PHYSICIAN Risk Management

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Non-compliant patient refuses treatment or test? How MD can prevent a lawsuit

Seemingly 'slam dunk' cases end up being settled

"Why did you have to settle a case when the patient didn't comply?" is a question **Ashley Watkins Umbach**, JD, senior risk management consultant at ProAssurance Companies in Birmingham, AL, is occasionally asked, and the answer is always the same: "It's because the doctor just didn't have any documentation to rely on," she says.

A recent successful lawsuit involving a patient's non-compliance "should have been a slam dunk and should have never been filed," says Umbach.

A gastroenterologist treating a close friend with colitis performed a colonoscopy that showed some dysplasia, and the doctor recommended a yearly colonoscopy.

The gastroenterologist called his friend to remind him to have the test, but the friend refused and said he couldn't make the time. "The second year, the [gastroenterologist] told him it was especially important that he have the test, but the friend said his stomach was feeling really great and he thought the colonoscopy would irritate it," she says. Seven years later, the patient was diagnosed with a rare form of aggressive cancer that he subsequently died from, and the family sued.

"Physicians need to document this interaction so they can prove that it happened years later."

"You'd never expect a suit would have been filed, because the patient refused the colonoscopy," says Umbach. Unfortunately, the doctor didn't chart the phone calls or the patient's refusal, so the jury had nothing but his word to rely upon.

"This also shows the problem of treating friends and not keeping a chart the same way you do with your other patients," says Umbach. "For various unusual reasons, the judge did not allow the [gastroenterologist] not to testify to anything that was not in the medical record." As a result, the case that initially seemed to be a "slam

INSIDE

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dunk" ended up being settled.

Show patient was fully informed

Bobbie S. Sprader, JD, an attorney with Bricker & Eckler in Columbus, OH, said, "Patients can refuse testing for a whole host of reasons, from fear and lack of time to lack of funding, and everything in between."

In one malpractice suit, a primary care physician recommended a colonoscopy, but a patient wanted to defer further testing. The patient sued after being diagnosed with colon cancer.

"He blamed the primary care physician for not following up further at subsequent visits and for not convincing him that the test was really necessary," says Sprader.

Documentation showing that the patient was fully informed of the risks of refusing the test makes such claims more defensible. "Physicians need to document this interaction so they can prove that it happened years later," she says.

Such documentation, says Sprader, "helps us defend cases when the patient does not get the recommended testing and then either 'forgets' that it was recommended or is no longer living and her family claims that she would never, ever decline a recommended test."

She says physicians should consider these practices:

• If there is a commercially available pamphlet that does a good job of explaining the reason for the recommendation, physicians should give it to the patient and note that this step was done.

• If the patient is declining testing for financial reasons, physicians can try to help.

"I am not saying that they pay for the study, but they may be able to push insurance to cover it or seek some form of discounted rate if the patient does not have insurance," says Sprader. The physician can offer an alternative plan that is less expensive, even if it is not as good.

"Again, they should document this compromise and note that it is due to patient preference and not physician preference," says Sprader.

Chart should reflect a caring MD

Umbach recommends physicians have a system in place for tracking no-shows and follow-up that doesn't occur and that everyone in the practice follow

Executive Summary

Successful malpractice suits can result even if a patient refused a treatment or test. To dissuade plaintiff attorneys from pursuing a claim involving a patient's non-compliance, physicians should document the following:

✦ that the patient was fully informed of the risks of refusing the test;
✦ that the patient admitted to non-compliance;
✦ the efforts to help patients resolve issues, financial or otherwise, that are resulting in non-compliance.

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Editorial Questions
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the same system.

"The more documentation you have, the better," says Umbach. One attempted phone call is not nearly as persuasive as documentation of repeated calls and the substance of the conversations. It is particularly important to document the facts that were conveyed to the patient about the risks of failing to take the recommended action.

"If you are unable to reach the patient, it's also helpful to document that you tried to contact them in various ways," says Umbach. This contact might include phone calls, letters, certified letters, or Googling for another address or phone number, especially if the condition requiring follow-up is severe.

"A jury wants to see that the physician cares about the patient," says Umbach. "Calling or writing to emphasize that the patient's health will be in jeopardy if he fails to follow up conveys this feeling."

Some documentation is always better than none. "A general notation that preventative screening was discussed is better than silence," says Sprader. "However, in order to dissuade a plaintiff's attorney from filing suit, the best documentation will state specifically what testing was recommended and why."

Patient must understand refusal

When a patient refuses a test or procedure, the physician must first be certain that the patient understands the consequences of doing so, says

Communication breakdowns are the most common complaint of patients in lawsuits.

James Scibilia, MD, a Beaver Falls, PA-based pediatrician and member of the American Academy of Pediatrics' Committee on Medical Liability and Risk Management.

"Often, the patient may not fully grasp the reason for the test or procedure, or what could happen if treatment is delayed," says Scibilia. The patient might be worried about the cost or confused due to medical terminology, language issues, or a mental or physical impairment such as hearing loss. "Educating the patient about the physician's thought process and specific concerns can be very enlightening to the patient," says Scibilia.

Communication breakdowns are the most common complaint of patients in lawsuits, he emphasizes. Empathic and comprehensive discussion with patients is an important element of managing this risk. "Document when patients admit to non-compliance, and document discussions or instructions you give to patients who are, or who are likely to be, non-compliant," says Scibilia.

In some states the principle of "comparative fault" or "contributory negligence" will place some of the blame on the patient for failure to get recommended treatment. "In these cases, the burden of proof is on the defendant to prove the plaintiff contributed to his own injury," cautions Scibilia.

SOURCES

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In employment contracts, beware of agreements for indemnification — Added liability is at stake

Should a physician employee agree to "indemnify, hold harmless, and defend the hospital from any and all loss, damage, cost, and expense the hospital may suffer that is in any way related to the physician's performance or failure to perform the services, responsibilities, and duties the physician has agreed to perform?"

"Imagine the scenarios that could be 'in any way related to the physician's performance or failure to perform' patient care services," says **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois in Chicago and a practicing attorney in Frankfort, IL.

Sullivan gives the example of a physician who assists a security guard in restraining a combative head-injured patient. In this scenario, the physician might be required to reimburse the hospital for all expenses if the hospital is later named as a defendant in a legal action brought by the patient. "Indemnification clauses are not appropriate in medical employment contracts," argues Sullivan. "In addition to causing financial risk, contractual indemnification may also void a physician's medical malpractice insurance coverage."

Clause complicates coverage

By agreeing to contractual indemnification, a physician could be required to provide full reimbursement to an employer for the events being indem-

nified. "At times, that indemnification may apply even though the employer's own negligence may have caused its damages," says Sullivan. For example, if a physician misses a heart attack in a busy emergency department and is sued, an indemnification agreement might force the physician to pay for all expenses the hospital incurs when defending the lawsuit, even if the malpractice occurred because the hospital grossly understaffed the emergency department.

"In addition, adding contractual indemnification to a medical group's service provider agreement with a hospital can unnecessarily complicate medical malpractice litigation," says Sullivan. In order to avoid indemnification during litigation, multiple defendants may disclose undesirable facts about the other defendants, increasing the liability for all defendants. For example, when attempting to enforce a mutual indemnification clause during one New York medical malpractice case, a defendant obstetrical resident alleged that the hospital should indemnify him because a hospital attending provided inadequate supervision.[1] In turn, the defendant hospital alleged that the resident should indemnify it because the resident withheld important information from the attending and provided substandard care.

"These allegations benefitted the plaintiff in the pending case against both defendants," says Sullivan.

Executive Summary

Indemnification clauses included in some contracts with employers, hospitals, and payers can complicate malpractice litigation and can result in additional liability for physicians.

✦ Physicians might be required to reimburse the hospital for all expenses if the hospital is later named as a defendant in a legal action.

✦Contractual indemnification could void medical malpractice insurance coverage.

✦ Physicians can potentially incur significant personal financial losses.

Coverage might be voided

There are two basic types of indemnity agreements, says **Robert J. Milligan**, JD, an attorney at Milligan Lawless in Phoenix. One is common law indemnity, under which the party which is solely at fault for a claim has to indemnify another party that is named in a lawsuit.

"That's what the law is in many states, in the absence of an agreement," says Milligan. The other type of indemnity is contractual, which in some cases is broader, such as agreeing to indemnify a party from any claims arising from the other party's conduct or the physician's conduct.

"Hospitals, payers, or others that physicians deal with may slide that broad indemnification provision into a contract," says Milligan. If a physician has granted this broader contractual indemnity to a hospital and a lawsuit occurs, the physician could end up without coverage for the indemnity obligation.

"The insurer will say, 'Check your policy; there's an exclusion for liability assumed under contract. We don't have to insure you because of that provision,'" says Milligan. "And the physician is out of luck."

Physicians often are unaware of the provision. "And when they do realize it, they say, 'Well, how often does that happen?'" says Milligan. "Maybe so, but when it does, you're going to be very unhappy. It's a low likelihood risk of a very bad problem."

Reference

1. Freeman v. Mercy Medical Center, 2008 NY Slip Op 31337(U).

SOURCES

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Radiologist dismissed from case due to documentation — Cases often hinge on communication of results

While reading a patient's MRI, a radiologist observed a flattening of the spinal cord at the C6-C7 level, which was considered a critical finding.

"The physician prepared a preliminary report and instructed his assistant to communicate the findings to the ordering physician, stat," says **Stephen Shows**, a risk management consultant for ProAssurance Companies in Birmingham, AL.

The assistant did so, but "the problem was that the ordering physician was the primary care physician, who had since referred the patient to a specialist," says Shows. The primary care physician assumed the specialist would communicate the results to the patient, but the specialist never received the results. "There was nothing to notify the radiologist he should send a copy to the specialist," Shows says. "As a result, there was a three-day delay in communicating the results to the patient, who eventually suffered paralysis."

The patient claimed this outcome could have been avoided had his results

been better communicated, and the patient sued the radiologist and the specialist. The claim against the radiologist eventually was dismissed.

"He was able to show he met the standard of care by having his office timely communicate the findings to the ordering physician," says Shows.

Executive Summary

Poor communication between ordering physicians and radiologists can result in malpractice claims alleging failure to notify patients of results.

✦ Ordering physicians should document that they called on a particular date to inquire about the results of a study.

✦ Policies should specify processes for documenting receipt and review of results, and notifying patients about recommended follow-up.

✦ Follow-up on "courtesy copies" of test results can include communication with the ordering physician as well as with the patient.

Charting can prevent claims

In a 2012 study by the Physician Insurers Association of America (PIAA) examining closed claims involving radiologists from 2012, 17 reported cases alleging failure to instruct or communicate with patient. Of those, five cases resulted in some type of indemnity payment.[1]

To avoid claims with these allegations, Shows says that a radiologist should document when, how, and to whom the results were communicated. "Without good documentation on any of these steps, the radiologist and the staff can only rely on memory. The better the documentation, the stronger the case," he says.

For the ordering physician, documentation demonstrating good tracking can prevent claims, says Shows. "If there is documentation showing the ordering physician called on a particular date to inquire about the results of a study, the patient may be less likely to find fault with the ordering physician," he explains.

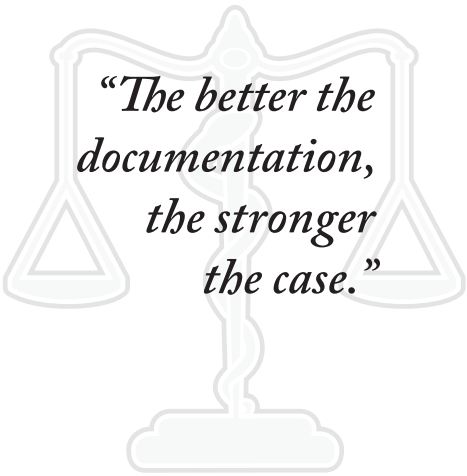
James W. Saxton, Esq., an attorney at Stevens & Lee in Lancaster, PA, commonly sees claims with these allegations:

• The ordering physician failed to follow up after receiving test results.

• The physician who received a copy of the test results, but was not the ordering physician, did not follow up with the patient and should have.

For example, primary care physicians who receive a copy of a report about X-rays ordered by a surgeon can find themselves a defendant in a case alleging failure to diagnose related to an incidental finding identified in the report. *(See related story on incidental findings, p. 118.)* "A strong test-tracking policy can help prevent both of these situations from occurring and can help defend such a case, should it be filed," says Saxton.

The policy should specify the process for documenting receipt and review of results, as well as the process for notifying the patient about recommended follow-up, he says. "Follow-up on 'courtesy copies' of test results can include communication with the ordering physician as well as with the patient," Saxton adds.



Once the test-tracking policy is in place, says Saxton, practices should "make sure that the policy is being followed, and that it is achieving the desired result."

Breakdowns result in claims

Shows says that a practice's tracking system should verify the following:

• The test was performed.

• Results were reported to the physician.

• The physician reviewed the results.

• The results were communicated to the patient.

• The results were acted upon.

A good tracking system alerts practices that patients have not been notified of the results of their studies. "A breakdown in any one of those steps could result in a delayed-diagnosis claim or failure-to-communicate claim," he warns.

Some practices rely on patients keeping their appointments to make sure the results are discussed with the patient. "This is a risky practice. If the patients do not keep the appointment, they do not receive the results," says Shows.

Shows discourages practices from telling their patients "if you don't hear from us, you can assume everything is fine."

"If the practice itself never receives the results, the patient is left assuming everything is fine, even though it may not be," says Shows. "All results, good or bad, should be communicated to the patients."

Reference

1. Physician Insurers Association of America. PIAA 2013 Risk Management Review – Radiology 2014.

SOURCES

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Practices' written policies can raise the bar for standard of care — Care must be reasonable, not necessarily 'gold standard'

The jury's job is to answer the question, "What was the standard of care that applies in this particular situation?" says **Stephen H. Mackauf**, JD, an attorney at Gair, Gair, Conason, Steigman, Mackauf, Bloom & Rubinowitz in New York, NY.

"The law does not set the applicable standard of medical care, nor does the judge or jury," says Mackauf. "The standard of care applicable to a particular medical situation is set by the medical profession."

If there are a range of reasonably acceptable options in a given situation, a physician is free to choose among any of the acceptable options. "A physician has complied with the standard of care if he or she chooses any of the acceptable options," says Mackauf.

Medical malpractice occurs, however, when a physician has deviated or departed from the list of acceptable options and instead is determined to have embarked on a course of conduct that no reasonable physician would have chosen under the circumstances, after a careful investigation and analysis of the available facts.

Higher standard of care

Contrary to what many physicians believe, the "standard of care" is not necessarily the best care a patient could possibly receive, says **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD. "It's what's reasonable for a practitioner working in similar circumstances," Cerniglia-Lowensen says.

"A lot of times, people take the gold standard and try to make that the standard of care," she says. "Plaintiff's experts often talk about pie-in-the-sky care." These phrases put the burden on the defense to educate the jury that their job is to determine that the physician's care was reasonable, even if not necessarily the best possible care.

"However, the fly in the ointment is that frequently practices will set their own standard, based on internal policies," says Cerniglia-Lowensen. For example, a practice might have its own guidelines for certain disease entities. These guidelines then can become the standard of care that the practice is expected to meet, even if it's higher than the standard practiced by other physicians in the community.

"If the physician deviates from the practice's guidelines, the plaintiff's counsel could say they didn't meet their own standard of care," she says.

Physicians might have a good reason for deviating from their own guidelines, or something typically done in the community, however. If so, "this should be documented to support their rationale," Cerniglia-Lowensen urges. *(See story, p. 115, on guidelines and the standard of care.)*

SOURCES

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Executive Summary

A physician has complied with the standard of care if he or she chooses any of the reasonably acceptable options in a given situation.

✦ Medical malpractice occurs when a physician embarks on a course of conduct that no reasonable physician would have chosen under the circumstances.

✦ Internal policies might result in a physician being held to a higher standard of care.

✦ If physicians deviate from their own practice guidelines, they should explain their rationale in the chart.

Claims alleging inappropriate referrals are 'relatively uncommon' — Referring doctors aren't vicariously liable

Referring a patient to a physician in the wrong specialty, or to a doctor who the referring physician knows or should know is impaired, could result in a lawsuit alleging negligent referral, according to **David S. Waxman**, JD, an attorney with Arnstein & Lehr in Chicago.

However, a referring doctor is not vicariously liable for the acts of an independent consultant. "As long as the negligent acts of the consultant

are not foreseeable, it is hard to see where a referring doctor can be held directly responsible for such acts," says Waxman.

While a referring physician generally can't be held liable if their consultant commits malpractice, there are exceptions. "If the consultant is known to be impaired, the referral could be called into question," says Waxman. "If the specialist is not in the field which the patient needs to see, there could be a problem."

Waxman says there is more potential for liability for a referring physician when the scope of the referral is still within their practice area. For example, if an internist refers to a pulmonologist or a cardiologist, it might be alleged that the internist should know enough about the lungs or the heart to have identified and or prevented the mistakes of the consultant.

"There, the internist is not responsible for the acts of the consultant," says Waxman. "But he or she might be accused of not acting on medical problems still within the realm of internal medicine."

Waxman says a referring physician "should certainly know something" about the consultant, such as board certification or hospital privileges. "Any questions regarding qualifications can be pretty easily resolved, either by Google, a staff member, or both," he says.

Executive Summary

Referring a patient to a physician in the wrong specialty, or to a doctor who the referring physician knows or should know is impaired, could result in a lawsuit alleging negligent referral.

✦ A referring doctor is not vicariously liable for the acts of an independent consultant.

✦ Referring physicians face greater risks when the scope of the referral is still within their practice area.

✦ Physician defendants would need to show they undertook due diligence consistent with what other colleagues would have done under the same or similar circumstances.

Demonstrate due diligence

Claims alleging that a physician breached the community standard, and thereby committed medical negligence, by inappropriately referring a patient to another practitioner are relatively uncommon, says **Richard F. Cahill**, Esq., vice president and associate general counsel for The Doctors Company, a Napa, CA-based medical malpractice insurer.

"Inevitably, the issue will be to what extent the referring physician was personally acquainted with the specialist, including his or her education, training, experience, board certification and other professional qualifications," says Cahill. If there is no personal knowledge on which to rely, the referring physician will need to be able to demonstrate, if an adverse event subsequently occurs and litigation ensues, that he or she undertook due diligence prior to the referral consistent with what other colleagues would have done under the same or similar circumstances

"The likelihood of an adverse jury verdict substantially increases if the referring physician knew, or should have known through the exercise of due diligence, of information that would lead a prudent practitioner to have declined making the referral," says Cahill.

SOURCES

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Malpractice claims against OB/GYNs often stem from 'one-size-fits-all' approach to labor and delivery

Over the past several years, the bulk of professional time for **Keith C. Volpi**, JD, has been spent defending obstetricians in medical negligence lawsuits.

"One of the greatest traps that an obstetrician can fall into is to adopt a one-size-fits-all approach to labor and delivery," Volpi says. Many obstetricians develop a list of standing orders that nurses use for each laboring patient.

"But there are pitfalls, including potential legal exposure, with this approach," says Volpi. Factors such as the mother's age, weight, and prenatal course, and the baby's gestational age and tolerance to labor often dictate relatively individualized labor and delivery care and treatment, he advises.

"To avoid potential legal exposure, a physician must remember that, even though the medical procedure may be routine, the patient may not be," says Volpi.

Pay close attention to details

MGIS Underwriting Managers in Salt Lake City, UT, sees considerable claims against OBs involving "routine" procedures, says **Molly Farrell**, vice president of operations.

"The problem is, when it comes to labor and delivery, there are no routine births," she says. "If a physician or nurse is not paying close attention to the details, you can end up with a claim."

Farrell often sees claims in which everyone was doing their job, but someone gets distracted, and, for example, doesn't notice a pattern of decelerations in the heart rate on the monitor. "By the time they do, it is often too late, or other problems begin to cascade," she says.

One missed deceleration is not always indicative of a problem. However, if the one deceleration is indicative of an ongoing problem, and the response is not timely, that issue can lead to a malpractice claim. "We also caution providers to be careful in the weeks and months leading to delivery," says Farrell. An expectant mother might experience a slightly abnormal weight gain or swelling that is at first ignored. However, by the time of the next visit, that slight gain could have turned into pre-eclampsia.

"In terms of how to prevent such occurrences, the age-old counsel remains true: Pay attention, be aware of even minor changes, take nothing for granted," says Farrell.

Ongoing education and training are important for risk management of OB cases, she says. "In addition, as we move to more hospital-based medicine and the use of more registry nurses, we'll need to do more to foster communication and cooperation among the care team," Farrell says.

This step means making sure that physicians and the entire nursing team have clear guidelines, protocols, and pathways for recognizing and managing problems. "Such actions will ultimately protect everyone; most importantly, the patient," says Farrell. *(See related story, below, on common allegations in claims against OB/GYNs.)*

Executive Summary

Claims against obstetricians involving routine procedures often involve the provider adopting a "one-size-fits-all" approach to labor and delivery, as opposed to an individual care plan. Here are some common allegations in such claims:

✦ that too much or too little oxytocin was administered;
✦ that a brachial plexus injury resulting from shoulder dystocia occurred;
✦ that the provider failed to perform a cesarean delivery in response to non-reassuring electronic fetal heart monitor tracings.

SOURCES

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Common allegations in 'routine' claims against OBs

Here are some common allegations in malpractice claims against obstetrician/gynecologists involving routine procedures:

• Too much or too little oxytocin was administered.

Many obstetricians adopt oxytocin protocols for the induction or augmentation of labor, which often dictate the frequency with which the oxytocin should be increased as labor progresses.

"But not every laboring woman has the same oxytocin needs," says Volpi. "Although two women may be receiving the same amount of oxytocin, they may have different responses to it."

Volpi recently defended two obstetrical malpractice cases with virtually identical facts, except for the oxytocin administration. "In the first case, the oxytocin was mechanically increased without an appreciation for the particular mother or infant," he says.

In the second case, the oxytocin was increased in a calculated manner in conjunction with the tolerance of the mother and infant. In the end, both patients received the same amount of oxytocin, and both infants alleged similar neurological injuries. "The treating obstetrician and labor & delivery nurses in the second case were able to defend their actions with more precision and credibility during their depositions, because they clearly tailored their care and treatment," says Volpi.

• An obstetrician's failure to perform a cesarean delivery in response to non-reassuring electronic fetal heart monitor tracings.

Many obstetricians use a baseline fetal heart rate or frequency of fetal heart rate decelerations to determine when a caesarean section is necessary. For example, an obstetrician might choose to perform a cesarean delivery when the fetal heart rate is 110 or less with recurrent late decelerations.

"But every fetus with a heart rate of 110 is not similarly situated," says Volpi. "A heart rate of 110 may be dangerous for a fetus with a previous baseline in the 160s. The same is not true for a fetus with abnormally low baseline in the 120s."

Several years ago, Volpi successfully defended an obstetrical malpractice lawsuit in which the allegation was that the treating obstetrician failed to diagnose and appropriately respond to fetal bradycardia as a result of electronic fetal heart monitoring tracings that showed a fetal heart rate in the 105 to 110 range. "The obstetrician really helped himself in this case by charting that the fetus had a lower-than-normal baseline

heart rate throughout the pregnancy and that a heart rate of 110 at full term was not unexpected for this fetus," says Volpi.

The opposing attorney argued that the standard of care would always require an emergent cesarean delivery of a fetus with a heart rate persistently in the 105 to 110 range. "But the treating obstetrician artfully explained that not all fetuses are created equal and that a tailored plan of care is always best," says Volpi.

• A shoulder dystocia occurring during normal, spontaneous vaginal delivery.

Spontaneous vaginal deliveries are routine OB/GYN procedures but can turn into high-risk situations if a shoulder dystocia occurs.

Stella M. Dantas, MD, a Hillsboro, OR-based obstetrician, says management of shoulder dystocia "can result in a liability claim made if there is a brachial plexus injury." Dantas, who is chair of the American Congress of Obstetricians and Gynecologists' Committee on Professional Liability, states the following physician practices can mitigate risks:

• Understand how to call for help when shoulder dystocia occurs.

• Practice techniques for managing shoulder dystocia with drills and simulations.

• Ensure carefully documentation of delivery, including the maneuvers used, any suspected injuries, and follow-up plans for the infant.

"A physician must make sure the record demonstrates awareness of any risk factors, that the patient was informed of any significant risk factors, and that standard of care was provided and practiced," says Dantas. ✦

Bad outcome may result from incomplete patient history — Over-reliance on information is legally risky

After a patient complained of knee problems and the triage nurse recorded a chief complaint of knee pain, the emergency physician diagnosed a musculoskeletal injury. Just before discharging the patient, however, the physician noted the patient appeared unsteady and ultimately diagnosed a subdural hematoma.[1]

If the chart showed that the physician had done a thorough assessment and found no indication of neurological causes for the patient's knee pain, this documentation of this information would have been legally protective for the physician, if the patient had returned with an subdural hematoma days later, according to **Krishan Soni**, MD, MBA, chief fellow in the Division of Cardiology at University of California, San Francisco.

Physicians need to understand that patients often give inaccurate information, whether intentionally or not, Soni underscores. "This is an important problem we face in medicine, and physicians need to take deliberate steps to countermand that," he says.

Some patients might knowingly alter their complaint to be seen more quickly. "A small number of patients may use certain buzzwords or change their story with that in mind," says Soni.

Patients don't always realize which pieces of their history are important. "Patients may have many symptoms and pick one to report which might not be the most medically relevant, causing providers to go down the wrong track," says Soni.

Patients might inadvertently use misleading terms to describe symptoms. "For example, Asian patients use the word 'dizziness' to describe a whole panoply of symptoms. To them, it may mean they are tired or lack energy," Soni says.

He gives these strategies to avoid malpractice suits related to inaccurate or misleading information given by patients:

• Always independently ask patients why they came in.

Most patients already have told a nurse their symptoms before the physician sees them. The nursing history "is often the 'launching off' point for the

Executive Summary

Over-reliance on information provided by patients presents legal risks for physicians, as patients might give inaccurate, misleading information for multiple reasons. To reduce risks, providers should consider the following:

✦ Ask patients "What else would you like to discuss?" before moving on to the diagnostic phase.

✦ Document that the worst case scenarios were considered.

✦ Avoid premature closure.

evaluation," says Soni. "But if you focus just on that piece of information, you are likely to miss out."

• Don't focus solely on the patient's specific complaint.

Soni recommends physicians ask themselves, "What is the worst thing that could be happening to this patient?" Document that other etiologies for the patient's complaints were at least considered.

Patients often don't reveal concerns

Aware of how busy their doctors are, many patients feel hesitant to raise concerns that seem trivial, says **Sue Larsen**, president of Astute Doctor Education, a New York City-based firm specializing in improving physicians' ability to communicate with patients. Others don't want to be judged negatively by their doctor or feel their doctor isn't interested.[2]

"Up to 45% of patient concerns are never raised or discussed," says Larsen.[3] "This can lead to missed or delayed diagnosis, accompanied by an increased risk of medical malpractice litigation." She suggests these approaches to reduce risks:

• Give patients the opportunity to discuss their concerns fully before moving on to the treatment stage.

"This can reveal important information that may affect the diagnosis and treatment choices," says Larsen.

• Always ask "What else would you like to discuss?" before moving on to the diagnostic phase.

"Patients often don't tell you important information and concerns in the first instance," says Larsen. "Sometimes they need a little persuasion."

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Claims suggest incidental findings are falling through the cracks — Obviousness of findings makes defense difficult

If a patient with suspected pneumonia receives a chest X-ray, the patient usually is contacted by the treating physician promptly about the findings. Even if not, the patient usually is interested enough in knowing the result to follow up on their own accord.

"However, a common scenario we see as medical malpractice lawyers is a patient who has a significant incidental finding on an imaging study, but is never informed of it and does not receive treatment for it on a timely basis," **Russell X. Pollock**, Esq., an attorney with Bergstresser & Pollock in Boston.

A chest X-ray might reveal a lung nodule suggestive of early stage lung cancer, for example. "It would be malpractice not to inform the patient of that incidental, yet significant finding," says Pollock.

Radiologists have a duty to make ensure that the patient is informed of a significant incidental finding, says Pollock. Other medical care providers, such as attending physicians or primary care physicians, might share this duty. "This is especially true when the condition is one that is within the province and knowledge of those other specialties," says Pollock. When a patient receives a CT scan, for example, the significance of a potential demyelinating process might not be evident to an emergency physician reviewing the report, but an incidental finding of a suspicious mass should be.

"Both of these findings require a discussion with the patient and follow up," says Pollock. "Both the radiologist and other physicians reviewing the report will be negligent if they fail to do so."

An uninformed patient, a treatable process, and significant damages all create the potential for a large verdict and strong settlement potential. "A dispute among the defendant physi-

Executive Summary

A common allegation in malpractice claims is that a patient has a significant incidental finding on an imaging study, but is never informed of it and does not receive treatment for it on a timely basis.

✦ Radiologists have a duty to make ensure that the patient is informed of a significant incidental finding.

✦ Other medical care providers, such as attending physicians or primary care physicians, may share this duty.

✦ Protocols should clearly state who is responsible for discussing the results with the patient.

cians about who was responsible for informing the patient about the incidental finding is another factor that could enhance the verdict and mandate settlement," adds Pollock.

He recommends protocols clearly stating who is responsible for discussing the results with the patient. The protocol could include a sign-off portion in the record showing that the patient was informed of the finding, the manner of communication, and when it occurred.

While Pollock notes that such a protocol will not relieve the radiologist or other specialist from negligence from liability if the patient is not informed of a significant result from an imaging study, "it should reduce the number of times such failures occur."

Language "particularly damning"

Yates, McLamb & Weyher in Raleigh, NC, has seen several claims in which a patient was diagnosed with metastatic cancer some time after an incidental finding in a radiology study was made, says **Ryan M. Shuirman**, JD.

"In these claims, the finding often has little relationship to the reason the patient was seeking a radiology study," he says. "Thus, it is not necessarily something the patient's attending physician feels requires acute follow up."

The radiologist often will note the finding and recommend clinical correlation or future follow up study. "But the attending fails to discuss an incidental finding with the patient and/or arrange for future follow up, since the attending's focus is the patient's acute presenting problem," says Shuirman.

"It would be malpractice not to inform the patient of that incidental, yet significant finding."

The obviousness of the finding to physicians who are not radiologists can make defending these claims more difficult. "Moreover, the language chosen by the radiologist in preparing a report from an imaging study can be particularly damning, if the radiologist specifically included recommendations for future follow-up studies," says Shuirman.

SOURCES

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COMING IN FUTURE MONTHS

✦ Unexpected malpractice risks of uninsured patients

✦ How to protect peer review data after an adverse event

✦ Claims are alleging failure to monitor patients

✦ How ACA could increase legal risks for physicians

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 indemnification clauses included in some employment contracts, says William Sullivan, DO, JD, FACEP?**
   A. Broadly worded indemnification clauses reduce liability for physicians.
   B. Under no circumstances would physicians be required to reimburse the hospital for all expenses for a subsequent legal action.
   C. Contractual indemnification will never void medical malpractice insurance coverage.
   D. By agreeing to contractual indemnification, a physician agrees to reimburse an employer for damages.

2. **Which is true regarding the standard of care, according to Stephen H. Mackauf, JD?**
   A. A physician has complied with the standard of care only if he or she chooses the best option in a given situation.
   B. Medical malpractice occurs when a physician embarks on a course of conduct that no reasonable physician would have chosen under the circumstances.
   C. A practice's internal policies cannot result in a physician being held to a higher standard of care.
   D. If physicians deviate from guidelines, they should not explain their rationale in the chart.

3. **Which is true regarding claims alleging negligent referrals, according to Richard F. Cahill, Esq?**
   A. Referring physicians cannot be held liable even if they refer a patient to a physician known to be impaired.
   B. A referring doctor is vicariously liable for the acts of an independent consultant.
   C. Referring physicians cannot be held liable for a negligent referral as long as the scope of the referral is still within their practice area.
   D. To avoid liability for a negligent referral, physician defendants would need to show they undertook due diligence consistent with what other colleagues would have done under the same or similar circumstances.

4. **Which is true regarding liability involving incidental findings, according to Russell X. Pollock, Esq.?**
   A. Radiologists have no duty to ensure that the patient is informed of a significant incidental finding.
   B. Only radiologists, not other medical care providers such as attending physicians or primary care physicians, have a duty to ensure patients are informed of a significant incidental finding.
   C. Clear evidence that the patient was never told of the finding, a treatable process, and significant damages all create the potential for a large verdict and strong settlement potential.
   D. A dispute among the defendant physicians about who was responsible for informing the patient about the incidental finding typically makes claims more defensible.

Physician Legal Review & Commentary

Expert analysis of recent lawsuits and their impact on physician risk management

Birth injury leads to a disabled infant and a $55 million verdict against physician, hospital

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News: The patient, a petite woman, was admitted to a hospital before giving birth. She was one week past her estimated delivery date. The initial stages of delivery were uneventful, but as labor progressed, fetal monitoring indicated that the infant was becoming hypoxic. In addition, prenatal records indicated that the gestational weight of the infant was high enough to pose a potential problem for the mother. Both of these critical pieces of data were allegedly ignored by the primary physician. After delivery, the infant was noted to be almost pulseless. The patient, her husband, and the child brought suit alleging that the physician failed to deliver the child by Cesarean section, which they claim led to serious disabilities. The defendant physician and hospital argued that the proper standard of care was met. The jury awarded $55 million in damages, with liability assessed 50% to the physician and 50% to the hospital.

Background: In this matter, the patient was a sixth-grade elementary school teacher admitted to the hospital in labor with her first child one week past her due date. Physicians did not identify any potential issues, despite the fact that the mother was petite and the child was quite large. The delivery began without complications, but the primary physician assisting in delivery failed to note the fetal monitoring strips which showed that the infant was experiencing decelerations of his heart rate. Such decelerations might be a sign of an infant in distress or indicative of a loss of oxygen to the brain. As time passed, the decelerations continued, and her labor failed to progress. This situation might have been from a shoulder dystocia or other complication resulting from the infant's size.

This situation might have been from a shoulder dystocia or other complication resulting from the infant's size.

At this point, an emergency cesarean section should have been considered. However, this physician opted to employ vacuum extraction, a procedure during which a physician applies a soft or rigid cup with a handle and a vacuum pump to the baby's head to help guide the baby out of the birth canal. This action is typically done during a contraction while the mother pushes. Vacuum extraction is a potential alternative to delivery assisted by forceps, or Cesarean section, but it can pose additional risks for injury beyond that caused by the loss of oxygen which was already occurring here. Vacuum extraction poses additional risks to mother and child including infant scalp lacerations, perineal tears, and excessive bleeding for the mother.

The assistance of the vacuum ultimately allowed for delivery to be completed, but there were significant injuries to the mother and the child. The mother was hemorrhaging a large amount of blood and required emergency surgery. Immediately after birth,

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the child was described as pale and hypotonic with poor respiratory effort. Furthermore, he barely had a pulse and also displayed seizure-like activity. The mother and child survived these immediate complications and the ensuing surgery. However, the child suffered serious injuries following the delivery, including cerebral palsy, as a direct result of the hypoxia, He remains developmentally disabled as well. Additionally, at the time of the trial, he was four years old, had trouble talking and walking, and still wore diapers.

The patient, her husband, and the child brought suit, claiming that the physician should have recognized the large size difference between mother and child, in addition to the preliminary loss of oxygen during delivery, necessitated a Cesarean section rather than simple vacuum extraction. The plaintiffs alleged that during the earlier stages of the delivery, the vital signs warned that vaginal delivery was dangerous, but this physician failed to recognize these warning signs, which constituted action falling below the proper standard of care. The physician and hospital defended on the grounds that both provided appropriate care and did not cause harm to the baby. At the end of the two-week civil trial, the jury found the hospital and delivering physician each 50% percent to blame for the child's injuries and disabilities. The jury delivered the $55 million verdict. However, the plaintiffs likely will receive less than this full amount, pursuant to a "high-low agreement" which sets a minimum and maximum recovery.

What this means to you: Birth injures, while uncommon, do occur despite best efforts of physicians and hospital staff. However, in this case, there was critical data available to the physician and staff that were not used to provide the safest delivery method for the mother and infant. If a medical professional deviates or fails to meet the standard of care, then medical malpractice likely has been committed, and the physician might be liable to the parents and/or injured child.

The primary issue becomes heavily factual, determining what the physician knew and did, along with what the physician should have known and should have done. Medical professionals must follow strict protocols in monitoring the child's vital signs and must take all necessary precautions to help prevent injuries during birth. In the case of a large child, particularly with a small or petite mother, increased attention must be given to ensure that vaginal delivery is a possible option, while considering alternatives that may be safer despite inherent risks in those alternatives. The physician should have been aware of the fetal weight from the mother's prenatal records or by ultrasound on her hospital admission, as well as the decelerations of the fetal heart rate visible on the fetal monitoring strips. Both of these indicators of potentially serious problems for mother and child required that the physician consider an immediate cesarean section to safely deliver the infant. The American Congress of Obstetricians and Gynecologists (ACOG) guidelines would indicate this action to be the standard of care.

The ACOG has established guidelines for physicians to follow during labor. Perinatal risk is high; hospitals spend more money defending "bad baby" claims than any other type of malpractice. Obstetricians and other physicians that deliver babies, such as family practice and general practitioners, face higher insurance costs to protect their careers from these claims. If a physician fails to follow ACOG guidelines and a hospital allows the medical staff to practice outside of these guidelines, both might be held responsible for an adverse outcome.

If the mother has had prenatal care, the hospital and physician must make arrangements to have those records available at the time of delivery. These should be reviewed by the physician for data that might indicate a higher risk during deliver, such as the estimated gestational weight of the infant. If the mother is diabetic or petite, a higher-than-average fetal weight can make for a difficult and high-risk delivery. All obstetrics patients should be monitored electronically during delivery. There is external monitoring that can measure uterine contractions and the fetal heart rate in response to them. A deceleration in the heart rate that does not return to baseline after a contraction or one that occurs after the contraction is an indication of a potentially serious problem, such as a tight nuchal cord that is depriving the infant of oxygen. There are also internal fetal scalp electrodes that can be placed by the physician once the membranes have ruptured. These give a more accurate measurement of the fetal heart rate and avoid interference from the maternal heart rate.

Obstetrics nurses should be as equally trained as physicians to read such monitoring strips. Physicians should heed the calls from nursing staff when abnormalities are detected; the delivery process is not a time for a power struggle or war of egos. Once a fetus is in jeopardy, every second counts. Teamwork is critical if the mother and infant are to be cared for safely. The 'decision-to-incision' time for the cesarean section will be reviewed critically by plaintiffs' attorneys. Had the physician and nursing staff worked together here, discussing the fetal strips and reviewing prenatal records, ultimately approaching the parents with their options to provide the best chance for an uncomplicated surgery, the child would have had a better chance for a normal life.

The preferences of the mother should be given weight, but the ultimate concern of the physician is guaranteeing a safe delivery for mother and child. Reducing risks is extremely important, and the parties should consider different options before settling on any one choice. Physicians generally must inform patients of all the risks and effects of procedures to allow the patient to make an informed decision.

In situations such as the one presented in this case, where the circumstances change, physicians should consult the patient to discuss changing the course of action, if the patient is in a condition to be consulted.

If the physician here properly identified the risks based on the increasing loss of oxygen to the child, he could have discussed this immediately with the mother and changed to cesarean delivery rather than vaginal delivery. Although a cesarean delivery has risks of its own, vaginal delivery of a large child might be more risky overall. There is no need to set in stone the particular course of action to be taken; indeed, determining such a thing beforehand and refusing to adapt to developments that naturally arise might put one at risk for failing to meet the standard of care when a reasonable physician in the same situation would have changed the plan rather than sticking with the original one.

Finally, this case also demonstrates the effective use of a "high-low" agreement, where parties might agree before trial to specific minimum and maximum recovery amounts. The plaintiff is thus guaranteed a certain minimum amount of recovery, while compromising with the defendant who receives a maximum cap on his own liability, which offers protection from an unaffordable jury verdict. Such high-low agreements are particularly valuable in situations in which the physician's liability appears low — that is, there is little or no variation from the standard of care — while the actual damages might be extremely high.

This possibility for enormous awards is quite possible in birth injury cases as evidenced here. The disabled and developmentally delayed child will require medical care and additional treatment during the entire course of his life, which results in huge costs to the family. If pretrial settlement attempts have failed, physicians and counsel might engage in later discussions to come to such a high-low agreement, which can prove beneficial to plaintiffs and defendants alike. These agreements can prevent runaway verdicts given by juries and protect physicians from eight figure damages.

Reference

Lehigh County Court of Common Pleas, PA. Case No. 2012-C-1224. Dec. 23, 2013. ✦

Amputee mother awarded $62 million in malpractice case

News: The patient, a 30-year-old woman, had an ectopic pregnancy and sought treatment by laparoscopic removal. She complained about abdominal pain after the procedure, but she was discharged only to return to the hospital. She was suffering from a severe infection, caused by a puncture to her intestine, that led to blood poisoning and gangrene, and it ultimately led to leg amputations. The patient brought suit and claimed that the failure to detect the puncture constituted negligence. The defendant physician and hospital denied negligence or any involvement in wrongdoing. The jury awarded $62 million in damages, allocated 40% to the hospital, 30% to the primary obstetrician and gynecologist, 20% to a second physician, and 10% to a third physician.

Background: In this matter, the patient was a 30-year-old medical assistant who was scheduled for a laparoscopic removal of an ectopic pregnancy, a common gynecological procedure that involves the removal of a fertilized egg that grows outside the uterus. After the procedure, the patient was feverish, had an abnormal heart rate, and complained of abdominal pain. These are not the expected postoperative symptoms of this procedure. She had a CT scan done, but physicians failed to detect a 5-mm hole in her colon, which was pierced during the laparoscopy. Following this scan, the patient was discharged, despite the continued pain.

The patient subsequently returned the day after discharge to the hospital, as the pain was persistent. The damage from the puncture led to a severe infection that, after her discharge, continued to spread throughout the patient's body. During her return visit, she was initially diagnosed with a small bowel obstruction. Several days later, she became septic. The infection was detected, but by this point, it was severe and led to blood poisoning and gangrene in her legs, which required both legs to be amputated below the knees. She was unaware of the amputation until she woke up from a coma in the intensive care unit. In addition, the patient lost most of her hearing as a side effect of the powerful antibiotics used to counter the infection. The patient spent a total of 73 days in intensive care unit, where she went into cardiac arrest three times and underwent a colostomy procedure.

The patient brought suit and named the hospital and multiple physicians as defendants. She alleged that the failure to recognize a bowel injury and the failure to perform additional tests before discharge constituted medical malpractice. The defendants argued that the physicians acted responsibly. They furthermore claimed that the injury occurred after the procedure and was related to an underlying bowel condition, rather than a surgical mistake. The defendants claimed the patient only survived because the physicians listened to her complaints and acted competently. The treatment she needed had very serious side effects, which were not the physicians' or hospital's fault, the defendants claimed.

The jury disagreed with these

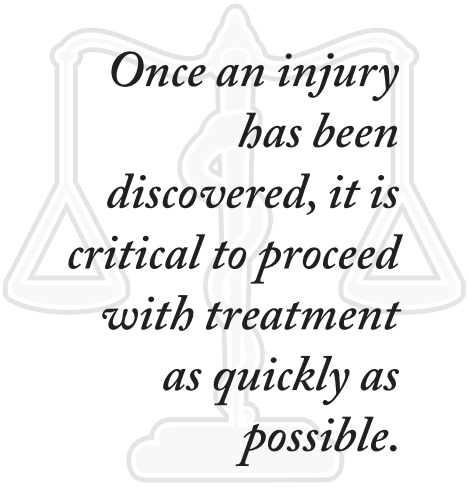
defenses. After three days of deliberation, the total verdict was $62 million, divided into $20 million for past pain and suffering, $38 million for future pain and suffering, along with $4 million for medical expenses. The jury allocated fault as well: 40% to the hospital, 30% to the primary obstetrician and gynecologist, 20% to a second physician, and 10% to a third physician.

What this means to you: The primary issue in this case was to what degree, if any, were the physicians negligent for failing to recognize the bowel injury and for discharging the patient without running additional tests. Hospitals and physicians should be wary of discharging patients who are complaining of pain that might be indicative of a more serious issue. Localized pain, in this case abdominal pain, might be a sign that necessitates further testing, especially following a surgical procedure in the same area where the pain is located. In particular, pain, fever, and an irregular heart rate can be early signs of sepsis, a known risk of any surgical procedure.

These symptoms in an otherwise healthy, young patient are significant and must be immediately investigated and treated. Even if the CT scan was read as negative by a radiologist, if symptoms persist, the scan should be repeated or done with contrast if not done so originally.

Critical thinking is essential. A common procedure with an uncommon result is a redflag that all is not well. Radiological misreads and discrepancies are not uncommon. Further follow-up, including that for suspicion of a bowel injury, should have been considered. If a reading does not match the symptoms, physicians and radiologists should meet and discuss this inconsistency.

Severe sepsis, a life-threatening condition, should be considered whenever a patient presents with persistent postoperative fever. Hospitals must monitor their sepsis mortality rates and have processes in place to guarantee that immediate action takes place to intervene with necessary fluids and antibiotics. Discharging the patient makes subsequent observation and testing impossible, so physicians should be cautious when a patient complains about serious pain. Physicians should be particularly cautious when that pain is coupled with other symptoms such as the fever and abnormal heart rate here. The combination of multiple symptoms should be a warning sign that investigation is required before discharge.



Once an injury has been discovered, it is critical to proceed with treatment as quickly as possible. A serious condition, such as gangrene in this case, requires immediate treatment; otherwise it might be potentially life-threatening. The physicians in this case did successfully save the patient from this threat, but their ultimate failure was before this condition set in. The defendants attempted to argue this point. Part of their defense was that the physicians acted reasonably and dutifully, which saved the patient's life although she lost her limbs. Juries might or might not be receptive to such tactics. This is highly dependent on the underlying facts and the jury itself. However, physicians are nonetheless obligated to live up to the standard of care and treat patients at a level that other reasonable physicians given the same situation would treat those patients. Saving a patient's life in the face of a life-threatening illness, regardless of potential liability, should be a physician's utmost concern.

This case also illustrates the possibility, usually dependent upon unique attributes of state law, for juries to award specific percentages of liability to different defendants. The hospital and each physician were held to be partially at fault, according to the jury's determination of the seriousness of each party's negligence. However, this situation does not necessarily mean that each specific defendant will end up paying only its "assigned" share.

In some medical malpractice cases, or at least with respect to certain kinds of damages in such cases, the liability might be "joint and several," This phrase means that the plaintiff can recover the full amount from any one defendant. In that case, it becomes that defendant's responsibility to seek contribution from the other defendants for their share of the liability. Often, the prospect of joint and several liability encourages plaintiffs to sue a defendant with "deep pockets," such as large corporations, insurers, or (in the medical malpractice situation), hospitals as opposed to, or in addition to, individual physicians. Hospitals or medical employer groups are more likely to have the resources to pay the full judgment, and then it is the hospital or employer group's responsibility to seek the proportional share of payment from other defendants, typically the physicians, found to be partially at fault, or to simply bear the entire financial burden if the physicians or other defendants are unable to pay. In the event of a medical malpractice action, it is recommended to consult with an attorney experienced in the potential application of joint and several liability to medical malpractice actions under the laws of your particular state.

Reference

Supreme Court of Kings County, NY. Case No. 28327/2010. Jan. 10, 2014. ✦