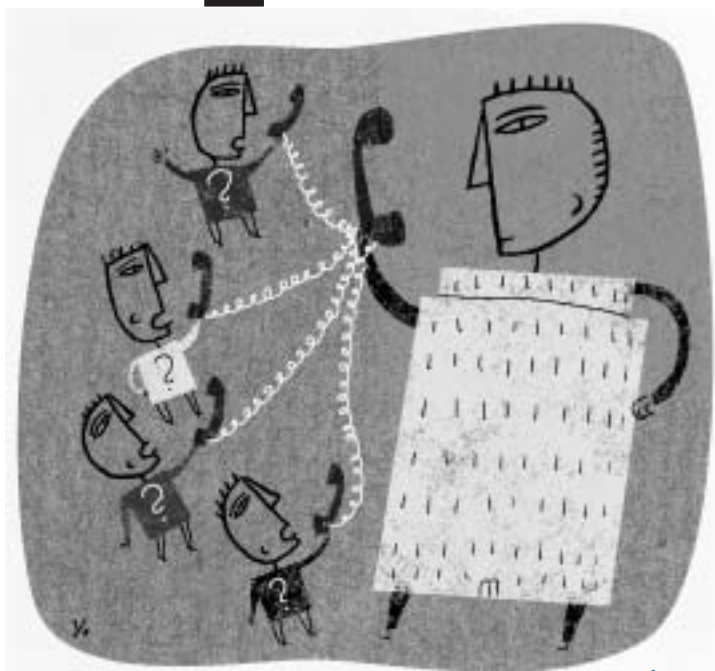


the Reporter



A physician's duty to nonpatients is a complex area of law and state courts around the country have taken contrary positions. In Texas, "permissive" reporting statutes and case law generally do not extend a physician's duty to third parties except in specific circumstances. This article will provide a summary of the reporting requirements for Texas physicians in three areas that affect third parties: reporting impaired drivers; reporting child abuse; and reporting patients who make threats of violence.

Reporting impaired drivers

By far, most third-party liability claims against physicians come from individuals who were injured in motor vehicle accidents caused by patients who allegedly should have been warned not to drive or whose potential for impaired driving should have been reported to driver's license authorities.

Duty-bound

physician reporting duties in Texas

by Laura Brockway, ELS

"My patient has experienced significant vision loss since I last saw her. It may not be safe for her to drive. Do I have to report her to the Department of Public Safety?"

"I'm worried that one of my patients is abusing her children. Do I need to report my suspicions — even if they are just suspicions?"

"My patient, who has just been through a nasty divorce, was in the office today. He was extremely agitated and spoke very seriously of his desire to physically harm his ex-wife. I know this patient has access to firearms. What should I do?"

In Texas, physicians are not obligated to report medical conditions that could affect a patient's ability to drive. Such reporting is strictly voluntary. (Six states — Nevada, Delaware, Georgia, Oregon California, and New Jersey — currently require physicians to report drivers who have conditions that could impair their ability to drive safely.)¹

According to the Texas Health and Safety Code, any physician licensed to practice in Texas may inform the Department of Public Safety (DPS) of a patient older than 15 years of age whom the physician has diagnosed as having a health condition that may interfere with the safe operation of a motor vehicle. This release of information is

continued on page 2

an exception to the patient-physician privilege requirements.²

Once a report is received by the DPS, the driver is notified in writing and is required to provide medical information from his/her personal physician. When this information is received, the case is referred to the Medical Advisory Board. The Medical Advisory Board is a panel of physicians that convene to review the medical information and make recommendations or issue opinions to the DPS. The DPS acts in accordance with the medical findings of the Medical Advisory Board. The final decision to issue, renew, restrict, or, revoke a license rests entirely with the DPS.³

Physicians who voluntarily report drivers or who examine patients for or on the recommendation of the Medical Advisory Board are not liable for a professional opinion, recommendation or report made under the Texas Health and Safety Code, Title 2, Chapter 12. Section 12.096.⁴

Detailed information on the Medical Advisory Board is available at <http://www.tdh.state.tx.us/hcqs/ems/MABphysician.htm>.

How to report

A Texas driver may be reported to the Medical Advisory Board by physicians, family, friends, acquaintances, or anonymously. All reports are kept confidential and are not included in public records. Reports must include the driver's full name, date of birth, or Texas driver's license number. Written reports should be sent to:

Texas Department of Public Safety
Driver Improvement Bureau
P.O. Box 4087
Austin, TX 78733-0320.

Reports can also be faxed to (512) 424-2501. Oral notification is not sufficient for the DPS to take action.⁵

Conditions that may impair driving

Examples of medical conditions that most commonly come under Medical Advisory Board review include:

- neurological problems (TIAs, stroke, convulsive disorders, movement disorders, narcolepsy, excessive daytime sleeping, seizures, etc.);
- general debility (aging, pulmonary disease, malignancies);
- psychiatric disorders;
- cardiovascular diseases;
- metabolic diseases (chronic renal failure, diabetes); and
- all others: unexplained blackout, drug and alcohol abuse, musculoskeletal, vision impairment.⁶

Patients with epilepsy are required to inform the DPS of their condition when they apply for a driver's license. Patients who develop epilepsy after receiving a license should notify the DPS once diagnosed. A physician must certify that the patient has been seizure free for six months before the patient can be licensed to drive. Annual medical updates are required after licensing. Persons with epilepsy will not be licensed to drive a passenger transport vehicle such as a bus, taxi, or emergency vehicle.⁷

The AMA publication *Physicians Guide to Assessing and Counseling Older Drivers* contains a comprehensive list of medications and conditions that may impair driving. This free publication is available at <http://www.ama-assn.org/ama/pub/category/10791.html>.

No duty to report in Texas

Citing the permissive reporting statute in the Texas Health and Safety Code, the Supreme Court of Texas declined to impose on physicians a duty to third parties for failing to report a patient to the DPS or for failing to warn the patient not to drive.⁸ In the case of *Praesel vs. Johnson*, Ronald Peterson was an epileptic who suffered a grand mal seizure while driving. He broadsided a vehicle

driven by Terri Lynn Praesel who died from the injuries she sustained. Her family filed a lawsuit against three physicians who had treated Peterson and a clinic where Peterson had been treated before the collision. The plaintiffs alleged that each physician was negligent for failing to warn Peterson not to drive and failure to contact the state Medical Advisory Board regarding Peterson's condition.

The court found that while state law permits a physician to share information with the DPS, "a report to the Medical Advisory Board by a treating physician does not translate into automatic revocation of the patient's license." Further, the court stated that the Department of Public Safety — not a patient's private physician — may determine if driving is permitted.⁸

Warning patients not to drive

While Texas physicians may not have a duty to third parties to report or warn patients not to drive, they do have a duty to inform patients how their condition or treatment can affect their ability to drive. "With regards to driving, physicians should advise and counsel their patients about medical conditions and possible medication side effects that may impair their ability to drive safely. Case law illustrates that failure to advise the patient about such medical conditions and medication side effects is considered negligent behavior."¹

One such case is the Texas case of *Gooden v. Tips*.⁹ Edith Goodpasture had been a patient of a Houston psychiatrist for 20 years. During that time, the psychiatrist treated the woman for a variety of problems, including depression and drug abuse. Goodpasture was driving her car under the influence of the sedative methaqualone, prescribed by the psychiatrist, when she struck and injured Mellie Gooden.

Gooden sued both Goodpasture and the psychiatrist. The allegations against the psychiatrist were that he had a duty to warn his patient not to drive while taking methaqualone, and that Gooden's injuries were the result of his failure to provide such warning. The trial court granted the psychiatrist summary judgment on the basis that Gooden was neither his patient nor an identifiable third party at risk. Gooden appealed, and the appellate court reasoned that, while Gooden as an individual may not have been an identifiable third party at risk, the danger created by allowing an impaired patient to drive was foreseeable. The court also placed a narrow limit on the scope of a physician's duty under such circumstances: "We hold only that, under the facts here alleged, Dr. Tips may have had a duty to warn his patient not to drive. We do not hold that he had a duty to prevent her from driving, if she so desired."⁹

Risk management considerations

• According to AMA Ethical Opinion E-2.24, "in situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the Department of Motor Vehicles."¹

• Remember that the physician's role is to report medical conditions that could impair safe driving. Physicians are not expected to determine a patient's ability to drive safely. That is the role of the DPS.

• At minimum, advise your patient when he or she is impaired and should not drive or engage in other potentially hazardous activities. Document the warning in the chart. In many cases, this may fulfill a duty to third parties.

• Even when such a warning appears obvious, remember that the patient may be so impaired that he or she does not recognize that a problem exists.

• Make sure that the warning is repeated on the labels of any relevant medications.

• Thorough documentation can provide evidence of your efforts to assess and maintain the patient's driving safety. Document any direct observation of functional deficits that may impair driving. Document any medical interventions and referrals you have made to improve the patient's function and any repeat

testing to measure improvement. Document your recommendation that the patient stop driving and include a summary of your interventions.

- Sample documentation can include:
 - “Discussed driving retirement with patient and sent letter to reinforce recommendation.”
 - “Discussed transportation options and gave copy of *Getting By Without Driving*.”
 - “Contacted family members with patient’s permission.”
 - “Reported patient to DPS with patient’s knowledge.”(Include copies of any written correspondence in the patient’s chart.)
- The American Medical Association’s Council on Ethical and Judicial Affairs recommends that physicians take the following steps to reduce the impact of breaching patient confidentiality when reporting patients to driver’s license authorities.
 - Before reporting, tell the patient what you are about to do. Explain the process and assure the patient that you will only disclose the minimum information required.
 - When submitting a report, provide only the information required. Consider giving the patient a copy of the report.
 - Before contacting the patient’s family members and caregivers, request the patient’s permission to speak with these parties. If your patient maintains decision-making capacity and denies permission for you to speak with these parties, you must respect the patient’s wishes.¹
- Follow up with patients to determine their success in using alternative transportation options and for any signs of social isolation and depression. Document any further interventions, including referral to a social worker, geriatric care manager, or mental health professional.

Reporting child abuse

The State of Texas has rules and guidelines in the Family Code that address requirements for reporting child abuse or neglect. If a professional such as a physician or other health care provider has cause to believe a child is being subjected to abuse, a report shall be made no later than 48 hours after the professional first suspects that the child has been or may be abused or neglected or is a victim of the offense of indecency with a child.¹⁰

Reports of abuse or indecency with a child shall be made to:

- Texas Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (DFPS Texas Abuse Hotline at 800-252-5400 operated 24 hours a day, 7 seven days a week or by fax to 800-647-7410); or
- any local or state law enforcement agency; or
- the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or
- the agency designated by the court to be responsible for the protection of children.

The law requires that the following be reported:

- name and address of minor, if known;
- name and address of the minor’s parent or person responsible for the care, custody, or welfare of the child if not the parent, if known; and
- any other pertinent information concerning the alleged or suspected abuse, if known.

Reports can be made anonymously. Unless waived in writing, the identity of the physician making a report is confidential, and may only be disclosed to a law enforcement officer for the purposes of conducting a criminal investigation of the report, or as defined by confidentiality provisions provided in Section 261.201 of the Family Code. In addition, the Family Code states that reporting

requirements apply regardless of professional confidentiality and licensing laws and rules for professionals.

Similar rules exist requiring professionals to report suspected abuse of elderly or disabled persons, or patients receiving inpatient mental health, chemical dependency, or medical rehabilitation services. For assistance in reporting any suspected abuse or neglect, contact the Texas DFPS abuse hotline at 800-252-5400. Operators are trained to direct incoming calls to appropriate agencies.¹⁰

Risk management considerations

- It is not a breach of confidentiality to report suspected child abuse or neglect.
- Physicians who report child abuse in good faith are immune from civil and criminal liability as long as the report is not a self-disclosure.
- Professionals cannot delegate the duty to report suspected child abuse or neglect to someone else.
- Failure to report suspected child abuse or neglect is a Class B misdemeanor.

Threats of violence

“The leading case of a therapist’s duty to warn third persons of impending danger from a patient is a case by the Supreme Court of California, *Tarasoff v. Regents of the University of California*.”¹¹

In 1969, a clinical psychologist at the University of California at Berkley student health center began treating a graduate student from India named Prosenjit Poddar. After several sessions, Poddar was diagnosed as a potentially dangerous paranoid schizophrenic. This diagnosis was based on Poddar’s “pathological attachment” to Tatiana Tarasoff. She did not return his affection, and with each rejection Poddar became increasingly depressed. During the ninth therapy session, Poddar confided in the psychologist his intent to kill Tarasoff when she returned from vacation in Brazil.

After consulting with the psychiatrist who had initially evaluated Poddar, the psychologist notified campus police and tried to initiate a civil commitment. The police took Poddar into custody, but released him after he promised to stay away from Tarasoff. The psychologist’s request for civil commitment was denied. Poddar never returned to therapy. Approximately three months later, shortly after her return from Brazil, Poddar stabbed and killed Tarasoff.¹²

Tarasoff’s parents filed a wrongful death suit against the University of California, the therapists who treated Poddar, and the campus police. In 1974 the Supreme Court of California, in a case known as *Tarasoff I*, found that both the police and the psychotherapists had a duty to warn Tarasoff of the threat Poddar posed. “Not surprisingly, a large portion of the psychotherapeutic community disagreed with the court’s ruling. The American Psychiatric Association, for example, filed an amicus brief emphasizing the sanctity of the psychotherapist-patient confidentiality.”¹³ The APA also argued that psychiatrists had no standard for predicting dangerousness and that the risks of such a duty could outweigh any protective benefits.¹⁴

The Supreme Court of California did rehear the case in 1976. In *Tarasoff II*, the court broadened the therapist’s duty to one of protecting potential victims using means that include warning. “When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of such duty, depending on the nature of the case, may call for the therapist to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.”¹³

The Tarasoff cases were determined by the Supreme Court of California and were binding only in that state. However, many other states have adopted the Tarasoff standard or similar standards

through court cases. These standards . . . “varied greatly, some more expansive than the Tarasoff principle, others, more restrictive. Such rules included, for example, foreseeable violence, foreseeable victim, identifiable victim, specificity, and zone of danger.”¹⁴

The duty to warn in Texas

Three years after the Tarasoff opinion, the Texas legislature created an exception to the rule of physician-patient confidentiality in a case where there is a risk of harm to the patient or others. These statutes are permissive — physicians are allowed to inform law enforcement personnel of threats made by patients but they are not required to do so.¹⁵

Regarding mental health records, Section 611.004 of the Health and Safety code allows a permissive breach of patient confidentiality. “A professional may disclose confidential information only: . . . (2) to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient; . . .”¹⁶

The same holds true for other medical records. Section 159.004 of the Occupations Code allows disclosure of confidential information by a physician to: “. . . (2) medical or law enforcement personnel, if the physician determines that there is a probability of: (A) imminent physical injury to the patient, the physician, or another person; or (B) immediate mental or emotional injury to the patient; . . .”¹⁷

In 1999 the Supreme Court of Texas declined to adopt a duty to warn third parties of patients’ threats in Texas.¹⁵

In the case of *Thapar v. Zezulka*, psychiatrist Dr. Renu Thapar began treating Freddy Ray Lilly in 1985. He was diagnosed with moderate to severe post-traumatic stress disorder, alcohol abuse, and paranoid and delusional beliefs concerning his stepfather, Henry Zezulka. For the majority of their relationship, Dr. Thapar treated Lilly on an outpatient basis. However, on six occasions Lilly was admitted in response to urgent treatment needs. One admission was made after Lilly threatened to commit suicide. In August 1988, Lilly told Dr. Thapar that he “felt like killing” Henry Zezulka. After hospitalization and treatment for seven days, Lilly was discharged. Within a month, Lilly shot and killed Henry Zezulka.

Henry Zezulka’s wife sued Dr. Thapar for negligence resulting in her husband’s wrongful death. Zezulka alleged negligence in diagnosing and treating Lilly and negligence in failing to warn of Lilly’s threats. The trial court granted a summary judgment to Dr. Thapar based on the fact that the psychiatrist had no physician-patient relationship with either of the Zezulkas. The appeals court reversed the summary judgment, and found that Dr. Thapar had a duty to warn the victim. The case was then appealed to the Supreme Court of Texas.

The Texas Supreme Court’s refusal to accept a duty to warn was based on Health and Safety Code Section 611.004 that governs confidentiality in physician-patient relationships. “The statute classifies communications between mental-health ‘professionals’ and their ‘patient(s)/client(s)’ as confidential and prohibits mental-health professionals from disclosing them to third parties unless an exception applies. . . . But a disclosure by Thapar to one of the Zezulkas would have violated the confidentiality statute because no exception in the statute provides for disclosure to third parties threatened by the patient.”

The Court further argued, “The confidentiality statute here evidences an intent to leave the decision of whether to disclose confidential information [to medical or law enforcement personnel] in the hands of the mental-health professional.”¹⁵ Full text of this decision is available at <http://caselaw.lp.findlaw.com/data2/texas-statecases/sc/971208o.htm>.

Risk management considerations

• The AMA Code of Medical Ethics addresses the issue of patients’ threats of violence directly in Opinion 5.05: “The obligation

to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself, and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.”¹⁸

• In a situation where a physician is treating an adult patient and that patient makes a threat against another adult, try to engage the patient in a discussion. Ask the patient to check into the hospital or to consult a psychiatrist. If the patient refuses and leaves the office, and the concern is valid, contact the police.

• Another alternative is to consult with a psychiatrist and consider the option of civil commitment if the patient refuses to check into a hospital.

• If threats relate to a child, state law requires physicians to report the threat.

• When dealing with a patient who exhibits signs of potential violence, careful documentation is essential. Document all assessments, evaluations, consultations, and actions taken (and why) and those rejected (and why). Document instructions and information given to the patient and family. Also note whether they agree with treatment decisions and any noncompliance.

• It is worthwhile for physicians to maintain a list of contacts and resources that are relevant to the scenarios discussed in this article. Doing so may save time when decisions need to be made and appropriate actions taken.

Sources

1. American Medical Association. A physician’s guide to assessing and counseling older drivers. Available at <http://www.ama-assn.org/ama/pub/category/10791.html>. Accessed February 13, 2006.
2. Texas Health and Safety Code, Title 2, Chapter 12, Section 12.096 Physician report. Available at <http://www.capitol.state.tx.us/statutes/docs/HS/content/htm/hs.002.00.000012.00.htm>. Accessed February 15, 2006.
3. Texas Department of State Health Services. Medical Advisory Board for Driver Licensing. Available at <http://www.tdh.state.tx.us/hcqs/ems/MABphysician.htm>. Accessed February 17, 2006.
4. Texas Health and Safety Code, Title 2, Chapter 12, Section 12.098 Liability. Available at <http://www.capitol.state.tx.us/statutes/docs/HS/content/htm/hs.002.00.000012.00.htm>. Accessed February 15, 2006.
5. Texas Department of Public Safety. The Medical Advisory Board. Available at http://www.txdps.state.tx.us/administration/driver_licensing_control/dic.htm. Accessed February 14, 2006.
6. Texas Department of State Health Services. Medical conditions that may preclude driving. Available at <http://www.tdh.state.tx.us/hcqs/ems/mabcond.htm>. Accessed February 13, 2006.
7. Texas Department of State Health Services. Driving with epilepsy. Available at <http://www.dshs.state.tx.us/epilepsy/driving.shtm>. Accessed February 10, 2006.
8. *Praesel v. Johnson*, 967 S.W.2d 391 (Tex. 1998). Available at <http://www.findlaw.com/11stategov/tx/1998tx.html>. Accessed February 13, 2006.
9. *Gooden v. Tips*, 651 S.W. 2d 364, 365 (Tex. App.—Tyler 1983 no wit).
10. Fulbright and Jaworski. *Texas Medical Jurisprudence*. Appendix D, page 473. 15th edition 2004.
11. Fulbright and Jaworski. *Texas Medical Jurisprudence*. Chapter 7 page 301. 15th edition 2004.
12. Ginsberg B. Tarasoff at thirty: victim’s knowledge shrinks the psychotherapist’s duty to warn and protect. *J Contemp Health Law Policy*. 2004 Winter; 21(1):1-35.
13. Scarano V, Baily C, Banfield J. The Texas Supreme Court speaks: mental health professionals have no duty to warn or protect third parties. *Tex Med*. 2002 Nov; 98(11):61-64.
14. Kachigian C, Felthous AR. Court responses to Tarasoff statutes. *J Am Acad Psychiatry Law*. 2004; 32(3):263-73.
15. *Thapar v. Zezulka*, 994 S.W. 2d 635, 638 (Tex. 1999).
16. Health and Safety Code. Mental Health Records. Section 611.004. Available at <http://www.capitol.state.tx.us/statutes/docs/HS/content/htm/hs.007.00.000611.00.htm>. Accessed February 14, 2006.

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ethics exchange

Patient safety and improving patient outcomes

by Howard Marcus, MD

This article is the fourth in a series of articles featured in the Reporter addressing the ethical concerns of physicians. The opinions expressed in "Ethics exchange" reflect the view of the author and do not constitute official policy statements of Texas Medical Liability Trust.

On January 6, 2006, a 63-year-old man, who was later discovered to be a newspaper reporter, was found lying on the sidewalk in a generally safe residential neighborhood in Washington, D.C. A neighbor called 911 and police officers arrived within a few minutes. The police thought that the man, now semi-conscious and unidentified because his wallet was missing, had suffered a seizure; no one realized that he had been assaulted. EMS firefighters arrived a few minutes later and concluded that the man was intoxicated. An ambulance was requested on a low priority basis. The patient eventually arrived at the hospital emergency department about an hour after he had initially been found lying on the street.

The ambulance technicians, in turn, told emergency room personnel that the man was drunk, and he was left unexamined on a hall stretcher for at least an hour until he began vomiting. He was then examined and discovered to have a severe closed head injury. He died two days later. Two men were subsequently arrested and charged with murder.¹

Medical errors are defined by the Institute of Medicine (IOM) as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."² One of the conclusions of the IOM's 1999 report "To Err is Human" is that "errors are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them." In the example above, the working diagnosis of alcohol intoxication made by the EMS/firefighters resulted in a faulty "hand-off" to the ambulance technicians, which then resulted in delay in evaluation, diagnosis, and treatment at the emergency department.

The first large analysis of medical error was the Harvard Medical Practice Study (HMPS) based on a retrospective review of more than 30,000 acute care hospitalizations.³

The HMPS found that adverse events occurred in 3.7% of hospitalizations and that 27% of adverse events were due to negligence. Extrapolation from the HMPS is the basis for oft-quoted 98,000 deaths related to preventable error that was widely publicized after the release of the "To Err is Human" report. A subsequent study of Utah/Colorado hospitals resulted in the estimate of 44,000 annual preventable deaths in the United States.⁴ Still other studies on outpatient medical care have demonstrated a preventable adverse medication event rate of between 1.6 and 3%.⁵⁻⁶ However, critics of patient error studies point out their potential for misinterpretation. Studies have revealed that in the HMPS, the three physician chart reviews were in agreement only 10% of the time, and two physician reviews were in agreement in only 34% of cases. Additionally, many patients were critically ill and actually suffered from the natural course of their illness. Others say that the error rate was exaggerated.⁷

While there is debate about the precise error rate, most of us would agree that one preventable error is one too many. The case of the Washington reporter makes this clear. What is being done to reduce errors in medicine? Can we follow the example of the U.S. commercial aviation industry in which fatalities occurred in 0.27 per million aircraft departures between 1990 and 1994, less than one third the rate in mid-20th century.⁸ The fact is that many health care-related organizations now focus on improving patient safety and on better outcomes.

The Institute of Medicine has made four recommendations for patient safety modifications:

- Establish a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety.
- Implement safety systems in health care organizations to ensure safe practices at the delivery level.
- Raise performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups and, group purchasers of health care.

- Identify and learn from errors by developing a nationwide reporting system.

In response to the IOM, Congress has recognized that improved patient safety requires data collection and analysis. "The Patient Safety and Quality Improvement Act of 2005" extends legal protections to doctors who voluntarily report their medical errors to certified patient safety organizations (PSOs). The new system, not yet implemented, is designed to function as follows: when a medical error or near-miss occurs, a physician will voluntarily inform his local PSO which will analyze the data to identify whether certain errors appear to be occurring too frequently in particular situations. The PSO will share these trends directly with providers, along with recommendations and other feedback for improving patient safety. Eventually HHS will use the data to develop national patient-safety guidelines. Doctors who provide information will remain anonymous and protected against civil or administrative proceedings.⁹

Many medical specialty societies have been addressing patient safety issues and can serve as models. In 1985, the American Society of Anesthesiologists (ASA) launched the Anesthesia Patient Safety Foundation and the ASA continues to fund it at about \$400,000 a year. As a result of evaluations from medical malpractice claims, "root cause analysis" research, and the willingness to invest in technology, there is now widespread use of such innovations as pulse oximetry and capnography. Simulation practice on high-tech mannequins allows for improved proficiency for anesthesiologists in training. The result has been a decrease in anesthesia-related deaths over the past two decades from one death in every 5,000 cases to one death per 200,000 to 300,000 cases. An additional benefit to anesthesiologists is a greater than 50% decline in anesthesia-related malpractice claims and a reduction in malpractice premiums.¹⁰⁻¹¹

Like the ASA, the American College of Radiology has made important contributions to patient safety. It has recently published

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Managing the medical record part 1

Course author

Mary Angela Meyer, JD, is a Houston-based attorney who has specialized in the defense of physicians and hospitals in malpractice lawsuits for nine years.

Disclosure

Mary Angela Meyer has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

TMLT designates this educational activity for a maximum of 1 category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

Ethics statement

This course has been designated by TMLT for 1 hour of education in medical ethics and/or professional responsibility.

Directions

Please read the entire article and answer the CME test questions. In order to receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Allow four to six weeks from receipt of test and evaluation form for delivery of certificate.

Estimated time to complete activity

It should take approximately one hour to read this article and complete the questions.

Release/review date

This activity is released on March 27, 2006, and expires on March 27, 2008. Please note this



CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

This CME activity is the first of a two-part series. Part 2 will be published in the May-June 2006 issue of the Reporter. This CME activity does not constitute legal or professional advice. If a situation arises in a physician's practice requiring legal or professional advice, the physician should consult with a lawyer or professional of his/her choosing.

Medical records

Physicians are often drawn into the legal process simply because they have medical records on a particular patient. Records may be requested because a patient is involved in legal proceedings against other persons and entities. If a patient is contemplating legal action against a physician, the first thing the plaintiff's attorney requests is medical records. It is imperative that every physician has a system in place allowing only the release of complete, legible, and organized records from the medical office. It is also imperative that the

person responsible for gathering and producing the record comply with state and federal laws regarding the release of confidential information.

The medical record is important for a number of reasons. If a physician is sued, the

Objectives

At the conclusion of this educational activity, the reader will be able to:

1. List the elements of a complete medical record according to Texas Medical Board (TMB) rules.
2. Respond to medical record requests from patients and their family members.
3. Be familiar with HIPAA and Texas law regarding records release and the privacy of protected health information.
4. Identify patient rights under HIPAA.

medical record will be key evidence. Physicians should write legibly, date their entries, and only record facts and observations. A word about late entries — if it is necessary to write a late entry, it should be dated as such. In most cases, late entries should not be added after the physician receives notice of a lawsuit. If notice of suit has been received, a physician should discuss whether a late entry should be written with his attorney before making any such additions.

The medical record is a summary of care and a very important tool. In addition to the medical record, the physician may also rely on customary practices when asked about care provided to a patient. If a physician were to chart all actions taken and all words spoken to a patient, there would not be any time for actual patient care. However, it is important to include a good summary of care given to each patient in the patient's chart. Memories may grow dim between the time of treatment and the filing of a lawsuit. A complete record greatly assists a physician's defense.

Case study

Dr. Good, a family physician, performed well-woman exams for Mrs. Clark for several years. Her breasts were described as "pendulous" and difficult to assess. In 1996, Dr. Good recommended that Mrs. Clark have yearly mammograms. Dr. Good explained the benefits of a yearly mammogram to Mrs. Clark. Mrs. Clark continued to see Dr. Good yearly. Each year Dr. Good performed a thorough breast exam but did not chart the exam since the results from each exam were negative.

In 1999 Mrs. Clark complained to Dr. Good about a painful lump in her right breast. Dr. Good asked her about the results of her yearly mammograms. She replied "what yearly mammograms?" Dr. Good immediately referred Mrs. Clark to a breast surgeon who performed a biopsy and diagnosed Mrs. Clark with invasive ductal carcinoma grade II. In 2000 Dr. Good was served with a notice of lawsuit. He pulled Mrs. Clark's record and realized that he had failed to document the referral for a mammogram in 1996. He also noticed that he failed to document yearly breast exams, and that Mrs. Clark did not have any breast complaints at her yearly visits. Dr. Good took his pen and made additional entries to the record. He did not date the new entries. Unknown to Dr. Good, the earlier, "incomplete" record had already been copied and given to Mrs. Clark six months earlier.

Dr. Good called his insurance company and was assigned a defense attorney. Dr. Good's attorney requested a copy of the record from the plaintiff's attorney and discovered that the original record had been

altered. During his deposition, Dr. Good was questioned about his record "alterations," and the plaintiff's lawyer implied that Dr. Good had been deceitful. An otherwise defensible case was promptly settled.

What are the lessons from this case? First, complete documentation would have prevented the need for record additions. Second, office personnel should always notify the physician before a patient chart is copied and produced. Third, records should not be supplemented after the fact unless the addition is clearly marked with the date and time. In most instances, it is too late to make a late entry after notice of suit has been received. Dr. Good could have testified about the information he added to the record. Instead, he set himself up for grueling cross-examination and a settlement of the case against him.

General regulations regarding medical records

Texas law and licensing regulations

The Texas Medical Board (TMB) rules provide that: "Each licensed physician of the Board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, 'adequate medical record' shall mean any records documenting or memorializing the history, diagnosis, and treatment of any patient. An adequate medical record should include 1) the reason for the encounter and relevant history, physical examination findings and prior diagnostic tests 2) an assessment, clinical impression, or diagnosis 3) a plan of care and 4) the date and legible identity of the observer."

The rules also require the following:

- 1) Past and present diagnoses should be accessible to the treating and or consulting physician.
- 2) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
- 3) The patient's progress, including response to treatment, change in diagnosis and patient's noncompliance should be documented.
- 4) Relevant risk factors should be identified.
- 5) The written plan for care should include when appropriate:
 - (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
 - (B) any referrals and consultations;
 - (C) patient/family education; and,
 - (D) specific instructions for follow up.
- 6) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements

should be supported by the documentation in the medical record.

7) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction."

It is important that all physicians adhere to these guidelines as closely as possible. Adherence will not only help assure that the medical record is complete, but it will also prevent difficult cross-examination if a suit is filed.

Physicians should maintain medical records for a minimum of seven years after the date of last encounter with each patient. The Occupational Safety and Health Act (OSHA) requires that medical and exposure records be retained by an employer for the duration of employment plus 30 years. Therefore, a physician who sees patients for a corporation or employer should coordinate with the corporation regarding the record retention plan.

If a patient was younger than 18 years when last treated by a physician, the medical records of the patient should be maintained until the patient reaches age 21, or for seven years from the date of last treatment, whichever is longer.

A physician may not destroy medical records that relate to any civil, criminal, or administrative proceeding if the physician knows the proceeding has not been resolved. Physicians should retain medical records longer when mandated by other federal or state statute or regulation.

No distinction is made regarding retention of the medical record of a deceased patient. Follow the guidelines above.

Access to health information

Medical records have always been considered confidential. The Hippocratic Oath reads in part, "[a]nd whatsoever I shall see or hear in the course of my profession, as well as outside of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." (Vol. 1 Hippocrates 301 W.H.S. Jones ed., 1995). The AMA Code of Medical Ethics states "the physician should not reveal confidential communications or information without the express consent of the patients." (AMA Code of Medical Ethics Section 5.05 1996-1997). Recently enacted federal and state laws have created more stringent requirements for confidentiality. It is

important that physicians be aware of these new regulations and comply with them completely.

Until recently, one had only to look to Texas statutes to determine when and how to release confidential patient records. However, with the implementation of the Health Information Portability and Accountability Act (HIPAA), there are many more precautions that must be taken. It is important for physicians to comply with Texas and federal law regarding medical records and to keep confidential, comprehensive, and legible records for all patients. The following is a brief summary of the laws regarding medical record confidentiality and release.

Texas law

Texas law provides that communications between a physician and patient in connection with any professional services as a physician to the patient, and records of the identity, diagnosis, evaluation, or treatment of a patient by a physician that are maintained by the physician are confidential and privileged.

In 2001, the Texas Legislature enacted the Texas Medical Records Privacy Act (the Privacy Act). The Privacy Act is the Texas codification of HIPAA. The legislature provided that covered entities must comply with the Privacy Act no later than September 1, 2003. The Privacy Act applies to physicians who fall under the defined "covered entities" of HIPAA. As stated above, HIPAA defines a "covered entity" as "a healthcare provider who transmits any health information in electronic form in connection with a transaction covered by this chapter." The Texas Privacy Act requirements are essentially the same as the HIPAA privacy requirements.

The Texas statute provides for state enforcement of HIPAA in addition to federal enforcement. The Texas Privacy Act mandates that all covered entities comply with the Federal HIPAA and Privacy Standards relating to:

- an individual's access to the individual's protected health information;
- amendment of protected health information;
- use and disclosure of protected health information, including requirements relating to consents; and
- notice of privacy practices for protected health information.

Like the federal statute, the Texas Privacy Act does not create a private cause of action for patients. However, it provides for the following remedies if the Privacy Act is violated:

- 1) the attorney general may institute an action for injunctive relief;
- 2) the attorney general may institute an

action for civil penalties not to exceed \$3,000.00 per violation;

3) the court may assess a civil penalty not to exceed \$250,000 if it finds that violations have occurred with a frequency as to constitute a pattern or practice;

4) individuals or facilities licensed by the state of Texas are subject to investigation and disciplinary proceedings, including probation or suspension by the licensing agency;

5) if there is evidence of a pattern or practice the agency may revoke the individual's or facility's license;

6) a covered entity shall be excluded from participating in any state funded health care program if a court finds a pattern or practice of violating the Medical Records Privacy Act.

Confidential medical records may not be disclosed without the patient's valid authorization or as further provided by law. The privilege of confidentiality belongs to the patient, but may be claimed by the doctor or the patient. The physician may claim the privilege of confidentiality only on behalf of the patient. The physician's authority to claim the privilege is presumed in the absence of evidence to the contrary. The prohibition on disclosure applies to confidential communications and records, no matter when the person was a patient, except for records more than 100 years old that are requested for historical research purposes.

A consent for the release of confidential information must be in writing and signed by 1) the patient, a parent or legal guardian if the patient is a minor, 2) a legal guardian if the patient had been declared incapacitated, 3) an attorney ad litem, or 4) a personal representative if the patient is deceased. The consent must state the information or records covered by the release, the reason for the release, and the person to whom the information is to be released. The person authorized to give consent may revoke the release at any time. A patient may not maintain an action against a physician for disclosure made in good faith reliance on an authorization if the physician did not have written notice that the authorization was revoked.

A physician who receives a consent for the release of medical information must furnish copies of the medical records requested or a summary or narrative of the records, including records received from another physician or other health care provider involved in the care or treatment of the patient. The exception to this requirement is if the physician believes that release of the medical record would be harmful to the mental, physical, or emotional health of a patient. Also, the physician may delete confidential information about another patient or family member of the patient who

has not consented to the release of the information. The records must be furnished no later than the 15th day after the request is received. If the physician denies the patient's request for records in whole or in part, the physician must furnish a written statement explaining the reason for the denial, a copy of which should be placed in the patient's chart. If requested in writing by a subsequent treating or consulting physician, a physician must furnish copies of the patient's chart to that physician.

Under Texas law, an exception to the privilege of confidentiality exists in the following court or administrative proceedings:

- 1) In a proceeding brought by the patient against the physician including, but not limited to, malpractice proceedings and criminal proceedings or license revocations proceeding in which the patient is the complaining witness and in which disclosure is relevant to the claim or defense of the physician;
- 2) If the patient or a person authorized to act on behalf of the patient submits a written consent to release the confidential information;
- 3) In a claim to substantiate and collect on a claim for medical services provided to a patient;
- 4) In a civil action or administrative proceeding, if relevant, brought by the patient or a person on the patient's behalf, if the patient or person is attempting to recover monetary damages for physical or mental condition including the patient's death;
- 5) In an injunction proceeding in which the records are relevant to a suit for the unauthorized release of medical records as provided by section 159.009 of the Medical Practice Act;
- 6) In a criminal investigation of a doctor in which the Texas Medical Board is participating in the investigation;
- 7) If there is a court order or court subpoena;
- 8) In an involuntary civil commitment hearing, proceeding for court ordered treatment, or a probable cause hearing; or
- 9) If the patient's physical or mental condition is relevant to the execution of a will.

HIPAA

If a patient requests access to his or her medical records, the health care provider must provide the access requested. This access includes inspection and/or a copy of the protected health information about the patient. There are exceptions to this rule, as noted earlier in this article. If the protected health information is maintained in more than one designated record set or at more than one location, the covered entity need only produce the protected health informa-

tion once in response to a request for access.

The health care provider must provide access to the protected health information in the form or format requested by the individual, if it is readily producible in such form or format. If the information is not readily accessible in the format requested, it must be produced in a readable hard copy form or such other form or format as agreed to by the covered entity and the individual. The health care provider may provide the individual with a summary of the protected health information requested in lieu of providing access to the protected health information or may provide an explanation of the protected health information to which access has been provided, if:

- (A) the individual agrees in advance to such a summary or explanation; and
- (B) the individual agrees in advance to the fees imposed, if any, by the covered entity for such summary or explanation.

If the requested information is on site, it must be provided within 30 days. If the request is denied in whole or in part, a written denial must be provided to the requesting party and placed in the patient's chart. If the records are stored off site, the records or a written denial must be provided to the requesting party no later than 60 days after the request.

Consent requirements

HIPAA consent is usually obtained by the covered entity before treatment. Under HIPAA, a consent should be written in plain language and:

- 1) inform the patient that patient information may be used and disclosed to carry out treatment, payment, or health care operations;
- 2) refer the patient to the notice required under HIPAA for a more complete description of the disclosures that may be made, and state that the patient has a right to review the notice prior to signing the consent;
- 3) if the health care provider has a right to change its privacy practices that are described in the notice, the consent must state that the terms of its notice may change and instruct the patient on how he or she may obtain a revised notice;
- 4) state that the individual has the right to request that the covered entity restrict how protected health information is used or disclosed, that the covered entity is not required to agree to requested restrictions, and that if the covered entity agrees to a requested restriction, the restriction is binding;
- 5) state that the patient has the right to revoke the consent in writing, except to the extent that the covered entity has already

taken action in reliance on the consent; and
6) be signed and dated by the individual.

"Health care operations" includes quality assessment and improvement activities, competence reviews, disclosure to insurance companies for underwriting, premium rating, or other activities related to contracting for health insurance or benefits or reinsurance of risk relating to claims for health care, disclosure for a medical or legal review and auditing functions and business planning and development. Therefore, once a patient has signed the HIPAA consent before treatment, records may be disclosed to these entities without further authorization.

Authorization requirements under HIPAA

Authorizations are used after treatment to obtain protected health information. A valid authorization under HIPAA must be written in plain language and contain the following elements:

1. a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
2. the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. the name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;
4. an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;
5. a statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization;
6. a statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA;
7. signature of the individual and date; and
8. if the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual.

Other patient rights under HIPAA

In addition to governing how and to whom health information can be released, HIPAA also sets forth a number of other patient rights regarding health information.

Amendments

Patients have the right to request amendments of erroneous or incomplete information contained within their medical record. A request for an amendment may be denied if the covered entity determines that the infor-

mation in the record is accurate and complete. The request may also be denied if the record was not created by the covered entity, is not a part of the designated record set to be produced, or is excepted from production. The covered entity may require that a request for amendment be made in writing and that a reason to support the amendment be provided. However, individuals must be informed in advance that a written request is required. Physicians must act on the request within 60 days of receipt of the request.

A denial of the request for amendment must be in writing and written in plain language. The denial must include a statement that the patient has a right to submit a written statement of disagreement with the denial to be kept in the medical record. The patient's written statement of disagreement may be reasonably limited in length. The covered entity may prepare a rebuttal to the written statement of disagreement. A copy of the rebuttal must be provided to the patient. The denial of the request for amendment must also include a statement that if the individual does not submit a written statement of disagreement, the individual may request that the covered entity provide the individual's request for amendment and the denial with any future disclosures of protected health information. The denial must describe the process by which the individual may complain to the covered entity pursuant to the complaint procedures established by the Privacy Rule, or to the Secretary of Health and Human Services. The description must include the name or title of the contact person or office designated for complaint according to the Privacy Rule.

A covered entity must amend protected health information about an individual in a designated record set, including any designated record sets (or copies thereof) held by a business associate. Therefore, the Privacy Rule requires covered entities to specify in the business associate contract that the business associate must amend protected health information when requested by the covered entity. The covered entity itself is responsible for addressing requests from individuals for amendment and coordinating such requests with its business associate. However, the Privacy Rule does not prevent the parties from agreeing by contract that the business associate will receive and address requests for amendment on behalf of the covered entity.

Patients also have the right to obtain an accounting of any disclosures of their information for any purposes other than treatment and payment. They have the right to file complaints if they believe the covered entity has not followed its privacy policies.

Accounting to the patient for disclosures

Patients are entitled to an accounting for all disclosures that have been made in the previous six years, except for disclosures 1) to carry out treatment, payment, or health care operations, 2) to individuals of protected health care information about them, 3) for the facility's directory or to persons involved in the individual's care or other notification purposes, 4) for national security or intelligence purposes, 5) to correctional institutions or law enforcement officials, and 6) that occurred before the compliance date for HIPAA. The accounting must include:

1. the date of the disclosure;
2. the name of the entity or person who received the protected health information and, if known, the address of such entity or person;
3. a brief description of the protected health information disclosed;
4. a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure; or, in lieu of such statement:

- (A) a copy of the individual's written authorization pursuant to section 164.508; or
- (B) a copy of a written request for a disclosure under section 4.502(a)(2)(ii) or 164.512, if any.

Conclusion

Although compliance with HIPAA and Texas law may be burdensome, it will assist the physician in maintaining confidentiality. Federal and state laws provide the guidelines for disclosure of protected medical information. If followed, these guidelines will assist in preventing improper disclosure of protected health information.

In summary, when releasing medical records containing private health information, a physician should:

1. review the request in its entirety;
2. determine whether an authorization that complies with state and federal law is needed;
3. if the authorization requirement is met, or if the request is exempt from the author-

- ization requirement, provide a complete copy of the record, or specify that records have been withheld;
4. provide the patient with an accounting if warranted.

For further information

1. Winn PA. Confidentiality in cyberspace: the HIPAA privacy rules and the common law. *Rutgers Law Journal*. Spring 2002.
2. Texas Occupations Code. Available at www.capitol.state.tx.us/statutes/oc.toc.htm.
3. Texas Medical Board rules. Available at www.tmb.state.tx.us/rules/rules/bdrules.php.
4. Texas Administrative Code. Available at [http://info.sos.state.tx.us/pls/pub/read-tac\\$ext.viewtac](http://info.sos.state.tx.us/pls/pub/read-tac$ext.viewtac).
5. The Health Insurance Portability and Accountability Act of 1996. Available at www.cms.hhs.gov/hipaageninfo/01_overview.asp?

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Ethics exchange . . . continued from page 5

guidelines for improving the reporting of diagnostic imaging findings with particular focus on avoiding communication lapses. 12 Situations that may require real-time, direct doctor-to-doctor communication in order to prevent error include:

- findings that suggest a need for immediate or urgent intervention;
- findings that are discrepant with a previous examination and where failure to act may adversely affect patient health; and
- findings that are unexpected by the treating physician and may be adverse to the patient's health.

Other professional associations, hospitals, and organizations are promoting patient safety initiatives. The Institute for Healthcare Improvement (IHI), a not-for-profit organization, has launched the 100,000 Lives Campaign. This campaign aims to enlist thousands of hospitals across the country in a commitment to implement changes in care that have been proven to prevent avoidable deaths. IHI recommends the following six changes in both inpatient and outpatient settings:

- Deploy rapid response teams . . . at the first sign of patient decline.
- Deliver reliable, evidence-based care for acute myocardial infarction . . . to prevent deaths from heart attack.

- Prevent adverse drug events (ADEs) . . . by implementing medication reconciliation.
- Prevent central line infections . . . by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle."
- Prevent surgical site infections . . . by reliably delivering the correct perioperative care.
- Prevent ventilator-associated pneumonia . . . by implementing a series of interdependent, scientifically grounded steps called the "Ventilator Bundle."¹³

Carefully designed procedures and systems, supported whenever possible by well-engineered technology, can help prevent the kinds of medical error illustrated by the unfortunate man found on a street in our nation's capital, only a few miles from the most advanced medical care in the world. By analyzing what went wrong and then implementing system changes to prevent errors we will, as in the aviation industry, improve outcomes for our patients.

Sources

1. Wilber DQ. Sources cite delay in aid to reporter. *Washington Post*. January 11, 2006.
2. Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human. Building a safer health system. Washington, DC: National Academy Press, 1999.
3. Brennan TA, et al. Incidence of adverse events and negligence in hospitalized patients. Results of

- the Harvard Medical Practice Study I. *NEJM*. 1991;324:370-376.
4. Thomas EJ, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. *Medical Care*. 2000; 38:261-271.
 5. Gurwitz JH, et al. Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting. *JAMA*. 2003;289:1107-1116.
 6. Gandhi TK, et al. Patient Safety: Adverse Drug Events in Ambulatory Care. *NEJM*. 2003;348:1556-1564.
 7. Hayward RA, Hofer TP. Estimating Hospital Deaths Due to Medical Errors. *JAMA*. 2001;286:415-420.
 8. Berwick DM, Leape LL. Reducing errors in medicine. *BMJ*. 1999;319:136-137.
 9. Guglielmo WJ. Is this the way to lower malpractice rates? *Medical Economics*. Dec 2, 2005.
 10. Hallinan JT. Heal thyself, once seen as risky, one group of doctors changes its ways. *Wall Street Journal*. June 21, 2005.
 11. Gaba DM. Anaesthesiology as a model for patient safety in health care. *BMJ* 2000;320:785-788.
 12. American College of Radiology. ACR Practice Guideline for Communication of Diagnostic Imaging Findings. Revised 2005. Available at http://www.acr.org/s_acr/bin.asp?CID=541&DID=12196&DOC=FILE.PDF. Accessed February 16, 2006.
 13. Institute for Healthcare Improvement. 100K Lives Campaign. Available at www.ihl.org/IHI/Programs/Campaign/Campaign.htm. Accessed January 10, 2006.

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closed claim studies

Failure to inform subsequent treating physician

by Barbara Rose and Laura Brockway

The following closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. The ultimate goal in presenting these cases is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation and physician action

A 25-year-old woman came to her ob-gyn to begin prenatal care on October 17. She was given a due date of May 4. This was the patient's third pregnancy.

A sonogram performed in the ob-gyn's office on December 9 revealed bilateral hydronephrosis and a distended bladder in the fetus. The ob-gyn recommended a perinatology consultation.

The patient was seen by a perinatologist on December 15. An ultrasound confirmed bilateral hydronephrosis with a slightly enlarged bladder. The perinatologist's impression was a partial bladder outlet obstruction. The patient returned on December 23, and was seen by another perinatologist. A second sonogram was performed and the perinatologist's impression was bilateral renal pelviectasis.

Reports from both sonograms were provided to the ob-gyn, who noted the results in the patient's prenatal record. There was no documentation that the ob-gyn discussed these findings with the patient.

On February 13, the ob-gyn admitted the patient to the hospital due to her complaints of back pain and fever. A bilateral renal ultrasound of the patient revealed moderate to marked right hydronephrosis and moderate left hydronephrosis. The radiologist recommended a repeat sonogram for evaluation of fetal kidneys in a few weeks. The ob-gyn did not order this sonogram.

On April 25, the ob-gyn admitted the patient for induction of labor. A male infant was delivered without complication. The baby weighed 6 pounds, 13 ounces and his APGAR scores were 8/9. The baby was given routine newborn care while in the hospital. He and the mother were discharged on April 26. The ob-gyn did not advise the attending pediatrician of the baby's abnormal renal condition.

The pediatrician saw the baby for a well-check on April 28. The pediatrician's note from this visit included the following statement: "urethral opening: one and LOW." The baby subsequently made several visits to the pediatrician for well checks and routine illnesses.

On November 3, the baby was brought to a local children's hospital with severe dehydration. He was admitted in renal failure secondary to renal dysplasia. The baby was ultimately diagnosed with chronic kidney failure and placed on peritoneal dialysis. Approximately 30 months later, the child underwent a kidney transplant with a kidney donated by his father. He is making a good recovery.

Allegations

A lawsuit was filed against the ob-gyn, alleging negligence in failing to discuss the hydronephrosis with the parents before delivery and failing to advise the pediatrician so follow-up care could be initiated. The plaintiff's expert alleged the child would require additional transplants in the future and had a reduced life expectancy as a result of the transplant.

Legal implications

This case was reviewed by three ob-gyns, a pediatrician, a pediatric nephrologist, and a pediatric urologist. They were all critical of the ob-gyn's failure to advise the parents and pediatrician of the condition of the fetus before delivery.

The two perinatologists (also named in the lawsuit) said they would testify that

they reported their findings as consultants to the ob-gyn, and it was her responsibility to discuss the findings with the parents and the pediatrician. Likewise, the pediatrician said she would testify that she was never advised of or provided a copy of the findings by the ob-gyn, which she would have expected.

The defendant explained that she informed the mother of the fetal kidney condition, and that she referred her to the perinatologist because of the finding of bilateral hydronephrosis on ultrasound. The ob-gyn claimed that she discussed the baby's condition with the mother throughout her pregnancy, but none of these discussions were documented. Further, the ob-gyn said she did not know the identity of the pediatrician, although the pediatrician's name appears in her records. The ob-gyn said it was her expectation that the pediatrician would look at the mother's chart after delivery. The ob-gyn thought the patient's prenatal and labor and delivery records would be combined with the baby's hospital record and reviewed by the treating pediatrician.

Causation became an important issue in this case. Among the experts who reviewed the medical records, there was a legitimate difference of opinion as to whether earlier diagnosis would have altered the outcome. Defense experts in pediatric urology and perinatology stated that the child's renal failure was the result of a congenital anomaly, unrelated to the actions of the ob-gyn. Given the end-stage renal failure suffered by the baby within 6 months of his birth, nothing could have been done that would have changed the baby's condition or outcome. Other consultants advised that earlier treatment could have possibly salvaged the kidneys and avoided the need for dialysis and transplant.

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Failure to monitor patient postoperatively

by Barbara Rose and Laura Brockway

Presentation

A seven-year-old girl was referred to an otorhinolaryngologist by her pediatrician. The patient had a history of Strep throat and she complained of trouble breathing in the mornings.

Physician action

A physical exam revealed a red throat, enlarged tonsils, and significant material within the crypts. The physician prescribed antibiotics.

Three weeks later, the patient returned. The antibiotics had alleviated some symptoms, but the patient still had enlarged tonsils and symptoms of sleep apnea. The otorhinolaryngologist recommended tonsillectomy and adenoidectomy.

One month after this office visit, the patient was admitted to a regional medical center for tonsillectomy and adenoidectomy. The surgery began at 7:45 a.m. and was completed without complication. The patient was extubated in good condition and transferred to the recovery room.

At 9:10 a.m., the patient was received in the PACU and was discharged to the pediatric unit at 10:09 a.m. Her respirations were unlabored on room air for the last 20 minutes in recovery without signs of distress. Oxygen saturation was 97%. An EKG indicated a normal sinus rhythm. Vital signs at discharge were: blood pressure 159/98 mm/Hg; pulse 132 bpm; respirations 12 breaths/minute. The floor nurses' notes indicated that the patient was asleep and exhibiting no signs of distress. Her color was good.

Vital signs taken at 11:15 a.m. were: blood pressure 112/67 mm/Hg; pulse 135 bpm; respirations 18 breaths/minute; and temperature 98.1 degrees. According to the nursing notes, the patient appeared to be asleep displaying no signs of distress. There were no concerns or complaints voiced at this time.

At 11:55 a.m., the patient's mother came out of the room crying for someone to check on her daughter. The nurses found the patient to be unresponsive and lying on her side. She was cyanotic with no pulse or respirations. A code was called. Before the code team arrived, a nurse gave a quick breath and the patient returned coffee ground emesis. Despite oral suctioning and defibrillation, the patient remained in asystole. She was pronounced dead at 1:26 p.m.

The otorhinolaryngologist's death summary for the patient indicated that at 11:55 am, the patient's mother reported that the

patient was resting comfortably and then seemed to stop snoring suddenly. An autopsy conducted the next day revealed a dilated right ventricle with normal wall thickness. Pathological findings included myocarditis, chronic pericarditis and pulmonary edema.

Allegations

Lawsuits were filed against the otorhinolaryngologist, his practice association, the anesthesiologist, the CRNA, and the hospital. The allegations included:

- failure to assess the patient for sleep apnea (otorhinolaryngologist);
- failure to take precautions to include ordering closer monitoring with pulse oximetry (otorhinolaryngologist);
- failure to conduct a complete physical exam and assessment of the patient during preoperative visits (practice association);
- failure to obtain respiratory rate, temperature and history during preoperative visits (practice association);
- administration of too high a dose of morphine (CRNA, anesthesiologist);
- failure to monitor the patient postoperatively (hospital); and
- failure to communicate abnormal vital signs to the physicians (hospital).

Legal implications

The plaintiff's experts concluded that this patient had clinically significant upper airway obstruction. Further, since obstructive sleep apnea had not been ruled out by polysomnography, the perioperative management of the patient should reflect the possibility that it existed. It was asserted that the otorhinolaryngologist should have communicated these issues to the care team and ordered closer monitoring of the patient. The plaintiffs also argued that the dose of sedating medications would have been smaller or the anesthesiology team would have changed medications if they had known about the sleep apnea.

A significant weakness in this case was the otorhinolaryngologist's failure to order postoperative pulse oximetry on the patient. A number of defense consultants said that a patient who has severe sleep apnea should be placed on pulse oximetry postoperatively. The defendant stated in his deposition that the patient did not have a confirmed case of sleep apnea. However, in his operative note he stated that the patient had severe sleep apnea and this was one of the reasons for performing the surgery.

Another issue that adversely affected

the defense of this case involved the poor care provided by the hospital nurses. The plaintiffs argued that the otorhinolaryngologist should have ordered closer monitoring. However, after the nurses were deposed, it was evident that they did not know the difference between normal and abnormal vital signs, did not know when to report abnormal vital signs, and failed to do hands-on physical assessments on this post-surgery patient. However, the plaintiffs still contended that if pulse oximetry had been ordered, the patient would not have died.

Disposition

Given the facts of this case, the defense felt the chance of a successful jury verdict was 50%. With the consent of the otorhinolaryngologist, this case was settled before trial. The outcome of the lawsuits against the anesthesiologist, the CRNA, and the hospital is unknown.

Risk management considerations

In hindsight one acknowledges the events of this case would be difficult to anticipate. No one involved in this child's care expected her sudden death. According to physician reviewers, nothing in this child's history dictated the need for a preoperative cardiology work up. Conjecture, not fact, reigns regarding actual cause of death as the autopsy was not conclusive. It was recorded as myocarditis and chronic pericarditis and the manner of death as natural causes. A chronic cardiac condition unrecognized due to an absence of symptoms would have been difficult to discern according to one consultant who further surmised that the patient's cardiac reserve may have been too weak to handle a probable pulmonary aspiration and hypoxia.

Whether pulse oximetry would have altered the outcome cannot be known. Physicians who review(ed) this case will have ongoing differences of opinion regarding this issue.

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Disposition

Based on the reviews of defense consultants and the anticipated testimony of the codefendants and pediatrician, this case was settled with the consent of the ob-gyn.

Risk management considerations

Communication lapses among physicians, their patients, and other health care providers are frequently the focus of malpractice claims. When issues relevant to patient care are not clearly documented in the medical record, the stage is set for allegations that conversations related to continuity of care never occurred. The comprehensive medical record is a chronological document of each patient's condition and care. The physician who orders tests or

referrals holds the responsibility to verify that the test or consult was done, to review the reports, to determine the next course of care, and to inform the patient.

When prenatal testing identifies fetal abnormalities, taking the time to inform the pediatrician would seem appropriate. One may surmise that continuity of care will be extended to the fetus and newborn. That pediatrician then has time to plan for the birth, perhaps consult a neonatologist or other pediatric specialist, and be available at, or soon after delivery.

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17. Occupations Code. Physician-patient Communication. Section 159.004. Available at <http://www.capitol.state.tx.us/statutes/docs/OC/content/htm/oc.003.00.000159.00.htm>. Accessed February 14, 2006.

18. AMA Council on Ethical and Judicial Affairs. Confidentiality. AMA Code of medical ethics. Issued December 1983; Updated June 1994. Available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-5.05.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-4.07. Accessed February 16, 2006.

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