PHYSICIAN Risk Management

March 2014 | Vol. 2, No. 9 Pages 97-108

Beware! In claims for routine procedures certain factors are consistently correlated

The fact that routine medical procedures — scopes, injections, punctures, biopsies, insertion of tubes, or imaging — were involved in a large percentage of malpractice claims didn't come as a surprise to researchers at CRICO Strategies.

"We are all aware of punctures or perforations from misdirected NG [nasogastric] tubes, nerve injuries from blood draws, and tissue damage from IV [intravenous] infiltrates. These events are typically related to technical skill," explains **Gretchen Ruoff**, MPH, CPHRM, program director of patient safety services for CRICO Strategies, a Cambridge, MA-based patient safety and medical professional liability company. One claim involved a splenic laceration during a screening colonoscopy, which resulted in an extended hospital course and admission to an intensive care unit.

"Close monitoring and swift responses to signs of a complication are critical to patient, and provider, safety."

The researchers were surprised, however, by these factors that were consistently correlated with the technical errors across multiple procedure types:

- working without adequate training or supervision;
- working with unfamiliar equipment;
- performing a procedure on an inappropriate candidate or in an unsuitable setting due to the patient's health status or comorbidities.

Researchers analyzed 1,497 malpractice cases filed from 2007 to 2011 that alleged malpractice involving a non-surgical procedure. More than two-thirds of the injuries were relatively minor or temporary, but 14% involved patients who died. The cases represent $215 million in incurred losses, and most involved skill-based errors.

Whether the injury was a known possible complication of the procedure or resulted from a judgment failure, the legal outcomes of these cases often hinged on these factors:

- failure to obtain or document a thorough, voluntary, informed consent;
- a provider's lack of appropriate credentials or experience with the procedure;
- failure to follow published safety policies.

INSIDE

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Financial Disclosure: Physician Editor **William Sullivan**, DO, JD, FACEP, Author **Stacey Kusterbeck**, 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.

"While these factors do not indicate negligence per se, cases with these factors are harder to defend in a court of law and in the court of public opinion," says Ruoff. She recommends that physicians take these actions to reduce liability risks:

• Diligently and thoroughly explain the risks, benefits, and alternatives of a procedure to the patient prior to a procedure. Accurately document these conversations in the medical record.

• Adhere closely to procedural protocols.

• Recognize that the end of a procedure does not mark the end of the provider's responsibility for monitoring, communication, and follow-up with the patient and the rest of the care team.

"Close monitoring and swift responses to signs of a complication are critical to patient, and provider, safety," says Ruoff.

• In the event of an untoward outcome, offer patients compassionate and informative communication and, when appropriate, disclosure and apology.

"This not only serves to minimize patients' worries, but also begins to rebuild the trust necessary for thorough recovery and healing," says Ruoff.

Executive Summary

Claims involving routine medical procedures — scopes, injections, punctures, biopsies, insertion of tubes, or imaging — resulted in $215 million in incurred losses, according to an analysis of 1,497 cases. In this study, legal outcomes often hinged on these factors:

- ✦ failure to obtain or document a thorough, voluntary informed consent;
- ✦ lack of appropriate credentials or experience with the procedure;
- ✦ failure to follow published safety policies.

Red flag: unmet expectations

Missed diagnosis following routine medical procedures can cause the relationship between the healthcare provider and the patient to deteriorate and cause the patient or a family member to seek representation for their harm.

Carmen Lester, RN, JD, CPHRM, co-owner of Yin Yang Medical Services, an Omaha, NE-based provider of risk management services, says, "Red flags should be raised when the patient's outcome differs from the patient's expectations."

For example, a patient with rectal bleeding undergoes a colonoscopy with negative results, only to find out later that colon cancer was missed on exam during the procedure. "The reassurance that she was initially given has now been replaced with anger and mistrust," says Lester.

Other examples of malpractice involving routine medical procedures include a failure to communicate pathology reports to appropriate physicians, often seen in cases involving biopsies; delayed diagnosis, when the diagnostic workup does not include all of the testing components needed to arrive at the definitive diagnosis; and

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

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

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complications or infections following routine procedures, such as insertion of a Foley catheter. "It is important to point out that there are surgical procedures that are considered 'routine,' such as appendectomies and cholecystecomies, that can have adverse outcomes," adds Lester. "We are currently seeing a case in the national news of a 13-year-old girl that was declared brain dead following a tonsillectomy."

When adverse events occur, physicians should notify their malpractice insurer of the potential compensatory event. "The family is most likely seeking counsel for representation," says **Jan Kleinhesselink**, RN, CPHQ, co-owner of Yin Yang Medical Services.

Physicians can take steps to prevent the same incidents from happening again by completing a root cause analysis. "Don't sweep adverse events under the rug," says Kleinhesselink. "Rather, focus on prevention of future occurrences."

Focus on underlying condition

Cases involving routine medical procedures are more defensible if the defense can convincingly argue that the patient's underlying condition ultimately caused the patient's bad outcome, says **Phillip B. Toutant**, Esq., an attorney in the Southfield, MI, office of The Health Law Partners.

Toutant recalls a wrongful death case in which a middle-aged woman with a history of alcoholic liver cirrhosis had a routine colonoscopy at an ambulatory surgery center. During the procedure, she suddenly became hypotensive, and it soon became evident that she was bleeding internally. "The ambulatory surgery center did not have packed red blood cells available, let alone platelets or even whole blood, which would have been far preferred for a patient with severe liver disease," says Toutant.

"Red flags should be raised when the patient's outcome differs from the patient's expectations."

It was discovered that the patient had a varix between her ovary and her large bowel, which ruptured during the procedure. The defense argued that the abnormality was significant and highly unexpected. The defense said that it was caused by portal hypertension, which was caused by her cirrhosis, which ultimately was caused by the patient's alcoholism. This alcoholism, they argued, resulted in the patient bleeding to death in what otherwise would have been a routine procedure.

Because the case involved a woman who was a co-owner of a sizeable business with significant income, there was potential for substantial wage loss damages in this wrongful death case. The case was settled for a dramatically lower amount than the plaintiff's lawyer's wage loss projections. The disparagement in the settlement amount was largely due to challenges in terms of proving violations of the standard of care.

"In cases where routine procedures result in significant morbidity or mortality, oftentimes the bad outcome is the result of latent, unpredictable, pre-existing pathology," says Toutant. "Needless to say, this aids in defending the providers." *(See related story, below, on the elements of negligence that a malpractice claim must meet to survive.)*

SOURCES/RESOURCE

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- CRICO Strategies' 2013 report, "Malpractice Risks in Routine Medical Procedures," is available free of charge. Go to http://bit.ly/1elGvl7 and next to the report title, select "PDF" or "Paper." ✦

Does claim meet all 4 elements of negligence?

While anyone can go to a plaintiff's attorney for what they perceive as a poor outcome, keep in mind that for a malpractice claim to survive, all four elements of negligence must be met, says **Jan Kleinhesselink**, RN, CPHQ, co-owner of Yin Yang Medical Services, a Nebraska-based provider of risk management services. These elements are: duty, breach of that duty, causation, and damages.

These elements are demonstrated in the following hypothetical case: A seemingly healthy 41-year-old female presents to a hospital emergency department with shortness of breath and right side pleuritic pain. The patient states that she thinks she pulled a muscle while working out that morning.

After running standard lab tests and a chest X-ray, all of which resulted in normal values, the patient was discharged to home with a muscle strain.

The patient later was found dead of a pulmonary emboli (PE).

Here is how the elements were met in this case:

• **Duty:** In this case, says Kleinhesselink, the emergency physician had a duty to evaluate and stabilize the patient.

• **Breach of duty:** "Since the patient didn't meet the normal profile for a PE, the physician failed to obtain a D-dimer and a CT scan," Kleinhesselink says. The plaintiff's attorney could argue that the duty was breached, based on the standard of care as presented as evidence through expert witnesses and as best practices identified by emergency medicine organizations.

• **Causation:** The plaintiff could argue that failure to obtain the additional tests to achieve a definitive diagnosis was the proximate cause of the patient's death. "Depending on the state, punitive damages could be awarded," says Kleinhesselink.

Risk reduction strategies

As a physician, there are two key ways to reduce your risk for a malpractice claim, says **Carmen Lester**, RN, JD, CPHRM, co-owner of Yin Yang Medical Services: Documentation and clear communication. She recommends these practices:

• Documentation should be objective, specific, compete, legible, authenticated, dated, and timed.

"Electronic health records assist in achieving these requirements," says Lester.

• The medical record should include patient history, assessments, diagnoses, patient progress, the reason for and results of diagnostic testing, the patient's response to treatment, any changes in interventions, patient noncompliance, and a plan of care until the next encounter.

• Communication with the patient and family needs to be upfront, sincere, and continued throughout the course of the doctor/patient relationship.

"Keep in mind that the natural tendency after an adverse outcome is avoidance," says Lester. "This only makes the patient and family feel isolated, helpless, and angry — which is when attorneys are contacted." ✦

Why some physicians really need 'tail' coverage: Gaps in coverage might exist when changing carriers

An anesthesiologist named in a malpractice suit soon regretted his previous decision not to purchase "tail" coverage when leaving his previous insurance carrier.

The new carrier was not willing to provide a retroactive date that would have enveloped the tail coverage time period. "Therefore, the individual had no coverage when a suit was filed before the effective date of the new carrier's policy," says **Michael R. Tamucci** Jr., vice president of claims at MagMutual, an Atlanta-based provider of medical professional liability insurance.

The physician had to pay for defense costs out of his own pocket. "The case was eventually dismissed without a loss payment, but with significant legal defense payments to his attorney," says Tamucci.

In this unfortunate scenario, the provider is at risk for being held personally liable for defending the claim and any related indemnity payments. **Kathryn Meyers**, director of broking at Aon National Health Care Practice in Chicago, says, "The option to purchase from the in-force carrier would likely have expired and would no longer be available. I am not aware of a carrier that would sell coverage for a known claim."

Though it's possible the carrier would provide some accommodation, there is certainly no obligation to do so. "The carrier may well be reluctant to do so, for fear of being drawn into the claim or any bad faith," says Meyers. "The carrier might direct the physician to appropriate legal counsel at preferred rates."

Confirm there are no lapses

Because doctors are at risk of losing their insurance benefit if they have a gap in coverage when changing carriers, "this begs the need for tail coverage," says Tamucci. "This provides extended reporting when the physician transfers from one practice to another. He gives these recommendations:

Executive Summary

If physicians fail to purchase "tail" coverage when leaving one carrier, they risk having no coverage if a suit is filed before the effective date of their new carrier's policy.

✦ Physicians can request a retroactive date from the new carrier that provides coverage for any potential coverage gaps.

✦ With tail coverage, physicians can report a case after their policy has expired or has been canceled as long as the incident took place during the time the expired or canceled policy was in place.

✦ The cost varies depending on the term of the "tail" and typically ranges from 100% to 250% of the mature policy premium.

• When leaving one insurance carrier, a physician should always purchase tail coverage or request a retroactive date from the new carrier that provides coverage for any potential coverage gaps.

"Physicians can seek guidance from the carrier or agent to confirm that there are no lapses," says Tamucci.

• Physicians should be aware that they will pay an additional premium for tail coverage, and it can be expensive.

"Pricing of tail coverage is typically pre-determined and documented in the insurance policy," says Meyers. Policy premiums are graduated in the first few years because risk is less. Tail insurance is calculated on the nondiscounted or "mature" policy premium.

The cost varies depending on the term of the tail, which could be one year, three years, five years, or unlimited, and typically it will range from 100%-250% of the mature policy premium. DDR [Death, Disability and Retirement] provisions might discount, or even waive, any tail premium requirement, says Meyers.

"A physician joining a new entity may be given or be able to procure 'nose/prior acts' coverage from the new entity at its rates," says Meyers. "This risk might even be assumed through the new entity's captive insurer."

Tail coverage purchased from a third-party insurer is more difficult to find, says Meyers, though some options exist. "Limits will be stand-alone and refreshed, since there are no existing policy limits to follow," she notes.

Tail coverage purchased from a third-party insurer is more difficult to find.

"Occurrence" policies

With tail coverage, physicians can report a case after their policy has expired or has been canceled, as long as the incident took place during the time the expired or canceled policy was in place and within the defined term of the tail, if not unlimited.

Most malpractice policies are "claims-made," says **Mike Merlo**, Esq., managing director of casualty legal and claims at Aon Risk Solutions in Chicago. This phrase means that coverage is triggered by notice of the claim given to the insurer during the policy period.

"In contrast, with an 'occurrence' policy, you can give notice of a claim years after the policy expires, provided the act or omission giving rise to the claim occurred during the policy period," says Merlo.

If a physician's malpractice policies have the more typical "claims-made" trigger, then tail coverage is an important option to consider, says Merlo, "particularly if the physician is changing insurance carriers or making other change to their insurance."

SOURCES

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To avoid suits, MDs must communicate and must partner with other doctors

Taking a "pause point" to consult with another provider can prevent a potential bad outcome and malpractice claim, according to **Peter J. Pronovost**, MD, PhD, FCCM, senior vice president for patient safety and quality and director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore, MD.

"What classically happens is that physicians make a plan — 'This is sepsis, and I will treat it' — but they get new data that suggests the plan isn't the right one," Pronovost says. "Too often, we don't build in those pause points to say, 'Do we need a new plan?'"

A 55-year-old, obese female with poorly-controlled Type II diabetes who sees a primary care provider, endocrinologist, orthopedic surgeon, cardiologist, and ophthalmologist is a typical patient in an aging population, says **Kathleen M. Roman**, MS, a Greenfield, IN-based risk management consultant. "Too often, providers make important care decisions without any personal contact with the others, other than reading whatever information may be retrievable within the records," says Roman.

A review of 2,466 claims between 2007 and 2011 by The Doctors Company found that communication failures among physicians contributed to 7% of patient injuries.

If one doctor knows something that might assist or influence care about to be provided by another, it doesn't always occur to them to pass along that information.

"Often, they assume that it's the patient's duty to pass the information along," Roman says. Patients don't

always have the clinical knowledge or the communication skills to provide that information to medical providers, however.

Naming multiple providers

Insufficient communication between providers is often a contributory cause in malpractice lawsuits that name more than one provider, reports Roman.

"When the facts of the case are analyzed, it often becomes apparent that the lack of communication led to misassumptions, incompatible treatment or medications, delays in diagnosis or treatment, or a variety of other factors that contribute to patient injury," she says. Roman recommends that practices develop processes that allow Provider A to automatically send reports, test results, and consult notes to requesting Provider B. At the same time, Provider A needs to be able to request information from providers outside the corporate structure who are treating the same patients.

"This type of communication can prevent potentially dangerous errors such as duplication of tests, incompatible medications, and lack of access to test results," says Roman.

Executive Summary

Insufficient communication between providers is often a contributory cause in malpractice lawsuits that name more than one provider.

✦ Providers must be able to request information from other providers who are treating the same patients.

✦ Interdisciplinary rounds with a "culture of inclusiveness" encourage individuals to speak up.

✦ In the outpatient setting, physicians can call a colleague to obtain a different perspective.

Consult with others

Interdisciplinary rounds should have a "culture of inclusiveness" that encourages people to speak up, advises Pronovost.

"When you are uncertain what's going on, or a patient is getting sicker, call a bedside huddle," he says. "Get all the team involved."

The same approach can be used in the outpatient setting by calling a colleague to get a different perspective or by including the patient or family, Pronovost says. "Physicians shouldn't hesitate to admit they don't know what's going on and invite the input of others," he says. Pronovost often says to colleagues, "Can you help me understand what you are seeing that makes you think that X is going on? From what I see, I am seeing a different picture."

Pronovost adds that the same behaviors that allow for low errors and safe care result in high patient satisfaction scores.

"If you get this right, you feel good and patients feel good, and you are more effective because harm is less," he says.

SOURCES

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Prevent successful suits alleging failure to transfer

Do you believe that the Emergency Medical Treatment and Labor Act (EMTALA) imposes a duty to transfer patients that cannot be stabilized?

This misconception is a common one, as EMTALA actually imposes a duty not to transfer a patient that cannot be stabilized unless certain criteria are met, says **Angela Cox,** JD, of Brennan, Manna & Diamond in Akron, OH.

"One of these criteria is that the hospital does not have the equipment or services necessary to stabilize the patient," she says.

Physicians have a legal obligation to transfer a patient when either the standard of care or the facility's licensure requires it, says Cox. For example, Ohio statutes require that newborns born under a certain gestation age and weight be transferred to a facility with a higher level of care, unless certain criteria are met. "Pediatric and trauma unit licensure are additional examples of where there may be a duty to transfer to a higher level of care," says Cox.

She is aware of malpractice claims in which hospitals had inoperable CT scanners and patients needed CT scans. "This created a duty to transfer patients to a facility that could perform the needed CT scan," says Cox.

In one such case, a young child with a head injury was taken to the emergency department (ED), where an X-ray revealed a skull fracture. The hospital's CT scanner was inoperable, and the child was not transferred for almost four hours. "By the time the child was transferred and a CT scan was performed, the child had sustained such severe brain damage that she died a few days later," says Cox. "The

child's parents claimed that she would have survived had she been transferred more promptly."[1] The hospital settled for $250,000 and received no contribution from the physicians.

"Failure-to-transfer" claims typically allege these areas:

• that a physician should have transferred the patient to a higher level of care;

• that the physician did not do so;

• that injuries resulted that would not have occurred if the patient had been transferred.

Another malpractice case involved a woman admitted to deliver a child who was diagnosed with eclampsia. A physician ordered that she be transferred to the facility's intensive care unit (ICU), which was full.[2] "The patient was admitted to a hospital ward, instead of being transferred to the ICU at a nearby facility. She subsequently died," says Cox. "Her husband claimed that the facility's failure to transfer her was the cause of her death."

Plaintiffs also might allege that the transfer occurred too late. "These cases tend to involve services that are ordered for a patient that are normally available at the facility, but for some reason, are not available at the particular time when ordered," says Cox. She says these items, if carefully documented, can dissuade plaintiff attorneys from filing suit in the first place:

• Documentation showing that the criteria were met for meeting exceptions to transfer requirements.

To avoid sanctions and possible license revocation from the medical board for not transferring a pregnant woman, for example, a qualified practitioner must certify that the requirements of an emergency medical condition, including that a transfer will pose a threat to the mother or fetus, have been met.

"These must be thoroughly documented," says Cox.

• If the patient refused the transfer, documentation as to why the transfer was recommended, the risks and benefits of the transfer, and that these were explained to the patient.

"Have the patient sign an acknowledgement," says Cox.

• An appropriate patient plan of care for the patient.

• Physician certification, if required.

"Violation of a statute may make it easier for a plaintiff to demonstrate that a physician's conduct fell below the standard of care," says Cox.

Executive Summary

Physicians have a legal obligation to transfer a patient when the standard of care or the facility's licensure requires it. This documentation can make "failure-to-transfer" claims more defensible:

✦ the criteria for meeting exceptions to transfer requirements;
✦ how criteria in policies were met;
✦ an appropriate patient plan of care.

Psychiatric patient risks

A hospital that does not have a psychiatric inpatient unit probably does not have the specialty services necessary to stabilize a psychiatric patient. Therefore, under EMTALA, the patient should be transferred to a hospital with the necessary services for stabilization, says **Mary Jean Geroulo**, JD, an attorney at Wilson Elser in Dallas.

Boarding a patient in the ED when the facility does not have services necessary for stabilization of the patient could be interpreted as a violation of EMTALA, Geroulo warns. "Simply medicating the patient generally will typically not qualify as stabilization," she adds.

Patients who are on involuntary holds have to be evaluated by a psychiatrist within a short period of time, to determine if the hold is justified. "Failure to provide a psychiatric evaluation could put the hospital and the attending physicians at risk," adds Geroulo.

Even if the patient is not on an involuntary hold, a psychiatric patient boarding in an ED is not likely to receive the treatment available on a psychiatric unit. That treatment includes evaluation by nurses, therapists, and social workers trained in the treatment and evaluation of patients with mental health disorders, she explains. Geroulo recommends these practices:

• Physicians should document in detail their efforts to have the patient transferred to a facility with the appropriate services and/or the hospital's efforts to make space available in its psychiatric unit.

• If the facility does not have the capability to treat the patient and other facilities with the capability have refused the transfer, the facility/physician should report the refusal to the Centers for Medicare & Medicaid Services as a potential violation of EMTALA.

"Lastly, the facility should document the efforts and steps made to keep the patient safe, and to provide services by persons trained in the evaluation and treatment of patients with psychiatric disorders," says Geroulo.

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Risk-prone practices continue in office setting — 'Vicarious liability' claims are rising

With more patient care rendered in the ambulatory setting, physician's offices have more potential "to be the setting for the beginnings, continuation, or genesis of an untoward outcome," warns **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, principal of the Kicklighter Group, a Tamarac, FL-based risk management consulting firm.

"In most, if not all states, there is little to no oversight of the physician's independent office practice setting," she says. Kicklighter is aware of many malpractice claims involving physician supervisors being sued for actions of team members, both physicians and non-physicians. *(See related story, p. 105, on one such claim.)*

Below are some areas of potential liability exposures in a physician's office- based practice:

• Failure to have a process in place to follow up on results of all ordered tests on a timely basis.

"These issues can not only lead to misdiagnosis or missed diagnosis, but also a claim for delay in diagnosis," says Kicklighter.

In addition, private payers and the Centers for Medicare & Medicaid Services require documentation of medical necessity. If there is no documented evidence that the results were obtained and considered by the ordering physician, says Kicklighter, "it is possible one might ask, 'If it wasn't important enough to follow up on, was it even medically necessary to order in the first place?'"

• Failure to maintain positive ongoing relationships with patients.

"This is a positive patient retention practice and a deterrent to claims," she says. Kicklighter advises physicians, whenever possible, to personally call the patient shortly after a visit, discharge, or treatment.

"If it wasn't important enough to follow up on, was it even medically necessary to order in the first place?'"

"Inquire how the patient is now feeling and if the medication or treatment is working," she says. "This allows the patient to convey information to the physician or to ask questions."

• Failure to set standards regarding triaging patients who call with a medical complaint but no appointment.

"This can lead to significant claims," she says. Kicklighter says guidelines should address:

- who may triage these calls;
- the process for handling calls from patients and others who want to speak to the doctor;
- the process for documenting such calls in the medical record;
- the process for handling and documenting after-hours calls.

• Failure of physicians or surgeons to understand their oversight role when employing or contracting with physician extenders such as advance nurse practitioners (NPs) or physician's assistants (PAs).

Kicklighter recommends providers use these approaches:

• Update protocols for independent practice as needed, to ensure compliance with state-specific laws and rules that govern the practice of NPs and PAs in the office-based practice setting.

• Periodically review medical records of patients seen by the NP and/or PA to verify complete documentation and compliance with established protocols.

• In those states where the NP and/or PA does not have authority to write prescriptions for controlled substances, have a system in place to review the medical record or actually see the patient on a timely basis, and if writing a prescription, document the verification of need in the record.

"To leave blank, signed prescriptions for the NP or PA to complete with the patient's name and drug can lead to drug diversion problems with the board of medicine, and a possible bad outcome," says Kicklighter.

Physicians often don't realize that they can be held vicariously liable for the action of their staff, regardless of whether the employee is a clerk, nurse, or physician's assistant, says **Steven Adler**, CEO of Physicians Indemnity Risk Retention Group, a Plantation, FL-based provider of professional liability insurance.

"What I find is that we focus so much on the physicians — and we

Executive Summary

Office-based practices face increased legal risks due to more patient care occurring in the ambulatory setting. Physicians often fail to realize that they can be held vicariously liable for the actions of their staff.

✦ Providers need to ensure timely follow up on receipt and results of all ordered tests on a timely basis.

✦ Standards are needed to triage patient calls.

✦ Physicians and surgeons need to understand their oversight role.

should — but there is a failure to focus on the office staff," he says.

Physicians Indemnity gives physicians premium discounts for taking a risk management course. "But not only do they have to take it, their staff has to take it," underscores Adler. "That physician is ultimately responsible for what transpires in his or her office." *(See related story, below, on legal risks of failure to inform patients of test results.)*

SOURCES

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Failure to review previous X-ray results, and the patient wasn't notified

A patient saw multiple physician internal medicine practices for an upper respiratory complaint, including one practice in which a nurse practitioner (NP) ordered a chest X-ray.

"Some time after, the patient returned and saw a physician with a compliant of chronic cough," says **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, principal of the Kicklighter Group, a Tamarac, FL-based risk management consulting firm. The physician ordered a chest X-ray, and the results stated that the lesion in the lung reported previously had progressed.

"In looking at the medical record, upon receipt of this report, the physician sees the previous report in the record was not followed up by anyone," says Kicklighter. "There are two problems here."

First, the results of the X-ray ordered by NP were not addressed by the practice when they were received. Kicklighter says a "fail-safe process" is to provide patients with results of all test results, normal or abnormal, with documentation of such notice. "The physician tried to blame the ARNP, but was reminded that the ARNP is an employee of the practice; therefore, the ARNP's exposure was the practice's," says Kicklighter.

Secondly, the physician failed to review the medical record when seeing the patient. "Had the record been reviewed, the previous visit assessment, conclusions, and orders would have been evident, and would have caused a review of the previously ordered X-ray report," says Kicklighter.

Tests never obtained

Steven Adler, CEO of Physicians Indemnity Risk Retention Group, a Plantation, FL-based provider of professional liability insurance, is seeing many more claims involving providers who failed to review test results or failed to follow up when patients didn't obtain a test. Here are some recent examples:

• A stat CT was ordered for a woman who presented with right lower quadrant abdominal pain, but the patient felt better and decided not to get the test. "The physician had no mechanism to remind them they needed the result of the test," says Adler. "The patient came back in three weeks and was referred to a GI." The patient's appendix ruptured and resulted in short bowel syndrome.

• A patient who presented with severe chest pain was referred to a GI. The patient returned with unrelenting pain, but never obtained the stress test that was ordered because there were problems getting authorization.

The patient had a coronary event and expired. "There was no follow-up with the physician or the staff as to the status of getting this patient authorized," says Adler.

• A physician ordered a CT scan after a diagnostic test revealed a suspected mass in a patient's lung, but the test was never done. "Months later, the doctor was called in as a consult when the patient was admitted months later for unrelated reasons," he says. "He never went back to his records to determine that the tests that had been ordered were never done." The patient later was diagnosed with advanced carcinoma of the lung and died shortly after.

During audits of physician's offices, Adler often finds there is no "tickler" system to remind the office that a patient never returned for a follow-up visit or obtained a diagnostic test.

"If you don't have a proper protocol, things are going to fall through the cracks," says Adler. "You just can't remember what you've ordered for 60 patients." ✦

Must expert be in same specialty? Not necessarily! Rules 'may not protect defendant physicians'

Physicians need to be aware that each state is unique in how it regulates medical expert witnesses, says **Holly Miller**, Esq., governmental affairs counsel for the Florida Medical Association.

"Most states have their own set of expert witness rules, which may not protect defendant physicians," says Miller.

For example, Florida law now requires that an expert witness in a medical malpractice suit be of the "same" specialty as a defendant physician. Before the law was passed in 2013, the requirement stated that experts needed to be in the "same or similar" specialty.

"Florida courts' interpretation of this 'or similar' designation was problematic," says Miller. "It led to plaintiffs' attorneys using this loophole to convince the courts to allow general surgeons to testify against neurologists and gastroenterologists to testify against hospitalists, and so on."

Physician specialties vary considerably in terms of education, training, and specific standards of care. "It is patently unfair to the defendant physician, and misleading to juries, to permit expert witnesses from one specialty to testify against a physician practicing in another specialty regarding the proper standard of care," argues Miller.

Courts sometimes make exceptions

While the general rule in many states is that the testifying expert has to be from the same specialty as the physician defendant, courts sometimes will make exceptions, says **Thomas R. McLean**, MD, JD, CEO of American Medical Litigation Support Services in Shawnee, KS.

McLean was an expert witness in a malpractice case involving a board-certified pediatric surgeon, and the opposing side argued that he should be disqualified because he was board-certified in general surgery. "In that particular case, the judge ruled that I could testify, since the case involved an issue of postoperative care which was common to both areas," he says.

The expert was allowed to testify because evidence showed he practiced in a rural setting very similar to that of the physician defendant.

It would have been difficult for the other side to find a board-certified pediatric surgeon to testify because of the scarcity of physicians in that particular subspecialty, he adds. In another case, an expert was allowed to testify despite not being licensed in Tennessee, thus circumventing a requirement for experts to be familiar with the practice of medicine in that state. The expert was allowed to testify because evidence showed he practiced in a rural setting very similar to that of the physician defendant.

While exceptions are made, says McLean, "you have to have a good argument for why there are special circumstances." *(See related story, below, on other expert witness requirements.)*

Executive Summary

Requirements for medical expert witnesses vary by state regarding the need to practice in the same specialty, where the physician is licensed, and other factors.

- ✦ Various medical societies have set forth rules for qualifications and conduct.
- ✦ Exceptions may be made to allow a witness to testify due to a scarcity of a particular specialty.
- ✦ The trial process allows the parties to test the expert's credibility.

SOURCES

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Can expert testify? Often, it depends on what state you're in

Whether a medical expert is qualified to testify often turns on a particular state statute, says **Thomas R. McLean**, MD, JD, CEO of American Medical Litigation Support Services in Shawnee, KS.

Factors include where the physician is licensed, board certification status, and whether the physician was practicing at the same time as the alleged malpractice incident.

"There is no question that these vary when you step across the state line," he says. McLean says that experts are rarely disqualified, however, as it can be disastrous for the attorneys involved. "The last thing a plaintiff or defense attorney wants is to hire an expert only to be told the expert isn't qualified," he says. "The case then collapses, and the opponent moves for summary judgment."

Various medical societies also

have set forth various rules for expert witness qualifications and conduct, notes **B. Sonny Bal**, MD, JD, MBA, professor of orthopaedic surgery at the University of Missouri School of Medicine in Columbia. "The testifying expert should be familiar with rules pertaining to a specific venue," he adds.

Time-tested legal mechanisms

Variations in expert witness requirements are unlikely to affect the outcome of malpractice cases, according to Bal, despite the fact that some states have a very low threshold for who qualifies as an expert.

The cross examination of the witness is a powerful and time-tested legal mechanism to test an expert's credibility, he says.

"The foundational knowledge upon which an expert bases the opinion proffered can likewise be tested very thoroughly in court," says Bal.

There is increasing scrutiny of opinions offered during trial litigation, he adds. All such opinions and testimony are in the written record and easily discovered. "This means that the expert must have a thorough understanding of the facts relevant to the case, impartiality, objectivity, and must possess the requisite knowledge to be able to offer an opinion," says Bal.

In his view, requiring experts to obtain limited licensure in states where experts are to testify, so that there can be medical board oversight, is unnecessary. "In our information age, with computerized records and easy search of databases, inaccurate and deceptive expert testimony can be readily identified by interested parties," Bal explains. One example of a database is TrialSmith (www.trialsmith.com), which is available to plaintiff's attorneys through their various state trial lawyers' associations. Lexis/Nexis also has a similar service, (https://idex.lexisnexis.com) now available to any subscriber who pays for the extra service. The trial process itself offers many opportunities for the parties to test the credibility and knowledge of the expert witness.

> ***"In our information age ... inaccurate and deceptive expert testimony can be readily identified by interested parties."***

"To the extent that counsel fail to cross examine an expert witness, that is a problem with the legal procedure itself and unlikely to be cured by increased medical board oversight," says Bal. ✦

COMING IN FUTURE MONTHS

✦ Why medical necessity is coming up in med/mal suits

✦ Use EMRs to ensure follow-up on all test results

✦ Allegations in claims involving incidental findings

✦ What to document if diagnostic test is not ordered

CME OBJECTIVES

After reading *Physician Risk Management*, the participant will be able to:

- describe the legal, clinical, financial, and managerial issues pertinent to physician risk management;
- explain the impact of risk management issues on patients, physicians, legal counsel, and management;
- identify solutions to risk management problems for physicians, administrators, risk managers, and insurers to use in overcoming the challenges they face in daily practice.

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you instantly. ✦

CME Questions

1. **Which is true regarding "tail" coverage, according to Michael R. Tamucci Jr?**
   A. If physicians fail to purchase "tail" coverage when leaving one carrier, they risk having no coverage if a suit is filed before the effective date of their new carrier's policy.
   B. It is never possible for physicians to obtain a retroactive date from the new carrier to provide coverage for any potential gaps.
   C. Tail coverage does not allow physicians to report a case after their policy has expired or has been canceled.
   D. Occurrence policies only cover physicians if the claim is reported at the time the incident occurred.

2. **Legal outcomes of malpractice claims involving routine medical procedures often hinged on which of these factors, according to a CRICO Strategies analysis?**
   A. Failure to obtain or document a thorough, voluntary, informed consent.
   B. A provider's lack of appropriate credentials or experience with the procedure.
   C. Performing a procedure on an inappropriate candidate or in an unsuitable setting.
   D. All of the above.

3. **Which is true regarding claims alleging failure to transfer, says Angela Cox, JD, of Brennan, Manna & Diamond?**
   A. Physicians have a legal obligation to transfer a patient when either the standard of care or the facility's licensure requires it.
   B. Physicians should never document how the criteria were met for exceptions to transfer requirements.
   C. The Emergency Medical Treatment and Labor Act (EMTALA) imposes a duty to transfer patients that cannot be stabilized.
   D. Boarding a patient in the emergency department when the facility does not have services necessary for stabilization of the patient cannot be interpreted as a violation of EMTALA.

4. **Which is true regarding requirements for expert witnesses testifying in medical malpractice cases?**
   A. To testify against a physician in a medical malpractice case, experts must be from the same specialty as the physician defendant, without exception.
   B. All states require experts to obtain limited licensure in the state where they are to testify, to ensure medical board oversight.
   C. Virtually all states allow physicians to testify against a physician practicing in another specialty regarding the standard of care.
   D. State statutes vary regarding whether experts need to be from the same specialty as the physician defendant.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICIAN RISK MANAGEMENT

Family members awarded $3.75 million in lung cancer diagnosis delay case

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News: The patient, a 74-year-old man, sought treatment for a cough. His physician ordered a chest X-ray followed by a CT scan. The CT scan revealed a consolidation in the right upper lobe of the lung, which was an abnormal finding. However, the physician failed to take subsequent action over the next 18 months, during which time the patient returned to the physician for other ailments. The physician finally ordered a second CT scan 20 months later which revealed that the original consolidation was a malignancy and that the cancer had progressed to an inoperable stage. The patient's surviving family brought suit alleging that the physician failed to take proper action and that this delay caused the patient's death. The defendant physician denied liability. The jury awarded $3.75 million in damages against the physician.

... the physician failed to order any follow-up testing at that time to rule out lung cancer or pneumonia.

Background: In this matter, the patient, an elderly man and former smoker, had a cough in September 2009 and sought treatment at a medical center. The physician initially ordered a chest X-ray and supplemented the X-ray with a CT scan, which showed aconsolidation in the right upper lobe of the lung. Such a consolidation is a significant and abnormal finding that necessitates additional care, as it might be a sign of lung cancer or pneumonia. However, the physician failed to order any follow-up testing at that time to rule out lung cancer or pneumonia.

Over the 18 months following the discovery of the consolidation, the patient continued to visit the same physician for other medical treatment. During these visits, the physician never ordered further testing to find out if the consolidation had resolved. The physician simply assumed that the consolidation was not cancer and conducted no follow-up to verify this assumption. The physician did order a second CT scan, but it was 20 months after the initial CT scan. This second scan allowed the physician to properly diagnose the patient with cancer, but at this point it was too late. The lung cancer had progressed from Stage I at the time of the initial scan, to Stage IV at the time of the second scan. At this point, the cancer was metastatic. Within a week, the cancer was noted to have spread to the patient's spine, which resulted in the patient losing the ability to walk. His physical symptoms grew increasingly

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.

worse, which required hospice care. The patient died nine months after the second scan.

The patient's widow, two sons, and a daughter brought suit. They claimed that the physician should have done additional testing to properly diagnose the cancer after the first CT scan revealed the abnormality. At that time, by eliminating other potential conditions and performing a subsequent CT scan to reconfirm the existence of the consolidation, a diagnosis of lung cancer would have been made andallowed for a simple surgical procedure to take out the mass when it was at Stage I. The plaintiffs alleged that treatment at Stage I was possible for this patient had the physician had properly diagnosed the condition. But for this improper diagnosis, the patient would have survived, they alleged. The physician defended on the basis that there were no signs or symptoms of lung cancer or pneumonia that would have required a follow-up from the CT scan. The physician claimed that he relied upon the report of a radiologist which did not advise follow-up and that the consolidation could have been a caused by several things. Experts on both sides debated the original stage of the cancer. The plaintiffs' experts said it was clinical Stage I in 2009, while the defense's experts used the "Doubling Time" theory to claim that the cancer was further along initially. The jury agreed with the plaintiffs, found the physician liable, and awarded the family $3.75 million.

What this means to you:
Physicians must act when presented with a condition that mandates investigation. Many ailments do not resolve themselves on their own, and inaction can bring rise to liability when the standard of care requires more. If a reasonable physician given the same or similar circumstances would have provided follow-up testing, then simply waiting for an issue to resolve itself would likely result in medical malpractice. Here, the physician recognized the abnormality from the CT scan, but he did not take action to discover the source of the consolidation. His delay of 20 months clearly constituted medical malpractice. Expert testimony revealed that a reasonable physician given an abnormal chest X-ray and CT scan, particularly from an elderly patient with a history of smoking, should immediately think lung cancer. With this specific patient history and recognized abnormality, prompt action was required. Failing to take that action drastically worsened the patient's condition. If the physician originally had diagnosed the patient correctly, the cancer could have been promptly treated and perhaps cured. Lung cancer, unlike some other types of cancer, progresses in such a way that early treatment is required for high survival rates. Treatment after Stage I typically results in less than a 50% chance of survival, whereas treatment during Stage I can be a simple surgical procedure to remove the cancerous mass.

Blindly relying on the reports and advice of others might be a dangerous practice for physicians. One of the physician's defenses here was that he relied upon a radiologist's report regarding the consolidation, which did not advise follow-up. When making determinations based upon reports of others, physicians further both their own best interests and the best interests of their patients by being critical of these reports. Rather than simply accepting the findings as true, one should look to the basis for those findings to determine if they have sufficient factual support. A physician might subject himself or herself to liability by accepting the judgments of another physician as his or her own without further critical analysis. This might vary based upon the nature of the report and its author, but when the nature regards a potentially life-threatening illness or the author is less qualified than the physician, then the physician might be putting himself or herself at risk by not verifying the accuracy of the report.

This case also illustrates that causation plays an extremely important role in medical malpractice cases. A malpractice case will be successful only if the plaintiff can prove causation and damages along with the underlying negligent action. If the patient's harm is not caused by the physician's negligence, then the malpractice suit necessarily fails. The plaintiffs' presentation suggested that at the time of the original CT scan, the physician had a three-month timeframe to act when treatment likely would have resulted in survival. The defense, on the other hand, attempted to argue that there was a disconnect between the harm and the negligence. The defense claimed that the cancer was further developed in the original 2009 CT scan so that any mistake by the physician resulted in lesser or no damages. Had the patient's cancer originally been at a more advanced stage the physician's failure to diagnose would have been less egregious from a damages perspective because the treatment at that time would have been less likely to be effective.

The defense also used the "Doubling Time" theory, which generally states that specific cancers have specific growth rates and that as a general rule, the rate of growth is faster in the early stages of the cancer and slows down as the cancer becomes more advanced. This theory and the science regarding tumor proliferation and growth are themselves constantly evolving, and some courts have found that the theory to be not customarily relied upon by experts in the field, thus disallowing expert testimony regarding it. In this case, however, the court allowed the theory to be presented, but the jury apparently rejected the defense's

posed theory and ruled in favor of the plaintiffs.

Finally, this case also shows that expert witnesses can play a key role in medical malpractice cases. Because jurors often have little or no knowledge of the standard of care a physician should be following, they must rely on other sources, and expert testimony is a major source that juries look to for guidance. Each side will have its own experts, who will often disagree about the proper standard of care. When this disagreement arises, the jury must decide which experts to rely upon. Thus, a knowledgeable expert with strong communication skills will be an important resource during trial. Physicians should work alongside counsel to select this expert, and the expert might help the case throughout litigation, not merely during the trial stage. Experts represent considerable investments in time and money, so interviewing or cross-referencing might be important to ensure that the expert is an appropriate match for the case. Potential methods for finding the right expert for litigation include networking with other attorneys or physicians for references, finding experts at trade shows or seminars held by those in the field, or searching local universities and colleges with specialized departments in the field. Professors might prove to be strong expert witnesses as they typically possess two qualities most sought in experts: knowledge and strong communication skills. Educating a jury through an expert is similar to educating students, as both require public speaking skills, thorough understanding of the field, and ample preparation for the testimony or lecture. These skills can translate into an impressive expert witness and an invaluable asset during litigation.

Expert testimony in this particular case, as with many medical malpractice cases, was indeed necessary for the plaintiffs' success. Causation, a required element for a medical malpractice claim, could not have been proved without this testimony. Each side presented expert testimony supporting its claim or defense, but the jury ultimately found one more believable than the other. An expert's credibility is important to establish and maintain throughout the course of litigation. The jury must believe an expert in order to give his or her medical theories weight. Wise counsel will attack the credibility of the opposing experts, and an expert who devotes his time solely to litigation might be viewed as a "hired gun" and arouse suspicion from the jury. In some cases, the facts might be so egregious that the expert testimony is merely a formality, but with many cases, a strong expert as opposed to a weak expert can make the case.

Reference

Circuit Court of Montgomery County, MD. Case No. 366803V. Nov. 27, 2013. ✦

Misdiagnosis results in bowel obstruction, patient's death, and a $2.4 million verdict

News: The patient, a 47-year-old woman, was admitted to a hospital's emergency department, complaining of severe back and abdominal pain. The physician diagnosed her with back spasms and sent her to an observation ward for monitoring and treatment without ordering additional tests or consulting any other physician. The patient died the following day as a result of a bowel obstruction, which the physician failed to diagnose. The patient's family filed suit against the physician and his employer group, and the family claimed that the physician's failure to diagnose fell below the standard of care. The defendants denied liability. The jury awarded $2.4 million in damages against the physician and his group.

Background: In this matter, the patient sought treatment at a hospital for severe back and abdominal pain. The attending physician initially diagnosed the patient as having back spasms. He did not conduct additional testing. Experts during the trial stated that the physician could have taken multiple courses of action to properly diagnose and treat the patient, such as: performing a thorough physical examination to rule out parts of his original differential; consulting a physician colleague in the emergency department; obtaining a surgical consultation; ordering serial blood work, a contrast CT scan, or repeat imaging. This physician did order a non-contrast CT scan, which he read as essentially normal. This fact, too, was debated and disproven during trial. The defense's own expert stated that the non-contrast CT was misread, and if it had been read properly, that might have informed the physician that there was more to this patient's condition.

Two years before these events, the patient underwent gastric bypass surgery. Known complications of that surgery are bowel obstruction and internal hernia. The physician here knew that the patient underwent the surgery, as it was listed in the patient's chart three times, and at least one entry was in the physician's own handwriting. However,

he did not initially consider bowel obstruction to be the proper diagnosis. The patient's condition was marked by extreme pain, which was characterized as "horrible, writhing, and tearful." The physician sent the patient to an observation ward with plenty of analgesics, but this masking the pain was an insufficient substitute for treatment. The patient's condition worsened quickly, and within 10 hours from the original diagnosis of back spasms, she died as the result of a bowel obstruction.

The patient's family claimed medical malpractice and alleged that the physician failed to correctly diagnose the condition and adequately treat the patient. As discussed above, experts during trial listed numerous possibilities which the physician could and should have taken to successfully diagnose the patient. The defendant physician testified during trial that he did not know what was going on with the patient, yet his primary defense was that his non-contrast CT scan, which was improperly read, was sufficient. He additionally claimed that he performed a thorough physical examination by listening for bowel sounds and took a thorough medical history, but the record in court did not support this claim. After deliberating for two hours, the jurors came back with a verdict for the plaintiffs and awarded them $2.4 million in damages.

What this means to you: The primary issue in this case, whether the physician was negligent for failing to correctly diagnose the bowel obstruction, is relatively straightforward. When a patient presents with symptoms and has a specific medical background that might give rise to increased risk of complications, these symptoms must be thoroughly investigated. Simply transferring a patient for observation and masking the symptoms with analgesics is not a proper treatment. Such steps might give rise to liability when the underlying condition continues and results in harm. During trial, the physician admitted that he did not know what was going on with the patient. His lack of knowledge alone did not subject him to liability, but rather his failure to act appropriately given the situation, and his lack of knowledge, did.

Physicians are not omniscient, and this is no excuse for medical malpractice. When encountering an unknown condition or ailment, physicians must take certain steps to ensure the well-being of their patients. The experts in the case here listed multiple actions that the physician could have taken to seek answers to his patient's unknown illness, such as obtaining a consultation from another physician or surgeon or performing additional tests to supplement knowledge and make a better diagnosis. Thesesteps are particularly important when the patient has a known history that might indicate a potentially life-threatening condition, as the bowel obstruction evidently was. Action must be taken. If the physician himself is unclear of the correct action to be taken, then more experienced physicians with specific expertise in the relevant area should be promptly consulted. Administering painkillers and waiting to see what happens is doubtfully the best solution to an unknown question, because this mere bandage is not a true remedy.

That said, unless a patient presents with a head injury, analgesics are important to provide quickly to patients in extreme pain. Pain in and of itself might mask other symptoms and should be relieved as quickly as possible. Had the physician re-evaluated the patient once her pain was controlled, he might have been alerted to her more subtle symptoms of abdominal pain. While bowel pain can refer to the back, as it did in this case, back pain usually does not refer to the abdomen. A bowel obstruction is a life-threatening medical emergency and requires immediate surgical consultation and intervention. Even if the patient had no complaints of abdominal pain, back pain that is so severe as to cause such an extreme reaction from the patient needs further exploration. With no history of back injury and a positive history of abdominal surgery, the physician's conclusions should have warranted additional testing and surgical consultation. His failure to do this step meant that he failed to provide the standard of care, thus committing malpractice.

Relatedly, documentation is not only critical but is actually mandated for proper medical diagnosis and treatment, as well as for assisting in potential future litigation related to such diagnosis and treatment. Keeping accurate records of exactly what types of tests are conducted might be essential to prove what actually happened and in this case, those actions did not fall within the proper standard of care required. Here, the physician's testimony stated that he performed a thorough physical examination and took a thorough medical history, but the objective record that was presented to the court and the jury differed. If the physician actually did perform such a thorough assessment, he should have noted this information somewhere in the patient's file. Documentation of that assessment could have been useful for providing a credible record to the court instead of having the jury rely solely on his word that he performed such actions. Many jurors might be skeptical of the defendant's own testimony when it is the only evidence supporting his point, and rightfully so, as the defendant has a strong interest to protect himself and avoid liability. Keeping the type of records required by the medical staff of the hospital is helpful for litigation and medical purposes.

Reference

Williamson County, IL. Case No. 2009L36. Dec. 4, 2013. ✦