PHYSICIAN Risk Management

November 2013 | Vol. 2, No. 5 Pages 49-60

Did MD fail to act on test results? Successful suits are occurring!

'Too many assumptions, too little communication'

Dr. A, an internal medicine physician, refers her patient with ongoing gastrointestinal distress symptoms to Dr. B, a gastroenterologist on staff at the same institution. Dr. B suspects possible colitis and orders a colonoscopy.

The colonoscopy is performed by Dr. C, whose operative note and positive findings are available in the medical record, to which Drs. A and B have access. However, no separate email or other alert is sent to Dr. A or Dr. B.

"Neither check the medical record for the test result. As a direct consequence, the patient's condition goes untreated for several months," says **Amy E. Goganian**, JD, an attorney with Goganian & Associates in Needham, MA.

Shortly thereafter, the patient files a claim against Drs. A, B, and C for failing to follow up on her positive test results. This scenario is a typical one of many recent malpractice claims handled by Goganian's firm.

Molly Farrell, vice president of operations for MGIS Underwriting Managers in Salt Lake City, UT, says, "Lack of follow-up on testing occurs much more often than it should. It's one of the areas we encourage physicians to monitor closely in order to improve outcomes and manage risk."

"Lack of follow-up on testing occurs much more often than it should."

Bobbie S. Sprader, JD, an attorney at Bricker & Eckler in Columbus, OH, has seen several cases involving an incidental finding on an X-ray taken during a hospitalization for an acute surgical condition. In one case, the surgeon handling the acute condition deferred follow-up to the patient's primary care physician. The surgeon assumed that the hospital would send the primary care physician a copy of the report and that he would see it and act upon it. "It was never clear whether the primary care physician ever got the report, but he definitely did not act upon it, as it went completely unaddressed," says Sprader.

The surgeon took the position that because the finding was non-surgical and non-acute, it fell outside of his duties to the patient. The primary care doctor took the position that he did not order the test and did not even know that it had been done. "There were too many

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cover

enclosed

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assumptions, and too little communication," says Sprader.

Here are some practices that could prevent successful lawsuits alleging failure to follow up on test results:

• Physicians should monitor patients for signs and symptoms associated with drug toxicity.

In one malpractice claim, a patient was prescribed a medication for treatment of bipolar disease. Farrell says, "The medication had several potential side effects, the most dangerous of which is aplastic anemia. Subsequently, the patient did develop aplastic anemia."

The physician ordered the blood levels, the results were elevated, and the physician didn't act upon the elevated results for two years. "Had the physician reviewed these timely, he would have had an opportunity to address the prescribed dosage," says Farrell. "The case was resolved in the low six figures, due to the off-set of the patient contribution."

Even though the subsequent litigation revealed that the patient consistently took more medication than was prescribed, adds Farrell, the physician was faulted for failure to follow-up on the test results.

• When test results of any kind are positive, lab personnel should document that the results were communicated to a clinician.

While most of the time the physician who ordered the test will review the results, acute and unexpected findings still deserve special attention, says Sprader. "The [lab personnel] would be well-served by stating right in the report that Dr. [Name] was advised that [finding] at [time]," says Sprader.

Farrell reports that members one radiology group saw a significant drop in their failure to diagnose claims after they began sending a notice to patients advising: "You recently had an X-ray read at X hospital and the results may require follow-up. Please take this report and share it with your primary care physician at your next visit."

The note ensures that even patients seen in a clinic setting notify their physician about recent films. "Often patients remember that the X-ray ruled out pneumonia, but don't recall the small mass that requires further work-up," says Farrell.

• Physicians should document verbal discussions that occur at handoffs.

"As a general rule, whoever ordered the test is responsible for [addressing] any abnormalities found, until an official hand-off occurs," says Sprader.

If the patient is hospitalized, the physician could document, for example, "Spoke with patient's PCP, Dr. Smith, who will follow up on [finding] as outpatient. Advised patient to see Dr. Smith in follow up in 2 weeks to address his [finding], indicates understanding."

Physicians sometimes do this step in writing, such as "Dear Dr. Smith: During a recent admission, patient was found to have [finding]. I have enclosed a copy of the report and will refer her back to you

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Claims alleging physicians failed to follow up on test results are on the rise. To reduce risks, document the following:

- ✦ verbal discussions that occur at handoffs;
- ✦ efforts made to follow up on tests;
- ✦ conversations with patients about test results.

Physician Risk Management (ISSN 2166-9015) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry NE, Suite 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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Editorial Questions

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for further work-up for this finding."

However, "passing the baton" by letter leaves open the possibility that physicians can later claim they never received the information, says Sprader.

• Check patients' contact information.

Dan Groszkruger, JD, MPH, principal of San Diego-based rskmgmt. inc, once represented a primary care physician whose medical group adopted a strict rule to avoid failure-to-notify situations. "This physician made it a practice to call every new patient and to call every patient whose test results came back abnormal, in the evening of the same day," he says.

Because the physician's office staff knew about this practice, extra care was invested in double-checking the accuracy of telephone numbers or alternative contacts. "Calling patients after episodes of care clearly goes beyond a physician's standard of care," acknowledges Groszkruger. "But it may represent an emerging best practice, applicable to some medical specialties."

Depending upon the physician's specialty, personal telephone calls to patients might be impractical, and physicians have to determine what criteria merits a call, says Groszkruger. "However, the very best way to prevent unhappiness or dissatisfaction leading to a lawsuit is to impress each patient that the physician really cares about the patient's welfare," he emphasizes. *(See related stories on tracking systems, below, and proving patients were informed of results, below.)*

SOURCES

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Tracking systems legally protective

Cambridge, MA-based CRICO has seen a marked increase in claims for failure to diagnose conditions, particularly cancers, that can be linked to a failure to follow-up on abnormal test results or on incidental findings reported on testing, reports assistant claims manager **Megan C. Tapply**, Esq.

"Often, the facts indicate that someone considered the follow-up, and maybe even wrote down what it should be, but then never implemented the plan," she says.

Tracking systems, whether in the form of a person, electronic system, or calendar or diary system, are the best way for providers to protect themselves from missing an abnormal result or from failing to follow-up on an incidental finding, Tapply says.

Amy E. Goganian, JD, an attorney with Goganian & Associates in Needham, MA, says, "Simply making the information available to providers by virtue of its inclusion in the medical record is not necessarily sufficient." A better practice is a policy of affirmatively notifying providers, via email or some other method, and double-checking that the results were received, Goganian says.

If presented with a claim based on failure to follow-up on a test result, physicians are in a much better position to defend themselves if they can detail the system the office uses to make sure test results don't get lost. Tapply recommends these practices:

• Include reporting on follow-up care by specialists.

"The communication gaps that often result in claims are those return loops from the specialist back to the primary provider," says Tapply.

She frequently sees a well-written consult note from a specialist laying out interventions to take after an abnormal result, and the note sent to the primary provider, but no evidence of any follow-up is in the chart. "Trying to defend that apparent disregard for the opinions of a consult requested specifically by the primary provider is an uphill battle," Tapply says.

• Document efforts made to follow-up on tests.

This step could be the only thing providers will be able to offer in their defense if a test result falls through the cracks.

"If the issue was that the patient failed to follow-up after being given specific instructions to do so, documentation of what those instructions were will be the saving grace," Tapply adds.

• Have a tickler system in the office to catch patients who would otherwise fall through the cracks.

This step can be the difference between a defensible case and one that must be settled. "A good system that can be defended, even in the face of a missed result, can shift the burden of follow-up from the provider to the patient," Tapply says. ✦

Patient told about results? Prove it!

When a patient's primary care provider was informed of a lung nodule noted as an incidental finding on a chest CT after a motor vehicle accident, he referred the patient to a pulmonologist for follow-up.

"When the patient arrived at the appointment with the pulmonologist, chest films in hand, the images

showing the lung nodule were missing," says **Megan C. Tapply**, Esq., an assistant claims manager at CRICO in Cambridge, MA. The pulmonologist asked the patient to get the full set of films and come back for follow-up.

"The providers involved recalled that the patient was informed that this was an important finding and could be cancer," she says. "The patient — when deposed, prior to her death — did not recall that part of their conversation."

Instead, she recalled leaving the appointment with the understanding that the pulmonologist or the primary care provider would be following up to get the films. "No one did, and five years elapsed," says Tapply. The patient never followed up, and the pulmonologist never made another appointment or followed up with the patient. Although the primary provider saw the patient for other reasons, the issue was never explored again.

The patient subsequently was re-evaluated when she began having symptoms. By then, her lung cancer had metastasized, was inoperable, and caused her death. The family sued the pulmonologist and primary care provider.

The variable that made the case particularly difficult to defend was the length of time between the initial imaging and the eventual diagnosis, Tapply says. "Often, when providers fail to initiate or complete appropriate follow-up after an abnormal result is reported, we can still defend the care by relying on causation experts," she says. The experts will testify that the delay of months or years did not change the overall outcome for the patient because the cancer was already metastasizing when the first incidental finding was noted.

The defense did have an expert who was willing to make that argument, but it would have been hard for a jury to accept, says Tapply, given the lengthy delay and the dramatic change in the size of the cancer between the first and second views. Another problem for the defense was that it didn't seem believable that the patient would not have followed up if she had really been told what the provider claimed, she explains.

"It was hard to imagine how a patient who was informed, well-educated, had lost family members to lung cancer, was a former smoker, and had at the very least been told that this was a significant finding requiring follow-up, just completely forgot about this for five years and failed to do anything," says Tapply.

Good documentation from the providers about their conversation with the patient made the case more defensible, although the specific mention of cancer wasn't documented.

"But whatever the patient's obligation, the physician's duty still comes down to the standard of care, and the standard of care requires follow-up on tests," says Tapply. "As is often the case, good documentation can save the provider." ✦

Lawsuits against primary care physicians entail drug errors and missed diagnoses

Most malpractice claims against primary care doctors are the result of missed or delayed diagnosis or drug errors, according to an analysis of 34 studies.[1]

Among adults, the most common alleged missed diagnoses were cancer, heart attack, appendicitis, ectopic pregnancy and broken bones. Among children, the most common alleged missed diagnoses were meningitis and cancers.

"The majority of healthcare occurs in primary care, so it is important to have a greater understanding of where claims arise in this setting," says **Emma Wallace**, MB, BAO, Bch, the study's lead author and a clinical research fellow at Royal College of Surgeons in Dublin, Ireland.

Primary care doctors must identify patients with serious underlying disease when faced with undifferentiated presentations in a setting of care where the prevalence of serious disease is lower when compared to the specialist setting, notes Wallace. "Clinical risk management systems and educational initiatives could help by focusing on diagnostic difficulties and highlighting conditions commonly leading to primary care claims" such as women with heart attacks presenting atypically says Wallace.

Most claims against primary care physicians involve failure to timely diagnose cancer or cardiovascular disease, notes **Mark L. Graber**, MD, FACP, senior fellow at RTI International in Research Triangle Park, NC, and founder and president of the Society to Improve Diagnosis in Medicine. "Make sure your patients are up to date on recommended cancer screenings," Graber advises. "Be sure to follow up on any abnormalities detected." Graber recommends these practices:

• Consider obtaining a second opinion if there is major diagnostic uncertainty.

"Second opinions may be one of the best strategies to detect diagnostic errors,"

Executive Summary

Missed or delayed diagnoses and drug errors are the most common malpractice claims against primary care physicians, according to a recent analysis.

- ✦ Be sure patients are up to date on cancer screenings.
- ✦ Consider a second opinion if there is major uncertainty in the diagnosis.
- ✦ Acknowledge if the diagnosis is not certain.

says Graber. This step can prevent errors that can lead to malpractice claims and also clearly indicate some uncertainty in the diagnosis that was addressed by requesting additional advice, thus making claims more defensible if they do occur, he says.

• Don't trust diagnoses presented by the patient or other physicians without rethinking the case.

• Make the patient your partner in diagnosis.

"Explain that we are always playing the odds," says Graber. "Make sure they know when and how to get back to you if their symptoms change or if they don't respond to treatment."

• Document your thinking, and point out areas of uncertainty and where you've made assumptions.

If several different diagnostic possibilities are reasonable, which is often the case, acknowledge that the diagnosis is not certain, advises Graber.

"Justify your subsequent actions accordingly, whether additional tests, consultation, trial of treatment, or 'wait and see,'" he says.

• Survey patients to obtain feedback on your communication style, and take actions to improve if you don't score well.

Graber says focus groups consisting of several patients, staff members, and someone with expertise in patient relations are a good way to explore what the physician does well and where improvements are needed.

"Communicating effectively with your patients is probably the most important factor in decisions to file a suit," says Graber.

Reference

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Fear of lawsuits linked to MDs' decisions

Some tort reforms don't lessen worries

Physicians' anxiety over malpractice lawsuits drives defensive medicine moreso than other measures of risk, suggests a new survey of more than 3,500 physicians treating more than 29,079 Medicare patients with chest pain, headache, or lower back pain.[1]

Physicians who were very concerned about malpractice risk were significantly more likely to order certain diagnostic tests. For example, 11.5% of those with a high level of concern were more likely to order advanced imaging for a headache patient, compared with 8.5% of those with medium concern and 6.4% of those with a low level of concern. Doctors in states with laws capping damages in malpractice cases were not significantly less worried.

"Physicians and physician groups often assert that concerns about being sued play a large role in their medical decision-making," says **Emily Carrier**, MD, the study's lead author and a senior researcher at the Center for Studying Health System Change in Washington, DC. However, studies that compare states with and without common tort reforms, such as damages caps, have found only small effects on total medical spending.

"Our study suggests that these two findings don't actually contradict each other," says Carrier. "It's just that these tort reforms may not do as much as we had thought to make physicians less worried about malpractice suits." Consider these approaches to reduce defensive medicine while limiting legal risks:

• Find out how your testing behavior compares with that of peers.

"Typically, physicians are held to the prevailing standard of care in their community," says Carrier. "They may find that they could test fewer low-risk patients and still be in line with that standard."

• Develop strong, positive relationships with patients.

Patients who are questioning whether they got good care probably don't realize how thorough your workup was. "But most patients will have an opinion on whether you listened to their concerns, answered their questions, and seemed to be on their side," says Carrier.

• Explain your reasoning to the patient.

Physicians should do this step in cases in which someone might criticize them for not ordering a test which the physician doesn't feel is indicated, says **Steven M. Levin**, JD, founder and senior partner at Levin & Perconti in Chicago.

"For example, there are certain CT scans of the heart where studies show that ordering the test and responding to the results can be riskier than not performing the test," says Levin.[2] If the physician properly explains this issue to the patient, the patient might decide to opt out.

Physicians who are considering ordering a test or performing a procedure only because they fear legal

Executive Summary

Physicians' concern about malpractice risk is linked to ordering certain diagnostic tests, and tort reform had little effect on this, says a new study. To reduce risks, do the following:

✦ Find out how your testing compares with peers.
✦ Explain your reasoning to the patient.
✦ Document the patient's response.

repercussions should explain the risks and benefits, and let the patient decide, Levin advises.

"Then, the physician should thoroughly document the conversation and the patient's response," he says.

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2. Hoffmann U, Truong QA, Schoenfeld DA, et al. Coronary CT angiography versus standard evaluation in acute chest pain. *NEJM* 2012; 367:299-308. ✦

Caught in plaintiff's 'wide-net' approach? Sit tight is sometimes best approach

While a defendant served with a new lawsuit often cannot believe that someone would be willing to criticize his or her care, the truth is that an expert already has offered a critical opinion, says **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC.

"Some physicians believe that all the defense lawyer needs to do is pick up the phone and call the plaintiff's lawyer and explain how the defendant could not have committed malpractice," he says.

In North Carolina, as in many other states, a plaintiff who files a malpractice claim must have had the case reviewed by someone who is reasonably expected to qualify to testify on the standard of care applicable to the defendant and also must also concluded that the care provided by the defendant was substandard. "Because of this pre-filing requirement, a plaintiff's lawyer who has filed suit against a defendant must have retained some expert witness who is prepared to come into a courtroom to be critical of a defendant," Shuirman says.

In lawsuits filed just prior to the expiration of the statute of limitations, however, a defendant might be included because an expert is critical of the care provided, but the causal relationship between the alleged malpractice and the patient's outcome has not been fully explored.

Here are some possible strategies for physicians who were only tangentially involved in the plaintiff's care:

• Discuss with counsel and insurance company the options available to try to obtain a dismissal at an early stage of the case.

Scott T. Heller, Esq., an attorney with Reiseman, Rosenberg, Jacobs & Heller in Morris Plains, NJ, says, "It's rare for plaintiff's counsel to agree to dismiss with prejudice, meaning you can't be brought back in the case, especially at an early stage of the case. The plaintiff is more likely to agree to a voluntary dismissal without prejudice.

If subsequent discovery shows that the physician really wasn't involved, this can be converted to a dismissal with prejudice, with the understanding that the doctor can be brought back into the case if good cause is shown.

• Allow the discovery process go forward.

Often the best approach is to wait until the dust settles through discovery and depositions.

"Maintain a consistent position that the care provided was appropriate and did not cause the bad outcome of which the plaintiff is complaining," says Shuirman.

While obtaining an affidavit of merit to keep a physician in the case isn't terribly costly, at a later point in time after depositions have been taken, an expert will have to specify alleged deviations from the standard of care.

"That is a much more expensive proposition, so the plaintiff lawyer might decide it's not worth the expense," Heller says. "Sometimes, it is better to just sit tight and wait, and try to get a dismissal later."

• Early in the case, physicians should meet with defense attorneys to review the available records regarding the doctor's involvement or lack thereof.

Heller has defended physicians who claimed to have no involvement in the case, "but in looking at the records, it turns out they actually were involved." Physicians might have had a supervisory role for others involved in the patient's care or might have communicated with others and it wasn't documented in the chart. If subsequent discovery shows the doctor was involved, he or she can be brought back into the case and could face possible sanctions.

"The doctor may find he or she can hardly testify to a vivid recollection of their participation in the care, when the doctor previously denied any involvement," adds Heller.

• Offer to appear for deposition at an early stage of the case, in the hope that the physician's limited involvement will be recognized.

This step has its own potential pitfalls, including the fact that plaintiff's

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If physician defendants are only tangentially involved in a plaintiff's care, they might be able to achieve an early dismissal.

✦ Consider allowing the discovery process to go forward.
✦ Review the available records regarding the doctor's involvement.
✦ Discuss whether to offer to appear for deposition at an early stage of the case.

theory of liability might not be well-understood. This situation makes it more difficult to prepare for the deposition of the defendant doctor, especially at the outset of the case, says Heller.

"This could result in a doctor unwittingly giving testimony which may prove harmful to his or her interests or the interests of colleagues who are or may become codefendants in the case," he says. *(See related story on NPDB reporting, below.)* ✦

When must sued physician report to NPDB?

One of the benefits of settling a malpractice lawsuit is a feeling of closure for the physician.

"It provides finality," says **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC. With a proper confidentiality provision, a settlement only allows people to know that a case was voluntarily dismissed if someone were to look in a public court file.

However, under current rules, any settlement that includes an indemnity payment to a claimant will result in a report to the National Practitioner Data Bank (NPDB). "If a physician does not want to be reported to the NPDB, then no settlement which includes an indemnity payment to a claimant can be considered," Shuirman says.

Sometimes, however, opportunities exist to resolve cases with cost reimbursement to the plaintiff's lawyer for expenses incurred in the litigation, he adds. This would not require a report to the NPDB. "A plaintiff or plaintiff's lawyer may lose appetite for a suit as evidence disclosed in discovery demonstrates that the plaintiff is unlikely to prevail at a trial," Shuirman says.

In this scenario, an agreement to reimburse the plaintiff's lawyer for the costs of the litigation allows the plaintiff to dismiss the case without having a debt owed to the plaintiff's lawyer. "It allows the plaintiff's lawyer to move on to another matter, having only lost his or her time invested in a case, which proved to be unfruitful," he says.

As unappealing as it might seem to allow the plaintiff and plaintiff's lawyer to get back to "even" through a cost reimbursement, such an agreement is likely to have the least negative impact on the physician, Shuirman says. "It may allow the physician to report on future licensure or credentialing applications that no indemnity money was paid on his or her behalf to settle a claim," he explains.

Consider outcome

Agreeing to settle with an indemnity payment of a small amount would trigger a report to the NPDB. "But it may still be a better outcome than accepting the risk of a large jury verdict, in cases where aggravating circumstances may impede a jury's ability to appreciate the 'innocent' defendant's 'innocence,'" Shuirman says.

He often advises defendants that having no settlements reported to the NPDB is better than having one, but having one small report to the NPDB is better than having one large verdict to report or more than one settlement to report.

"The physician should also keep in mind who would be looking at an NPDB report in the future and whether a future credentialing committee, for instance, would understand the decision to settle for a small amount without a great deal of explanation," Shuirman says. ✦

Patient is no-show, has bad outcome? Successful lawsuit could occur

In a recent malpractice claim, the plaintiff was a man diagnosed with prostate cancer who followed up regularly with his physician for a year. He was put on medication after he started to experience some complications.

"The physician asked the patient to return in 10 days, but the patient did not show up," says **Ashley Watkins Umbach**, JD, senior risk management consultant at ProAssurance Companies in Birmingham, AL.

Nurses documented subsequent conversations with the man and his wife about the importance of following up, and then sent a letter urging him to seek follow-up care. They put a copy of the letter in his chart. The man developed complications and filed a lawsuit, claiming the problems occurred due to the doctor's negligence.

"When we tried the case, we showed jurors all of the documentation we had on his failure to follow up, not only with our office, but with other treating physicians during the same time period," says Umbach. This documentation included evidence that the patient was reluctant to return to the defendant physician.

"We had a difficult time coming up with a defense expert, and we were worried defending the case on the medicine," Umbach says. However, the jurors ended up essentially disregarding the medicine involved, and instead, focused on the patient's failure to follow up.

After returning a defense verdict, one juror told defense attorneys he didn't believe the patient should have been allowed to sue because he didn't follow the doctor's instructions. "The fact that the physicians not only tracked no shows and non-compliance, but also documented it, made all the difference in the case," she says.

A survey of 723 patient care sites

found that more than half said making referrals and follow-up appointments was their top risk management problem.[1] "Patients who fail to keep appointments appear to be making a choice that should affect only them individually," Umbach says. "Unfortunately, we have seen many lawsuits arise out of circumstances in which a physician failed to follow up on the no-show."

Umbach says a common theme in these lawsuits is conditions that worsened because patients failed to obtain followup care after receiving abnormal test or laboratory results, which results in the condition not being diagnosed as soon as it otherwise would have been. In the above case, for example, the patient was just beginning to experience mild complications a year after a procedure. "These likely could have been managed with medication, had he received regular care," Umbach says. "Because of his failure to keep appointments, those complications led to a decreased quality of life, which caused him to sue."

Brenda C. Tuck, RN, MSN, CPHRM, a senior risk management consultant in ProAssurance Cos.' Washington, DC, office, says these practices can make claims more defensible:

• Closely track patient referrals for consultation with a specialist or diagnostic tests.

"If appropriate treatment is not provided and disease later develops, the [referring] provider is potentially liable for incomplete followup," she says.

In the event the patient refuses to comply with the recommended referral, the provider should document this refusal in the medical record, says Tuck.

"Healthcare providers often ask how much followup is reasonable," says Umbach. "It will differ according to the situation and the condition the patient is being asked to follow up on." In the case of a patient with a suspicious mammogram, physicians might make two phone calls, send a letter, and a certified letter, for example. However, if a study reveals an abdominal aortic aneurysm and the patient already has left, physicians should send an ambulance to transport the patient to the emergency department immediately.

• Ensure telephone messages received by staff members are dated and timed and accurately state what the patient is calling about.

"Often, telephone messages can be a source of communication gaps and can have damaging legal ramifications," Tuck says.

If a provider is off work or out of the office and his partner receives a message from the provider's patient from the previous day, the provider should be able to clearly follow the communication chain documented in the medical record, she adds.

• Exercise caution when allowing personnel, particularly unlicensed staff, to triage telephone calls and/or make decisions regarding renewal of prescriptions.

All staff must use provider-approved triage protocols and have documented evidence of training on accurate use of the protocols, advises Tuck. "Ensure that the medical record reflects provider involvement in all aspects of treatment and care of the patient," she adds.

Executive Summary

Patients who fail to show up for follow-up appointments present legal risks for physicians. To avoid successful lawsuits, do the following:

- ✦ Closely track all patient referrals.
- ✦ Ensure that patients' telephone messages are followed up on.
- ✦ Ensure that staff training on triage protocols is documented.

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Study: Many surgical claims involve postoperative care

Several years ago, The Doctors Company conducted a study of surgical specialties, looking at preoperative, intraoperative, and postoperative phases of surgical care.

"We were surprised by the number of life-threatening complications that manifest themselves in the postoperative period. In the past, many assumed that the majority of risks to patients were during surgery," says **Donald J. Palmisano**, MD, JD, FACS, a member of the Board of Governors of The Doctors Company.

The postoperative phase of patient care then became the focus of a March 2013 study conducted by The Doctors Company of medical liability claims filed against general surgeons.[1] A review of individual claims revealed that many patient injuries resulted from delayed discovery of surgical complications such as punctures of bowel, bladder, and blood vessels. Patients experienced complications such as deep vein thrombosis, pulmonary embolus, pneumonia, infections, and brain damage from hypoxemia.

Based on the claims in the analysis, Palmisano gives these risk-reducing strategies:

• Assess patients prior to surgery to determine whether they are candidates for the recommended procedure.

"Some patients don't survive successful surgical procedures due to co-morbidities," he notes.

• Train nursing staff who provide care

to patients in the postoperative phase to recognize symptoms of complications, including bleeding or drops in hemoglobin; increased respiratory rate; increased heart rate; temperature increase above a designated degree; more pain than is anticipated for the type of surgery; any changes to neurological assessment including patient complaints of inability to move an extremity; any changes to mental status; unexpected inability to urinate; and low urine output.

• Screen patients for sleep apnea due to the effects of narcotic analgesics on the respiratory system.

• Administer prophylaxis to patients at risk of developing deep vein thrombosis.

Poor communication

In reviewing documentation of cases involving postoperative complications, it often becomes very clear that physicians have not communicated with the nurses, says **Phyllis Miller**, RN, a legal nurse analyst in the Minneapolis office of Robins, Kaplan, Miller & Ciresi.

"If the nurses are documenting that the patient was up all night with terrible pain and bloating, and the physician says the patient is looking good and ready to go home, that is not helpful either to the patient or to defend a potential claim," says Miller.

Many of the claims involving postop complications in The Doctor's Company were rooted in poor communication, says Palmisano. Here are some examples:

• Physicians did not read the medical record or did not communicate about a patient's aortic and pulmonary stenosis. This issue resulted in complications postoperatively and the patient's death. "In several cases, patients were known to have cardiac problems, but the surgeon did not receive the information prior to surgery," says Palmisano. "Some reports were filed before being reviewed by the surgeon."

In some cases, the problem was not identified in the pre-operative history and physical, or was not communicated by the referring physician. "There were situations where the patient's cardiac condition was documented in the patient's medical record, but was not read by the surgeon and not factored into the plan for surgery," adds Palmisano.

• Nurses observed elevated patient temperature but did not call the surgeon prior to discharging the patient, who later was found to be septic.

• Nurses notified a surgeon that the patient complained that they could not move their legs, and the surgeon delayed referring the patients to a neurologist. The patient suffered paralysis from an epidural hematoma.

• A patient's low sodium level was not communicated by the surgeon to the nephrologist, and the patient suffered stroke-like symptoms that were attributed to hyponatremia.

• A patient's abdominal pain was treated by a family physician, who failed to communicate to the surgeon that he was seeing blood following enemas. The patient died of sepsis due to a perforated bowel.

In this case, the patient presented to the emergency department with abdominal pain, and the emergency physician ordered a surgical consult. The surgeon examined the patient and found guarding, hypoactive bowel sounds, and impacted fecal material. An enema was ordered, but no diagnostic tests were ordered. The patient was admitted to the hospital.

"The patient continued to have pain, so the family practice physician ordered another enema. No fecal material returned, but blood was seen in the enema fluid," says Palmisano. "The family physician attempted to contact a surgeon, without success."

The patient's pain was intense and treated with morphine, but no other attempts to reach the surgeon were made throughout the night. The following morning, the surgeon ordered an X-ray. "The interpretation was perforated viscous with significant free air. The surgeon took the patient to surgery and found a perforated sigmoid colon with fecal peritonitis," says Palmisano. "The patient later expired from septic shock."

No explanation was made for why the surgeon was unavailable when called by the family physician, says Palmisano, and it was also unclear why the nurses did not contact the surgeon when the patient's intense pain persisted. "Blood in the bowel indicates possible perforation and warrants further investigation. Continued intense pain should have prompted further diagnostic workup and should have caused the nurses to notify the surgeon of the patient's condition," says Palmisano. The delay in diagnosing the patient's condition decreased the chance that the patient would survive, he says.

Protocols should require nurses to call surgeons with elevated heart rates and temperatures prior to discharging patients, says Palmisano, and discharge instructions need to clearly outline situations when patients should seek care. "Patients need instructions about when they should seek further care. This is often dependent on the type of surgery," he adds. Palmisano says patients should seek care if they are bleeding, have a fever, have pain that is not controlled by their medications, have shortness of breath, have a rapid heart rate, or experience any significant change in their status.

"This especially true for patients who are discharged right after surgery," says Palmisano. "Even serious complications

Executive Summary

Delayed discovery of surgical complications resulted in a significant number of malpractice claims against general surgeons, according to a recent study. To prevent lawsuits involving the postoperative phase of care, do the following:

- Assess patients' comorbidities.
- Train nurses on signs of complications.
- Require nurses to report elevated heart rates and temperatures prior to discharge.

may not manifest themselves until later." *(See related story, below, on documentation that makes claims more defensible.)*

Reference

1. Palmisano DJ, Ranum D. Symptoms of normal recovery or complication: The risks of postoperative care. *Bulletin ACS 2013*; 98(6):28-32. ✦

Postoperative complication? Tip to help defense

In the event a malpractice lawsuit is filed alleging failure to diagnose and treat a surgical complication, **Donald J. Palmisano**, MD, JD, FACS, a member of the Board of Governors at The Doctors Company, says this documentation can make the claim more defensible:

• evidence that assessments and vital signs that are performed at regular intervals according to hospital policies or physician orders, providing a clear picture of the care received by the patient;

"Some complications or other conditions don't become evident until later," explains Palmisano. "Documentation of vital signs may show that earlier interventions were not required."

• documentation of physicians' responses to nurses' calls demonstrates that surgeons or other physicians were giving appropriate attention to the patients' changing conditions;

• documentation of clinical rationale for conducting surgery, despite the fact that a patient has co-morbidities;

• documentation of informed consent discussions;

• compliance with protocols. "This helps to demonstrate that an appropriate level of care was provided," Palmisano says. ✦

Few cases allege failure to treat pain — Most claims allege excessive prescribing

(Editor's Note: This is the second part of a two-part series on legal risks involving pain management. This month, we report on cases alleging under treatment of pain. Last month, we covered allegations of overprescribing of opioids.)

Malpractice claims involving excessive prescribing of opioid analgesics are increasing, but malpractice risks also stem from withholding appropriate opioid analgesics.

"Physicians are increasingly feeling caught between the ethical requirements to address patients' pain and being seen as ordering too many controlled substances," says **Glenna Schindler**, MPH, RN, CPHQ, CPHRM, a risk management specialist at Endurance Risk Solutions in Chesterfield, MO. "It is a growing dilemma."

At times, physicians do not want to prescribe controlled substances to patients with history of substance use disorder for fear of triggering further addiction problems. "This indicates a lack of knowledge in treating both acute and chronic pain and how to meet the pain relief needs of patients," says Schindler.

Physicians sometimes withhold appropriate opioids out of an exaggerated concern about regulatory scrutiny or unwarranted fears about the risks and side effects of opioids, according to **Ben A. Rich**, JD, PhD, professor and an alumni association endowed chair of bioethics at the University of California — Davis Health System's School of Medicine. "Erring in either direction may constitute a departure from the standard of care and thus generate potential medical malpractice liability," says Rich.

Several medical board decisions have imposed disciplinary sanctions on physicians for failure to properly manage pain or demonstrating deficiencies in this area of practice.[1, 2]

The Joint Commission's 2000 "pain as the fifth vital sign" campaign could be used as evidence to help an attorney prove whether a physician defendant violated the standard of care, adds Rich. However, it has not had much of an effect on individual physician prescribing practices, particularly with regard to chronic pain, he says. "The initiative has been much maligned by many physicians, who claim that pain cannot legitimately be considered a vital sign since there is no objective way to measure it," says Rich.

Substantial damages

Several malpractice claims from the 1990s to the early 2000s, which found healthcare professionals liable for undertreating pain, made it clear that juries are prepared to award substantial damages

Executive Summary

Both excessive prescribing and withholding of opioid analgesics can constitute a departure from the standard of care.

✦ Physicians face possible disciplinary sanctions from state medical boards for failure to manage pain.

✦ Juries have awarded substantial damages in cases involving inadequate pain management.

✦ Litigation typically involves excessive prescribing of opioids to patient who subsequently died of drug overdoses.

when patients are subjected to unnecessary pain and suffering because of the ignorance or indifference of clinicians, says Rich.[3-5]

A 1991 case involved an elderly man with advanced prostate cancer whose nurse at a skilled nursing facility replaced his opioid regimen with a mild tranquilizer. The facility was later sanctioned by the state licensing authority for substandard care of patients.

"Following his death his family brought suit, alleging, in what appears to be a case of first impression, that his suffering was the product of substandard care," says Rich. After a trial on the merits, a rural North Carolina jury awarded compensatory damages of $7.5 million and an additional $7.5 million in punitive damages.

A 1999 case involved an 85-year-old man with severe persistent pain not well-controlled on oral Vicodin. He was given morphine after complaining of severe pain at an emergency department, and the morphine then was discontinued by a hospitalist. The family filed a complaint against the hospitalist with the Medical Board of California for failure to treat the patient's pain. "The board's expert reviewer opined that the pain management was inadequate, but the board declined to take disciplinary action based only on a single episode," says Rich.

The family filed a claim grounded on elder abuse against the medical center and the hospitalist because a standard malpractice claim would not suffice for recovery in California's framework of tort reform legislation. A jury concluded that the hospitalist's management of the pain was sufficiently substandard to constitute elder abuse and awarded $1.5 million in damages.

"The verdict was subsequently reduced by the court on the grounds that the statute set a lower limit on damages for pain and suffering," notes Rich.

In a 2002 case involving a man with terminal mesothelioma, the patient received no analgesics until the fourth day after admission, despite an advanced directive specifically requesting aggressive pain relief even with the risk of hastening his death. After his death in the facility, the family filed an elder abuse claim. On the eve of trial, all defendants — the hospital, physicians, and skilled nursing facility settled with the plaintiffs for an undisclosed sum. The physician subsequently was disciplined by the medical board for demonstrating material knowledge deficits concerning the use of analgesics.

"Post-2004, the pendulum seemed to be swinging [in the opposite direction]," says Rich. "Most litigation is now of the criminal variety against physicians, for carelessly and excessively prescribing opioids to patients who subsequently died of drug overdoses."

References

1. Oregon Board of Medical Examiners, Stipulated Order in the Matter of Paul A. Bilder, MD, September 1999.
2. Medical Board of California, In the Matter of the Accusation against Eugene B. Whitney, MD, March 2003.
3. Estate of Henry James v. Hillhaven Corp., 89 CVS 64 (Superior Court of Hertford Co., NC, 1991)
4. Bergman v. Chin, et al., No. H205732-1 (Superior Court of Alameda Co, CA 1999)
5. Tomlinson v. Bayberry Care Center, et al. No. C 02-00120 (Superior Court of Contra Costa Co., CA 2002).

SOURCES

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COMING IN FUTURE MONTHS

✦ Prevent successful failure to diagnose suits

✦ Surprising legal risks of team-based care

✦ Update on new expert witness rules

✦ What to do if patient refuses diagnostic test

CME OBJECTIVES

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

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

CME INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.

2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CME Questions

1. **Which is true regarding followup with test results, according to Amy E. Goganian, JD, an attorney with Goganian & Associates?**
   A. The physician who ordered the test is always solely responsible for any abnormalities found, even after an official handoff occurs.
   B. Physicians should inform specialists of test results only in writing.
   C. It is always sufficient to simply make results available to providers by virtue of their inclusion in the medical record.
   D. Physicians should double-check with other providers that results were received.

2. **Which is recommended for primary care physicians to reduce legal risks, says Mark L. Graber, MD, FACP, senior fellow at RTI International?**
   A. Avoid surveying patients on your communication style.
   B. Obtain a second opinion only if the patient requests it.
   C. Consider obtaining a second opinion if there is major diagnostic uncertainty.
   D. Exclude any acknowledgement of uncertainty in your documentation.

3. **Which is true regarding reporting to the National Practitioner Data Bank (NPDB), according to Ryan M. Shuirman, JD, an attorney at Yates, McLamb & Weyher?**
   A. Settlements with a proper confidentiality provision preclude anyone from learning that a case was voluntarily dismissed, even if someone were to look in a public court file.
   B. Under current rules, any settlement which includes an indemnity payment to a claimant will result in a report to the NPDB.
   C. Cost reimbursement to the plaintiff's lawyer for expenses incurred in the litigation always requires a report to the NPDB.
   D. Reporting to the NPDB is not required if physicians agree to settle with an indemnity payment of a small amount.

4. **Which is recommended to decrease legal risks involving patients who fail to keep followup appointments, according to Brenda C. Tuck, RN, MSN, CPHRM, a senior risk management consultant at ProAssurance Cos.?**
   A. If appropriate treatment is not provided by a specialist, the referring provider is never even partially liable for incomplete follow up.
   B. It is not advisable for providers to document a patient's refusal to comply with a recommended referral.
   C. If a provider is out of the office and a partner receives a message from the provider's patient from the previous day, only the initial provider should respond.
   D. Ensure that staff use provider-approved protocols when triaging patients' telephone calls.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Numbness and difficulty after orthopedic surgery result in more than $1 million verdict for the plaintiff

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News: The plaintiff underwent an anterior lumbar interbody fusion in 2002 and suffered pain, numbness, and difficulty walking as a result of the procedure. The plaintiff brought this action for medical malpractice against the orthopedic surgeon. A jury rendered a verdict in favor of the plaintiff in the amount of $1.1 million.

Background: The plaintiff developed a back problem in 2001. He consulted with an orthopedic surgeon specializing in spine surgery, who initially recommended conservative therapies. The conservative therapies were unsuccessful. Diagnostic testing was conducted and revealed the degeneration of discs and cartilage in the plaintiff's lower back. The orthopedic surgeon recommended the plaintiff undergo an anterior lumbar interbody fusion.

The plaintiff agreed to the procedure, and it was performed at a medical center in April 2002 by the orthopedic surgeon and two other vascular surgeons. There were no complications with the spinal fusion part of the surgery, but complications arose with respect to accessing the plaintiff's spine. As such, vascular injuries occurred causing substantial bleeding and requiring conversion from a laparoscopic, minimally invasive approach to a more intrusive open approach. After the vascular injuries arose, the orthopedic surgeon left the surgery table. The vascular surgeon was called in to make the necessary vascular repairs. Once the vascular repairs were complete and the bleeding controlled, the orthopedic surgeon returned to complete the surgery.

The plaintiff suffered the permanent loss of the peroneal nerve in his left leg.

Following the surgery, the plaintiff was taken to the post-anesthesia care unit (PACU) at the medical center, where he was monitored and given intravenous fluid. He was then transferred to ICU for monitoring. Later that evening, the orthopedic surgeon was contacted by a hospital nurse due to concerns over the plaintiff's symptoms. The orthopedic surgeon assessed the plaintiff and saw no symptoms of complications (i.e. compartment syndrome).

However, the following morning, the orthopedic surgeon suspected that the plaintiff suffered from compartment syndrome in his left calf area. He informed the vascular surgeon that morning. Surgery to relieve the pressure in his legs was not conducted until about 2 p.m., when the compartment syndrome had reached an advanced state. The plaintiff suffered the permanent loss of the peroneal nerve in his left leg. As a result, the plaintiff alleges that he now experiences pain, numbness, and difficulty walking.

At trial, the plaintiff argued that the orthopedic surgeon advised him that he would supervise the surgical team performing the surgery. The orthopedic surgeon disputed this point

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Ericka Fang, Esq., Bruce Cohn,** and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

and denied any general responsibility for the plaintiff's condition as the admitting physician. The orthopedic surgeon further testified that he was not qualified to treat the compartment syndrome and that vascular issues were the vascular surgeon's responsibility. He acknowledged that the vascular surgeon did not act quickly upon being informed of the suspected compartment syndrome, but he denied any responsibility for the delay. The jury found for the plaintiff and awarded damages in the amount of $1.1 million.

What this means to you:
Compartment syndrome is not infrequently seen as a basis for malpractice liability. The issue in these cases usually is failing to diagnose timely, often because the condition is thought to be less serious or the patient does not present with classic signs and symptoms of the disease. This case report compounds the delay with confusion over who was responsible for what, which further delayed the diagnosis.

Compartment syndrome is particularly dangerous medically and legally because of the declining likelihood of a good result as time goes by. The medical nature of this is self-evident and might cause the judge or jury to be punitive. The testimony of the plaintiff's experts follows a predictable pattern. If only the doctor had diagnosed or at least suspected compartment syndrome a few hours earlier, the patient would have been timely operated on and everything would be fine.

This case also shows the problem of determining who is the captain of the ship or the primary practitioner responsible, particularly when many surgical specialties are involved. The multiple surgeon conundrum is compounded by the finger pointing that invariably results as each doctor tried to exculpate themselves by blaming the others.

In this case, there was an apparent vascular injury. The orthopedic surgeon could not say for sure whether he or the vascular surgery caused this injury. What is clear is that the orthopedic surgeon left the OR while the repairs were going on. This is a problem medical-legally. Even if there was nothing for the orthopedic surgeon to do in regard to the vascular repair, his leaving after a complication was discovered will not sit well with the finder of facts. The patient underwent a nine-hour surgery and appeared well in the postoperative care unit, then transferred to the surgical ICU. Five hours after the surgery, the nurse called the orthopedic surgeon due to concerns about the patient's symptoms. This call is the first opportunity to make the diagnosis. It appears from the case report that the orthopedic surgeon reported being familiar with the syndrome, but a significant issue would be what is in the record.

This case also shows the problem of determining who is the captain of the ship ... when many surgical specialties are involved.

Often in malpractice cases, we are searching retrospectively what the doctor was thinking about. Did he consider compartment syndrome and, if so, does the record reflect his differential diagnosis? Reading the chart at trial, if there is a particularly worrisome cause of a patient's symptoms, there should be clear evidence of its consideration and if discounted, what facts were used to discount the possibility? The orthopedic surgeon did suspect compartment syndrome the following morning at 6:30 a.m. There is some dispute over the contents of a call to the vascular surgeon by the orthopedic surgeon that morning and also evidence that a nurse called the vascular surgeon at about 6:30 a.m. At this point, there is clear consideration to the syndrome. Again, we have to look at the facts of the case from the perspective of a lay juror, not a clinician. The physician was considering a serious condition, which had the potential to cause significant harm, and he left the hospital without doing anything to confirm the diagnosis.

The orthopedic surgeon then performs elective surgery at another hospital, while the resolution of the patient's problem is still uncertain, which is another "red flag" to the jury. The vascular surgeon finally performed surgery to treat the problem, some seven hours after it was first suspected. There's no surprise that there was permanent damage to the patient's peroneal nerve.

Amazingly, the attending physician attempted to deny responsibility for the patient's general condition as the admitting physician. He also used as a defense that his index of suspicion was not high for compartment syndrome because he was not present for the entire initial operation. This is a no-win argument. The orthopedic surgeon was the physician mainly responsible for the patient. If he could not perform the surgery to decrease the compartment pressures, he needed to ensure that someone who could was called and available. What this means to you is that the primary surgeon must have a high index of suspicion for dangerous conditions. Once the suspicion is there, the primary surgeon must rule out the complication or ensure appropriate additional treatment.

Having appropriately raised the alarm on compartment syndrome, the doctor should not have left the hospital until the condition was ruled out, further testing was being done, or definitive treatment by a specific practitioner was instituted.

Reference:

New Hampshire Supreme Court, 965 A.2d 1040 (2009) ✦

Diagnosis of pneumonia instead of CHF results in plaintiff's verdict at trial

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News: The plaintiff's decedent suffered from congestive heart failure (CHF), which contributed to her subsequent stroke and death. The plaintiff brought this action for medical malpractice against numerous physicians and the hospital as the administrator of his wife's estate. The plaintiff alleged that the defendants negligently delayed in the diagnosis of the decedent's congestive heart failure and further alleged that the delay caused or contributed to her subsequent stroke and death. The jury found that the decedent's death was caused by the negligence of the defendants and awarded plaintiff damages in the amount of $667,000.

Background: On Feb. 9, 2008, the plaintiff's decedent gave birth to twins at a hospital in North Carolina. Two days later, her obstetrician ordered an abdominal X-ray that indicated she could be suffering from pneumonia. The plaintiff's decedent was treated with antibiotics and discharged on Feb. 13. On Feb. 15, the plaintiff's decedent experienced shortness of breath and went to the office of her primary care physician for treatment. He referred her to the emergency department for further evaluation. X-rays were conducted at the hospital, and she was diagnosed with pneumonia, given a different class of antibiotics, and discharged home the same day.

On Feb. 22, the plaintiff's decedent returned to the emergency department at the same hospital with complaints of shortness of breath. An emergency physician's assistant at the defendant hospital briefly examined her and then ordered a flu swab, a strep test, and a chest X-ray. The flu swab and strep test were negative. The physician's assistant consulted with a physician at the defendant hospital about the chest X-ray. Both agreed that the plaintiff's decedent suffered from pneumonia. She received prescriptions for antibiotics that provided broader coverage that the one she had previously taken and was discharged home with instructions to return to the emergency room if her symptoms continued or worsened.

Her Feb. 22 chest X-ray was interpreted on Feb. 25, because there were no radiologists on duty at the defendant hospital over the weekend. When a radiologist interpreted the chest X-ray, his diagnosis was different from that of the emergency department physician and ED physician assistant. The radiologist advised that she was suffering from worsening congestive heart failure. On Feb. 27, an emergency department physician instructed one of the emergency department nurses to contact the plaintiff's decedent with a warning that she should see her primary care physician as soon as possible. The nurse called and left a voicemail message for the plaintiff's decedent that day and spoke to the plaintiff on Feb. 28, 2008. The plaintiff was unable to schedule a visit with a cardiologist or internist until mid-March, and the emergency department nurse recommended returning to the ED. The plaintiff's decedent did not come to the emergency department that day.

On March 1, the plaintiff's decedent returned to the defendant hospital and was admitted. On March 2, 2008, she was transferred to another hospital in North Carolina. On March 4, the plaintiff's decedent suffered an embolus to her kidney and was started on coagulation therapy. On March 7, she suffered a stroke. Thereafter, she continued to decline until her death on March 23. According to her death certificate, her death was a result of complications from her stroke.

Prior to trial, the plaintiff settled this matter with the defendant hospital. The action proceeded to trial with the emergency department physician assistant, radiologist, emergency department physician and physician practice groups as defendants.

At trial, the plaintiff argued that his wife's death was caused by the negligence of the defendants. The plaintiff further alleged that the defendants negligently delayed the diagnosis of his wife's congestive heart failure and that the delay caused or contributed to her subsequent stroke and death. The jury returned a verdict for the plaintiff against the physician group and the ED physician assistant in the amount of $667,000. The jury also found that the decedent's death was not caused by the negligence of the radiologist or the ED physician. The ED physician assistant and the physician practice group appealed the decision. Upon appeal, the court ruled that the defendants were entitled to a new trial. The new trial has not been held.

What this means to you:
Sometimes you get multiple chances

to jump back off the malpractice ledge, and sometimes multiple chances are just not enough. The plaintiff's decedent delivered twins. A X-ray taken by her obstetrician caused the doctor to suspect pneumonia. He gave her antibiotics, and she was discharged. Two days later, she has shortness of breath and her primary care physician sends her to the ED, and there are more antibiotics. Seven days after that time, she went back to the same emergency department, where a physician assistant orders testing including an X-ray, which is not interpreted for three more days. She eventually is called and told to consult her primary care physician or an internist. By the time she does get back, her situation goes bad quickly. She suffers multiple medical complications and a steady decline to her death, some six weeks after the birth of her twins.

Clearly the damage aspect of this case is awful; a young mother of twins who expires soon after the birth. The liability aspects of this case when viewed from the retrospective would seem almost incredible if we had not seen similar situations in the past. The providers went into a virtual multiplex and went into the wrong theater. In this case they also stayed in the wrong theater.

The obstetrician made a presumptive diagnosis of pneumonia and gave antibiotics. Clearly the symptoms did not get better. In spite of this fact, the first emergency department visit resulted in the same diagnosis and more antibiotics. The case report indicates that X-rays were taken at the first emergency department visit. It would be interesting to review those films with the knowledge of what ultimately occurred. The classic danger here is accepting the prior diagnosis. Most likely, when the patient presented for the first emergency department visit, she told the physician that she had been diagnosed with pneumonia previously. This diagnosis might have colored the ED physician's evaluation. The patient was assumed to have pneumonia, which did not respond to the first set of antibiotics, and the antibiotics were changed. The assumption by that physician might even have affected the interpretation of the X-rays as showing pneumonia. The patient might have been better off coming in off the street with no prior diagnosis.

A third medical encounter ensues on the 22nd when the patient again presents to the emergency department. The physician assistant does a full work-up with a chest X-ray. After consulting with a physician, the physician assistant again diagnoses pneumonia. What follows is a delay in a definitive reading by a radiologist, followed by a delay in getting the patient to definitive care, which contributes to a bad outcome.

Why three sets of providers came up with the same incorrect diagnosis will weigh heavily on the minds of the jury.

There are multiple issues here. If the patient had pneumonia and did not improve on different antibiotics, the diagnosis should have been questioned. Why three sets of providers came up with the same incorrect diagnosis will weigh heavily on the minds of the jury. Jury instructions routinely tell jurors to use their common sense, and the continued adherence to a diagnosis in the face of no improvement clearly will violate this rule.

The delay in a definitive read is also a problem. It is common for different hospitals to have different levels of staffing, with some having weekend radiologists and some not. This situation is fine as long as the emergency department attending who is trained to read X-rays comes up with the same opinion as the subsequent review by the radiologist. This situation is one of those in which everything is fine if you are right but not if you are wrong.

The delay in getting the patient back is also an issue. Once having identified a potentially life-threatening condition, the patient should have been told to return to the emergency department immediately. The rather vague advice of making an appointment to see a doctor in the face of worsening congestive heart failure simply is not enough. If the patient had been directed to return to the emergency department, a consultation with a cardiologist could have been obtained quickly. It might not have changed the outcome, as the patient came back to the emergency department anyway after trying to make an appointment, but it would have made the case more defensible.

One item that is surprising is the failure of the verdict to find liability on the part of the ED physician but hitting the physician assistant. Considering that the physician assistant consulted the ED physician, the ED doctor generally would be liable for the actions of the physician assistant as well.

The diagnosis should have been questioned. The failure of the hospital to have radiological over-reads in a more timely fashion created delay, which resulted in greater exposure. What this means to you is that accepting another practitioner's diagnosis, especially in the face of evidence that it might be wrong, will subject you to a negative verdict.

Reference

Washington Supreme Court, 285 P.3d 873 (2012). ✦