules, admission is appropriate if, based on the physician's initial intent, a patient is expected to require inpatient care for 24 hours or more.

"Differences in the CMS rule and each state's Medicaid rule add a layer of complexity, increasing the risk of billing and documentation errors as physicians attempt to comply with different rules related to inpatient admissions," says Turner. To minimize risk, physicians should remain vigilant about appropriately documenting the reason for admission orders regardless of the payer, she advises.

For shorter admissions, physicians might simply choose to bill for the care on an outpatient basis to avoid problems with CMS auditors, which results in less reimbursement. It's also possible that some physicians will avoid discharging patients before two consecutive midnights have passed to comply with the requirements for reimbursement at the inpatient level. *(See related story, below, on legal risks of failing to admit patients.)*

"If Medicare perceives that you are 'gaming the system' by keeping a patient in the hospital longer just to run out the clock, the auditors are going to come looking for you," warns McMenamin. "My guess is that if they think you are playing games, they are going to look at you pretty closely."

Use "first class" documentation

If the physician does pursue inpatient reimbursement for a shorter hospital stay, McMenamin says, "then you have to be prepared to defend yourself. Your documentation has to be first class."

In this scenario, physicians need to document why inpatient admission is needed and why they expect it to be longer than two midnights. "Physicians should write a very complete note — not just about the patient's immediate problem, but other medical problems as well," advises McMenamin.

For example, if a patient is being admitted for congestive heart failure, the physician also should document that patient's recent myocardial infarction, the renal failure complicating the cardiac problems, and the fact the patient has some hypoxia related to pulmonary edema. "If you document all of that for purposes of demonstrating to a Medicare auditor why it's not a garden variety case and you may have the patient in for a while, it can help you from a professional liability point of view as well," says McMenamin.

The requirements potentially could decrease malpractice exposure for physicians because documentation will be more thorough and complete.

If the patient has a bad outcome and sues, "you now have this chart that is chock-full of information about how sick the patient was," says McMenamin. "You are facing a lawsuit, but the chart makes it clear that you had a tough case on your hands." ✦

> ***"... you have to be prepared to defend yourself. Your documentation has to be first class."***

Executive Summary

New Centers for Medicare & Medicaid Services (CMS) rules for justifying assigning inpatient status to a patient require physicians to document why inpatient admission is necessary and why they anticipate a stay of at least two consecutive midnights. To minimize risk, physicians should do the following:

- ✦ Carefully, consistently, and thoroughly document the reason for admission orders regardless of the payer.
- ✦ Be prepared to defend why they pursued inpatient reimbursement for a shorter hospital stay.
- ✦ Specify the patient's other medical problems.

New CMS rules could make MDs less likely to admit

'Robust' documentation needed to support decision

The 2014 Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System rules present challenges to the independent medical-decision making of physicians, according to Cori Casey Turner, JD, a partner at Husch Blackwell in Kansas City, MO.

Some physicians might be reluctant to admit a patient as an inpatient if they believe that the patient's stay might not span two midnights,

she explains.

"The determination regarding whether to admit a patient may no longer truly reflect the acuity of care a patient needs; but rather, also take into account the anticipated duration of the inpatient stay," says Turner.

In situations in which a patient is acute, but is likely to respond quickly once admitted, the Medicare rule could discourage physicians to admit a patient even if that is the best course of treatment. "This fact could potentially be used by plaintiff's counsel as evidence of professional negligence," says Turner.

Plaintiff attorneys might look for cases in which a patient was not admitted, but instead was treated as an outpatient, says **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician. "They may argue that the reason the patient wasn't admitted is that the physician was trying to help the hospital, which didn't want to be audited, and withheld care and managed the patient as though outpatient management was sufficient when in reality it wasn't," he says.

This argument might not be successful, however, says McMenamin, since "the distinction between outpatient and inpatient management is considerably thinner than it once was."

Patients admitted to observation typically receive the same level of care they would as inpatients, he explains. "The only difference is the status that the hospital or doctor has assigned; not the intensity or complexity of the care," says McMenamin.

Ensure consistency

To minimize malpractice liability, physicians should be familiar with hospital policies regarding hospital admissions, says **Wakaba Tessier,** JD, an attorney at Husch Blackwell.

"Most hospital admission policies take into consideration InterQual evidence-based clinical guidelines or similar clinical criteria which support the appropriateness of care," says Tessier.

Accordingly, ensuring that a physician's practices are consistent with hospital policy and maintaining robust documentation of admission and discharge decisions might decrease the risk associated with medical malpractice suits, she says.

Because the new CMS rules require a physician to sign a statement attesting that the patient will require two overnights for a full admission, it's possible that physicians might face civil liability if CMS later determines that the attestations were made in error.

"However, the risk of liability is significantly less if the error is inadvertent and not intentional," says Tessier. "Ultimately, physicians are responsible for the care of their patients."

CMS has stated that it will evaluate the physician's expectation based on the information available to the admitting practitioner at the time of the admission.

"Accordingly, admitting a patient that could benefit from inpatient treatment that the physician suspects may not ultimately span two midnights should be supported by robust medical record documentation highlighting the medical necessity of the inpatient admission," says Tessier. ✦

COMING IN FUTURE MONTHS

✦ Legal risks of cognitively impaired physicians

✦ Why patient portals can prevent med/mal suits

✦ How malpractice can result in criminal charges

✦ Malpractice risks of routine medical procedures

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 practices are recommended to prevent malpractice claims involving radiology study findings, according to Jennifer L'Hommedieu Stankus, MD, JD, an attending physician at Group Health Physicians?

A. There should be mechanisms in place for specific diagnoses, such as lung nodules, to make patients aware of the abnormal finding.

B. As a standard practice, physicians should rely on the radiologist's interpretation.

C. If the radiologist is not available, physicians should not consult another physician such as a general surgeon or a neurologist.

D. Physicians should keep in mind that only the radiologist will be named in a malpractice suit if there is a missed read.

2. Which is true regarding claims involving deep vein thrombosis, according to Robert J. Conroy, JD, MPH, an attorney at Kern Augustine Conroy & Schoppmann?

A. There is no disagreement regarding which medication should be used and how long to use it.

B. Claims typically allege that physicians ordered insufficient prophylaxis or otherwise failed to prevent the condition.

C. If blood thinners are discontinued, physicians should not document reasons for doing so.

D. Physicians should not routinely refer patients with large blood clots to an interventional radiology specialist.

3. Which is recommended for physicians to reduce risks, in light of new Centers for Medicare & Medicaid Services rules for justifying assigning inpatient status?

A. Physicians should avoid specifying the patient's other medical problems.

B. Physicians should always choose to bill for the care of an admitted patient on an outpatient basis if the stay is expected to be less than two consecutive midnights.

C. Physicians should avoid discharging admitted patients before two consecutive midnights have passed, in order to comply with the requirements.

D. Regardless of the payer, physicians should meticulously document the reasons for admitting the patient.

4. Which should physicians do to avoid failure to diagnose claims, according to Rich Cahill, vice president and associate general counsel at The Doctors Company?

A. Never require patients to sign an agreement for "conditions of treatment" at the outset of care.

B. Avoid counseling patients even in the event of continued non-adherence.

C. Have procedures to reconnect with patients who fail to keep scheduled appointments or obtain requested laboratory testing.

D. Avoid terminating non-compliant patients from the practice under any circumstances.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICIAN RISK MANAGEMENT

Failure to follow up on coronary artery perforation results in $5.68 million verdict from jury

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News: A patient, age 49, was admitted with an acute myocardial infarction and rushed to a cardiac catheterization lab for a cardiac catheterization and angioplasty. A physician perforated a small coronary artery during the angioplasty but did not adequately treat the patient after being notified of her declining vital signs. After the patient coded, she was revived but was pronounced brain dead due to cerebral anoxia, and subsequently taken off life support by family two days later. The patient's surviving son brought suit alleging that the physician failed to take prompt action and that this delay caused the patient's injury.The defendant physician denied liability.The jury awarded $5.68 million in damages.

Background: In this matter, the patient had an acute myocardial infarction. She was promptly taken to a cardiac catheterization lab. A physician and staff promptly performed a cardiac catheterization and angioplasty. During the angioplasty, a small coronary artery was perforated. This is one of the many known risks of this procedure. Perforation of a cardiac artery is dangerous and requires close monitoring because it can result in cardiac tamponade, an emergent condition in which blood fills the pericardium, increasing pressure and decreasing efficiency of the heart. If tamponade is left untreated, it can lead to heart failure, shock, and death.

Physicians should plan for the worse, rather than hope for the best.

The physician was aware of the perforation asit was discovered before the patient left the cath lab. The hospital staff was advised as well, and the patient was monitored after the angioplasty. Shortly after leaving the lab, the patient's blood pressure dropped, which is indicative of a possible tamponade. Nursing staff notified the physician of this development at 2 a.m. The physician assumed this situation was presumptive tamponade, but he was about to begin treating another emergent patient. The physician had an unexplained 30-minute delay, as he did not begin treating the other patient until about 2:30 a.m. and did not find another physician to take care of the tamponade patient. Because the original patient received no immediate treatment for the tamponade, she coded at 4 a.m. When physicians finally arrived to care for her, they relieved the tamponade by draining the excess blood through pericardiocentesis. This action allowed the heart to resume functioning, but the damage was already done: The patient was brain dead from oxygen deprivation.

The patient's surviving son brought suit and claimed that the physician should have taken immediate action at 2 a.m. when the signs

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of tamponade were evident. At that time, the physician could have confirmed and treated the tamponade himself, or gotten another physician to treat the condition. Indeed, the primary issue in this case readily was conceded by the physician: Both the physician and the plaintiff's expert physicians admitted that the patient's perforation and signs of tamponade required immediate care. Testimony and reports during the trial brought out that the nurses attempted to persuade the physician to treat the patient or call in another physician. They were rebuked by the physician, who delayed without reason and made no calls. The physician himself admitted that the patient presumptively had tamponade, but his defense was that the hospital's call schedule was a recipe for disaster: the two competing groups of cardiologists created dynamics that didn't allow much calling between the groups. After two and one-half hours of deliberation, the jury found the physician liable and the hospital not liable. The verdict of $5.68 million subsequently was reduced based on statutory limits.

What this means to you:
Emergent conditions such as tamponade require treatment quickly. In this case, by the time the tamponade was recognized and treated, it was too late. Had a physician performed the pericardiocentesis procedure sooner, the patient's life would have been saved. Failing to treat an emergent condition can be extremely dangerous to patients and easily can create liability for a physician when other reasonable physicians in the same situation would have recognized the need for, and actually performed, treatment. If members of the medical staff know there is a critical condition that might result in serious injury or death, something must be done immediately. Waiting is not only not an option, it might be considered reckless behavior. Multiple emergent patients might prevent a physician from dealing with all of them simultaneously, and this alone will not result in liability. However, given this situation, the physician must take steps to ensure that all patients are being adequately treated. Each physician should have a plan in place that adequately provides him or her with enough coverage to accomplish this step.

Also playing a significant role in the events here are the inherent risks of cardiac catheterization, which patients must be thoroughly informed of prior to the procedure. Perforation is a known risk of angioplasty, and tamponade is a known risk of perforation. The physician was aware of these facts and knew that the patient's artery was perforated. When a situation arises that has possible heightened risks, physicians must be particularly cautious and monitor the patient, and they must be ready to respond if any of these risks develop. Evidence at trial revealed that this physician had patients with perforations before, but they had resolved uneventfully. This situation might not always be the case, and physicians cannot rely on the best outcome happening every time. In fact, the longer one practices, the more likely it is that one will see a multitude of outcomes and many of those will be far from the best. Physicians should plan for the worse, rather than hope for the best. A keen awareness of the possible risks allows the physician to prepare for them and immediately intervene to mitigate those risks.

According to the physician, another important issue in this case related to call schedules. The physician claimed the hospital was at fault because the call schedule was a disaster. The hospital allowed two cardiologist groups to handle scheduling, and the two competed against each other rather than working together to fulfill patient needs. The physician blamed this situation as the reason for being unable to find another physician to cover his original tamponade patient.

Call schedules are particularly important for emergency situations, because physicians must have the option of calling another physician when multiple or large-scale emergencies happen. One physician simply cannot perform two surgeries at the same time. Hospitals should try to ensure that clinical areas have sufficient physician coverage at all times. If not, hospital administrators need to approach their medical staffs and insist that schedules be adjusted. In most cases, hospitals' boards of directors ultimately are responsible for credentialing the medical staff.Physicians with inadequate time-off coverage might be impacted negatively during the credentialing review process. The politics between competing physicians or physician groups must not be allowed to impact patient care.

Also of interest was that during deliberations, members of the jury asked a question regarding the damages award. The phrasing of the question suggested the jury was considering finding the hospital partially liable based on its scheduling problems. Ultimately, however, the jury believed that the physician individually was more culpable than the hospital, likely because of the unexplained 30-minute delay and his failure to even attempt to contact a replacement. However, while the jury did not hold the hospital responsible in this instance, hospitals do need to train their nursing staff to go up the chain-of-command when they realize that a patient is in need of immediate critical care and they are not able to get a physician to respond. The physician could have used the chain of command as well. The house supervisor, administrator on call, or some senior hospital representative should have been contacted by the physician or nursing staff so

that the chiefof staff or other senior medical staff leader could intervene. Had this contact been done, the hospital's scheduling practices would not have been at issue. Relatedly, it is in a hospital's interest to supplement training in chain-of-command issues with written policies and documentation that all relevant staff personnel have received copies of the written policies as well as parallel verbal training. In any event, if a call scheduling issue creates problems for a physician, the physician still might be responsible to patients to respond to them in a timely manner and, if otherwise preoccupied, the physician must make reasonable efforts to find a replacement. Doing nothing, or waiting and hoping for a condition to resolve itself, is insufficient and might result in liability.

Reference:

Case No. 53C06-0812-CT-03249.Monroe Circuit Court, IN.Oct. 1, 2013. ✦

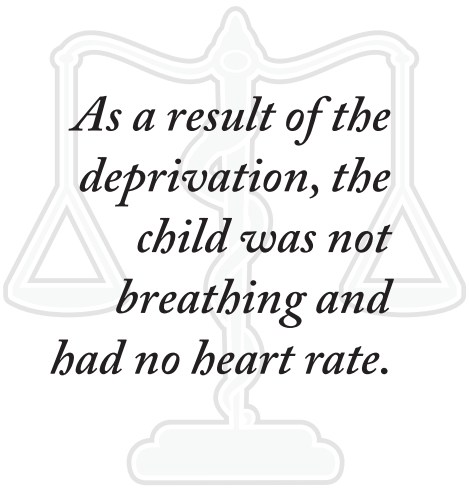
Mother and child awarded $4 million in birth injury suit

News: A patient, age 27, was in labor and began vaginal delivery of a 10-pound child at a hospital, assisted by an obstetrician-gynecologist. When delivery plateaued at 9 cm dilation, the physician administered oxytocin and performed a forceps-aided delivery. The baby's shoulder was stuck, resulting in three and one-half minutes of no oxygen and blood flow. The baby was delivered limp and had to be resuscitated by a neonatal unit, and the child later was diagnosed with mild cerebral palsy. The mother and child brought suit against the physician, and they claimed that the physician should have performed a cesarean section because of the child's size and strained delivery. The physician argued he met the standard of care. The jury awarded $4 million in damages against the physician.

Background: The patient was in labor and admitted to a hospital in the morning. She was four days past due, and prior to going into labor, an ultrasound and sonogram revealed that the unborn baby's fetal weight was approximately 10 pounds. Her obstetrician-gynecologist, the defendant physician, assured her that this substantial weight was nothing to be alarmed about. After being admitted, she quickly arrived at 9 cm dilation. However, her dilation plateaued, and she remained dilated at 9 cm for several hours.

The physician ordered oxytocin to assist with the delivery, and finally, at midnight, the patient was at 10 cm, which allowed for delivery to continue.

The mother unsuccessfully pushed for more than two hours, as the baby resisted descending. The physician opted to use forceps to aid in delivery. While doing so, the baby's head emerged and immediately retracted, an event known as a turtle sign. This event also is indicative of shoulder dystocia, a condition in which the head successfully delivers but the shoulder is stuck on the mother's pubic bone. The physician attempted to continue with vaginal delivery and administered a number of successful measures to assist delivery, including pushing the patient's knees back to widen the birth canal, applying pressure to the pubic area, and mounting the mother and pushing on her abdomen. Eventually, the baby was delivered, but there was three and one-half minutes prior to delivery in which the umbilical cord was impaired and the child received no oxygen and blood flow. As a result of the deprivation, the child was not breathing and had no heart rate. She was resuscitated by a neonatal unit and later diagnosed with mild cerebral palsy. The mother suffered bladder and bowel incontinence as a result of severe tearing, which extended to her anal sphincter, and the overall trauma of the birth.



The plaintiffs sued the physician and alleged that he should have performed a cesarean section to deliver the baby after the oxytocin was ineffective. According to the plaintiffs' experts, the large size of the baby and the use of forceps increased risk of shoulder dystocia, and the physician's use of forceps here was a further breach of the standard of care. The physician offered several bases for defense: shoulder dystocia is unpredictable and uncommon, cesarean sections are not a required preventative measure, pushing the head back into the pelvis would have been more dangerous than continuing with the vaginal delivery, and any injury was caused by resuscitation efforts after delivery. The jury came back with a unanimous verdict for the plaintiffs, which totaled $4 million, nearly $2 million for the mother individually and more than $2 million for the daughter individually.

What this means to you: The primary issue in this case was whether the physician took appropriate action and met the standard of care when delivering the patient's baby. This determination, made by the jury, is heavily (often exclusively) based on expert testimony. Naturally (or at least unsurprisingly), the experts on each side almost always clash and claim that their side has the correct interpretation. Here, the defendant's experts claimed that a prophylactic cesarean section is not recommended by the American Congress of Obstetricians and Gynecologists, while the plaintiffs' experts testified that the large size and increased risk of shoulder dystocia required a cesarean section.

Experts on each side contradicting each other is almost inevitable during trials, and picking an expert might be a key factor in the outcome of the case. Thus, it is important to work with counsel and select a strong expert team early in the case so that the expert can help shape the discovery and pretrial preparations. There are various ways to select an expert, and going with the most published or most famous expert might not always be the right call. If you are considering an expert who has a great deal of experience testifying, it is important to at least make sure that the expert has a balanced resume and is not simply a show pony for the plaintiffs' bar on one hand or the defense bar on the other hand. Among other reasons, such show pony experts generate a trail of deposition and trial transcripts over time, and plaintiffs' counsel and defense counsel share materials behind the scenes. Eventually they build a war chest of mistakes and inconsistencies that can be used to impeach the expert. The force of such impeachment becomes enhanced if the expert appears to a jury to lack neutrality because he or she testifies exclusively or almost exclusively for one side or the other. It might be better to seek out someone knowledgeable in the field with little or even no prior experience as a testifying expert. As long as the person has a deep understanding of the field and a strong ability to communicate, experienced litigation counsel should be able to shape that person into a persuasive testifying expert.

Although there might be multiple methods for treating a condition, and experts might conflict on which method is preferred, physicians might be well-suited by informing their patients of these options, in the right circumstances. Letting patients know the risks of all possible procedures and allowing them to make an informed decision is extremely important. If the physician makes the decision without consulting the patient and informing them of the risks and sideeffects, there might be liability. This liability is not always the case, however, as sometimes a patient might not be able to make decisions, such as when the patient is incapacitated or unconscious, or delaying treatment risks serious bodily harm. Physicians should nonetheless make it a practice of informing patients of their options whenever possible, and when their options or the circumstances surrounding them change, physicians should go back to the patient with this updated information and inform the patient anew. Allowing patients to make an informed decision might prevent liability on the physician's part.

Also, adapting treatment to a situation as it unfolds is critical. Physicians must be able to change treatments when one proves to be ineffective and decide a new course of action based on the updated circumstances. The physician here deemed vaginal delivery to be a valid option originally, but as the delivery progressed and was difficult, he should have re-evaluated whether to continue. When there are multiple options, consider those reasonable options. Cesarean section was a reasonable, better alternative to instrument-assisted delivery, particularly after the oxytocin was found to be ineffective in this case. Some courses of treatment might not be able to be halted once begun, but for those in which cessation is possible, it might be necessary if the treatment is futile and another alternative is required. Physicians must be aware of changing circumstances that require different procedures or treatment than the original diagnosis speculated, and they must take action accordingly.

The rarity of a condition might have an influence on a physician's liability, but is primarily relevant to the threshold issue of considering what the reasonable physician would have done in the same or similar circumstances. If a condition is sufficiently rare that a reasonable physician would not know how to treat it, then this situation might preclude negligence liability. There is no clear number or standard here for what constitutes sufficient rarity, rather it is a specific factual determination to be made by a jury. A defense expert stated that shoulder dystocia occurred in 0.6% to 1.4% of deliveries. It is unclear exactly how the jury viewed this statistic, but given that it found the defendant liable, it is reasonable to assume that this percentage was not low enough to find that a reasonable physician would be unable to recognize and treat the condition. Instead of relying on rarity of the condition as a defense, because this defense is unreliable, physicians should attempt to be prepared to treat such rare conditions and seek additional information when situations arise with conditions that are uncommon or unfamiliar to them.

Reference

Case No. 2011-C-3016.Lehigh County Court of Common Pleas, PA, Sept. 7, 2013. ✦