

the Reporter

Shoulder dystocia: a liability risk

by Jane Mueller, Vice President, Risk Management

Shoulder dystocia, failure of the shoulders to deliver spontaneously after delivery of the fetal head, is an obstetric emergency, placing both the pregnant woman and fetus at risk for injury.¹ It presents an extremely difficult situation for physicians. Reported incidence ranges from less than 1 percent to slightly more than 4 percent among vaginal cephalic deliveries.² The reported incidence varies greatly depending on the criteria used for diagnosis and therefore on how dystocia is defined and coded. Some define shoulder dystocia by deliveries requiring a maneuver and others accept clinician's judgment, as noted in the chart, that shoulder dystocia occurred.³ Birth injury related to alleged mismanagement of shoulder dystocia is a common claim in obstetric malpractice cases.

Various brachial plexus injuries including Erb's Palsy and fractures of the clavicle or humerus can be associated with shoulder dystocia. The risk of hypoxic brain damage exists, and in rare cases, fetal death may result if delivery is not expedited. When shoulder dystocia occurs during delivery of an infant, the mother is at risk of obstetric hemorrhage and third and fourth degree lacerations.⁴ Some obstetrical emergencies can be anticipated and therefore prepared for by clinicians. However, this is not the case with shoulder dystocia.

Some studies demonstrate that injury to the brachial plexus may be the result of a difficult delivery and yet others show that the injury may also follow an apparently easy



delivery. There is also increasing evidence that brachial plexus impairments may exist in the fetus before labor.⁵

Several maternal and fetal factors are widely known to be statistically associated with shoulder dystocia, although none of these factors is known to be predictive of its occurrence. These include antepartum factors such as fetal macrosomia, maternal diabetes, postdatism, maternal obesity or excessive maternal weight gain during pregnancy, and previous delivery of a large infant and intrapartum factors such as protracted labor, prolonged second stage of labor, and operative mid-forceps delivery.⁶ Fetal macrosomia and gestational diabetes mellitus (GDM) have been shown to be risk factors

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most strongly associated with dystocia.⁷ Many studies support a fetal weight greater than 4,500 g as an appropriate indicator of fetal macrosomia.⁸⁻¹¹ Unfortunately, it is impossible to accurately predict the weight of a fetus pre-delivery.

Some researchers found the highest frequency of shoulder dystocia occurred in infants weighing more than 4,500 g. However, they also emphasized that although the frequency of shoulder dystocia increased with greater birth weight, nearly half the births with shoulder dystocia involved infants weighing less than 4,000 g.¹² ACOG recommends screening pregnant women for GDM, whether by patient history, clinical risk factors for GDM or a laboratory test to determine blood glucose levels. In the absence of known risk factors for GDM, a personal history may be sufficient.¹³ Weighing the risks described above, ACOG concluded that there are no data to support a policy of cesarean delivery purely on the basis of GDM with fetal macrosomia. Due to the higher likelihood of shoulder dystocia and macrosomia in women with GDM, cesarean delivery may be considered when the estimated fetal weight is 4,500 g or greater,¹⁴ although generally a trial of labor will be attempted first. Likewise, when glucose levels are under control and no other complications arise, there is no strong evidence to support routine delivery before 40 weeks of gestation.¹⁵ ACOG has cited a study that calculated that 3,695 cesarean section deliveries would be required to prevent one permanent injury at a cost of \$8.7 million for each injury avoided.¹⁶ Despite identifying risk factors, predicting which patients are likely to experience shoulder dystocia has been unsuccessful.

Plaintiffs' attorneys generally allege that the physician should have suspected macrosomia and performed a cesarean section. Other factors plaintiffs' attorneys consider are whether appropriate delivery techniques were used once shoulder dystocia was encountered and the severity of the injury.

TMLT shoulder dystocia claims data reviewed for 1993-2001 revealed the following common allegations:

- Failure to appreciate prenatal risk factors such as —
 - excessive weight gain
 - positive glucose screening test
 - presence or history of diabetes mellitus
 - pelvic deformity
 - sonographic evidence of a large fetus
 - previous delivery of large infant
 - history of shoulder dystocia in previous deliveries
 - prolonged second stage of labor;
- Failure to accurately estimate fetal weight prior to delivery;
- Failure to perform a glucose tolerance test when urine tests positive for sugar;
- Failure to follow up with treatment when patient tests positive for gestational diabetes;
- Failure to call for back-up;
- Failure to correctly perform maneuvers to deliver the shoulders or to perform them in the appropriate order;
- Excessive or early use of vacuum or forceps;
- Excessive or early application of traction;
- Use of fundal pressure rather than suprapubic pressure.

Not surprisingly, 75 percent of the claims reviewed involved obstetricians and 6 percent involved family practitioners performing obstetrics. Of interest, 8 percent of the claims were also filed against the professional association or corporation (i.e. the clinic or group in which the physician was a partner, associate or employee), thus resulting in two separate claims and two defendants. The remaining 11 percent of the claims involved other health care providers (i.e. pediatricians, anesthesiologists, general surgeons, surgical assistants) who assisted in the care and treatment of the patients.

As mentioned previously, injuries include trauma to the brachial plexus, fractured clavicle or humerus, brain damage and in rare cases, fetal death. The majority of claims reviewed involved brachial plexus injuries resulting in either temporary or permanent paralysis or palsy. Fortunately, most incidents of Erb's Palsy resolve without permanent disability. Fewer than 10 percent of all shoulder dystocia cases result in a persistent brachial plexus injury.¹⁷

Risk management considerations

Although shoulder dystocia is impossible to predict, appropriate management, including a plan of action and accurate documentation, can assist in the defense of a medical liability claim when injury occurs. The medical record will be used to review the events and outcomes. It is critical that the medical record accurately reflect diligent prenatal care and appropriate delivery plans.

The prenatal period is the ideal time for physicians to evaluate pertinent risk factors and when appropriate, inform patients of the potential risk of shoulder dystocia and related injuries. Discussions about the risks of a trial of labor for vaginal delivery versus cesarean section should be documented, along with the patient's understanding of the potential risks. When cesarean section is indicated, documentation of the discussion as well as the patient's consent should be recorded in the medical record.

In the presence of antepartum risk factors, it is also important to document:

- awareness of those factors;
- clinical evaluations (e.g. sonographic determinations of fetal weight); *
- delivery plan (e.g. trial of labor);
- justification for the plan.

Sharing the delivery plan with other physicians/partners who may be on-call for the managing physician will be of great help if the delivering physician is different from the physician who provided prenatal care.

The outcome of many lawsuits hinges on the quality of documentation of the patient's labor and delivery. Accurate, thorough and repeated documentation of the intrapartum course will greatly assist in the defense of the case. In the case of prolonged labor, documentation of the reasons for the prolonged labor, the plan and any pertinent medical decision-making related to continuing labor with planned vaginal delivery is needed.¹⁸

Documentation of any maneuvers employed during the delivery process to free the shoulders may include the maneuvers used, the order in which they were performed, the degree of difficulty and the time frame (a minute-by-minute account should be avoided unless there is absolute certainty that the times are accurate). Documenting the use of suprapubic pressure, if employed, may help to avoid later allegations of fundal pressure.

Additionally, documenting the severity of the impaction in the medical record may later help to explain any impairment. Include all necessary events in the documentation, as well as reasons for decisions and actions. You may want to consider using the terms “brachial plexus impairment” or “palsy” and avoid the term “injury” since the latter implies direct physical trauma.¹⁹

Review the electronic fetal monitoring (EFM) strip and talk with other providers in attendance to gain the most accurate understanding of clinical circumstances. Be aware that when the nurse’s note and the physician’s note do not coincide, allegations about the care rendered are likely to result.

Once a dystocia and/or resulting Erb’s Palsy has occurred, talk to the parents and explain that shoulder dystocia is an uncommon, although possible, complication of childbirth. Explain that it is impossible to predict and that the appropriate medical care was given. Refer to any pre-delivery discussion on the subject when appropriate. Discuss the facts as are known at the time. It is important to communicate with the health care team prior to talking with the parents to achieve consensus as to the factual details and sequence of what occurred and what needs to be done in response. Offer any appropriate support. Expressing your sorrow for the unexpected outcome and empathizing with the parent’s distress is not an admission of liability.

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* ACOG notes that ultrasound measurements to determine macrosomia have limited accuracy. See Reference 1.

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Through the maze

the TMLT claim process

By Laura Hale

Malpractice claim statistics have been much discussed recently among legislators, attorneys, physicians and insurance industry representatives. The Texas State Board of Medical Examiners, the Texas Department of Insurance, the Texas Medical Association and the four remaining insurance carriers in Texas have all issued claim statistics, which have been evaluated and re-evaluated by all concerned parties. Amid these discussions, the question arose about how exactly a claim is defined, and at what point during the life of a claim should an insurance carrier begin investigating that claim. This article will discuss the TMLT claim process and will address what constitutes a claim.

The TMLT claim process

A claim is defined in the TMLT policy as:

- the receipt by the policyholder of a summons or citation in a lawsuit;
- the receipt by the policyholder of a written notice of claim sent pursuant to Article 4590i Section 4.01 of the Texas Medical Liability and Insurance Improvement Act, (a “Notice of Claim” letter);
- the receipt by the policyholder of a written demand from a patient or patient’s representative for monetary damages.

If a policyholder reports the receipt of any of the above, a claim file is set up. If the policyholder reports something other than a notice of claim letter, a lawsuit or a written demand from a patient, the claim department makes note of the report but does not open a claim file. This includes reports of unusual incidents, medical record requests and verbal threats.

Once a claim file is set up, the loss is assigned to a claim supervisor and coverage is entered and verified. A response letter is sent to the policyholder and the plaintiff’s attorney. TMLT also notifies the TSBME when a claim file is set up, as required by law.

The claim supervisor performs a preliminary investigation over the next several weeks, including collecting and reviewing the relevant medical records and referring the case to independent medical consultants for evaluation. During this time, the case may become a lawsuit or it may stay a claim.

If a suit is not filed, the case remains a claim. After the initial investigation, the claim is re-evaluated on a routine basis. A decision is made during this time frame as to whether the claim can be closed. If no lawsuit is filed or if TMLT receives no response from the plaintiff’s attorney after the initial claim letter or after the claim is denied, TMLT will often close the claim. There are other times when TMLT waits until the statute of limitations expires before closing the claim. It is important to realize, however, that even if a

claim never develops into a lawsuit, TMLT resources are still spent to deal with them.

If a lawsuit is filed, a defense attorney is assigned to the case. The policyholder receives a letter from the claim supervisor advising of the attorney assignment. TMLT is required to report any change in the status of the claim to the TSBME.

Under the direction of the TMLT claim supervisor, the defense attorney now prepares the case for trial, conducting discovery, locating expert witness testimony and taking depositions. The claim supervisor, the attorney and the policyholder work together in the development of a defense strategy.

At this stage, the policyholder, the attorney and the claim supervisor may decide to explore settlement of the case. Policyholder consent must be given for any settlement. If the option exploring settlement is agreed to, negotiations begin. If acceptable terms are reached during settlement negotiations, the case is settled. A case may also be settled before trial during mediation. Also during this phase, a case may be dropped by the plaintiff or dismissed by a judge.

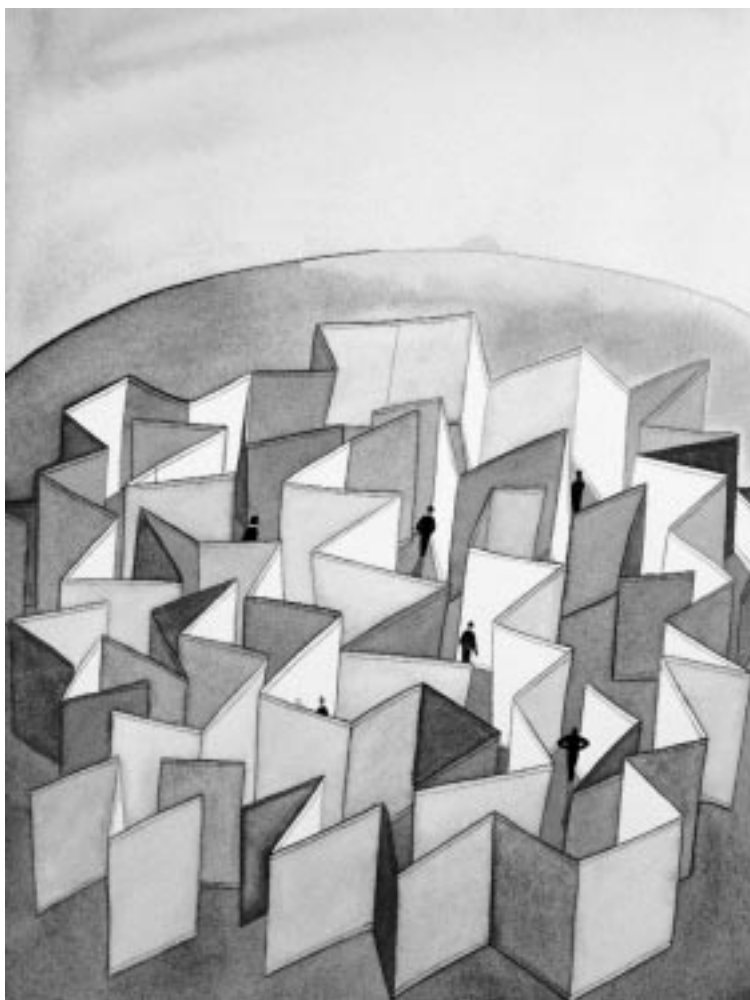
If the decision is made to proceed with the trial, a trial date is scheduled. A trial may last anywhere from a few days to weeks. If the defense wins at trial, the claim is then closed. If the defense loses at trial, TMLT explores resolution either by paying the award, negotiating a more favorable settlement or by pursuing post-judgement options such as appeal.

Regardless of how a claim is closed, when it is closed, TMLT submits a final report to the TSBME as required. If a claim is closed with indemnity payment to the plaintiff, TMLT must also notify the National Practitioner Data Bank. Claims with indemnity payments over \$10,000 are also reported to the Texas Department of Insurance. The report made to TDI is for statistical purposes only.

A claim by any other name

The discussion about when insurance carriers should begin investigating claims has been centered on the 4590i “Notice of Claim” letter. Under current Texas law, all medical malpractice claims begin with the filing of a 4590i “Notice of Claim” letter which extends the statute of limitations by 75 days and initiates a 60 day abatement period designed to allow both parties time to investigate a claim and resolve it if possible. If the claim does not resolve within 60 days, plaintiffs are free to file a lawsuit.

Some theorize that carriers should not begin investigating claims at the notice of claim stage, but should wait to do so when



a lawsuit is filed. They say that beginning the investigation at this stage is justified because some notices do not become lawsuits, and this “hands-off” approach would reduce legal and claims-handling expenses. TMLT does not subscribe to this approach.

As stated above, the TMLT claim department begins investigating a claim when the policyholder reports receipt of a 4590i “Notice of Claim” letter.

“At TMLT, we are handling claims in good faith for our policyholders by initiating an investigation on receipt of a 4590i letter. Article 4590i prescribes the notice of claim letter as the only notice required to advise the physician of an impending lawsuit. Some of the letters received make monetary demands. We cannot ignore those letters, nor should physicians want us to,” says Bob Fields, executive vice president of claim operations at TMLT.

“We could also be thwarting the legislative intent of 4590i,” continues Fields. “The purpose of the notice of claim letter is to trigger an investigation to see if a claim has merit before litigation. Each side gives records, and the burden is put on both sides to resolve the claim before litigation.”

Beginning an investigation early in the life of the claim allows TMLT claim representatives time to obtain all relevant medical records, refer the case to independent medical consultants for evaluation and consult with the physician regarding the case.

“Many times we are already behind when the notice of claim letter comes in because we had no idea a claim was in the works. The plaintiff’s attorney may already have the medical records and may have already obtained an expert opinion on the case. Ignoring a notice of claim letter when it’s received is a poor way to defend a doctor,” says Fields.

A number of claims are also resolved during this pre-lawsuit phase. Approximately one-third of claims closed in the years 2000 and 2001 were closed during the notice of claim stage. Of the claims in which indemnity was paid in 2000 and 2001, 4 percent were paid at the notice of claim stage.

In Texas, malpractice carriers are required by law to report claims to the TSBME. This includes the receipt of a 4590i “Notice of Claim” letter. There is no statutory requirement for physicians to report claims, lawsuits or settlements to the TSBME, apart from the questionnaire sent to physicians annually when they renew their licenses. The policyholder must report the claim under the terms of their policy and the burden of reporting claims falls on the insurance carriers.

“Any written communication indicating a claim is being considered triggers our responsibility to report to the TSBME. Plaintiff attorneys may try to downplay the significance of these letters by saying they are just sending them as a way to obtain medical records, but that notice of claim will appear on the physician’s record at the board of medical examiners and it can never be removed,” says Fields.

“It is important for our policyholders to know that we don’t take 4590i letters lightly. We know to our doctor out there who has just received one, it is not ‘only’ a notice of claim letter,” says Fields. “Our strategy of early investigation and evaluation helps us provide a strong defense for physicians.”



Through the maze

the role of the TMLT claim supervisors

By Dana Leidig

If you are among those physicians who have experienced a claim or lawsuit, you have firsthand experience with TMLT's claim management process and the important role played by your claim supervisor. If you have never experienced a claim, the following information will increase your knowledge and reinforce your confidence, that, should you ever have a claim, you will be in trustworthy hands.

Whenever TMLT is notified that a 4590i letter has been received, a claim file is opened and investigation begins. While the threat of a claim or lawsuit can be a very frightening, isolating, and emotionally numbing experience for our policyholder, knowledgeable TMLT claim staff get to work immediately to manage the claim.

In 2001, TMLT took in approximately 3,000 new claims. The Trust secures the services of scores of experienced medical malpractice attorneys to defend these claims. Generally, claims do not close the same year they are filed, so processing them can carry over several years. In a given year, an individual defense attorney may handle an average of 40 TMLT cases.

Defense attorneys work closely with TMLT claim supervisors and other claim staff. Twenty TMLT claim supervisors oversee the claims defended by these attorneys, and each claim supervisor is responsible for 120-140 claims a year. In spite of what these numbers indicate about the sad state of medical malpractice in Texas, what do they mean for you if you are involved in litigation?

The sheer quantity of cases adds up to a large volume of valuable claims handling experience for TMLT claim supervisors. These supervisors have been through thousands of cases each. Their average experience level is 18 years and they are well-versed in navigating one of the nation's toughest legal environments — Texas.

TMLT claim supervisors actually accumulate more medical malpractice litigation experience than do defense attorneys over the course of their careers. This aggregation of knowledge serves as a valuable resource for the defense attorneys with whom they work and as an information resource for physicians. Their knowledge also contributes to TMLT's strong record of success in the courtroom and in claims closed with no indemnity paid.

The claim supervisor is part of a team of three that includes defense counsel and the policyholder. Together, they will decide key issues, such as whether to settle a case or take it to trial. TMLT does not settle a case without policyholder consent and claim supervisors ensure that the policyholder has the information he or she needs to make this decision.

The claim supervisor puts solid experience to work evaluating all aspects of the claim, locating respected medical experts to

review records or serve as expert witnesses, coordinating, negotiating, and overseeing the process. As a claim develops, they are active behind the scenes, working closely with defense counsel and helping develop a defense strategy.

Initially, they may want to interview the physician by phone to review the medical record or discuss the claim. Teresa Canant-Finch, claim supervisor eastern region, says "Physicians who read their mail, prepare and attend depositions, and review the medical records involved will be well prepared to handle the litigation process. It's like anything — if you study, you'll be confident and you can be more successful because you are knowledgeable about what is going on in your case."

"The importance of the claim supervisor in the defense process is especially evident at mediation," states Canant-Finch. "This is your one, full, undivided day with the doctor, facing a barrage of allegations, and a team working to resolve the situation. Most physicians come away from this experience feeling good about their claim supervisor and their performance in the mediation process. They can see firsthand the level of involvement and expertise."

A claim supervisor cannot always return phone calls the same day. They travel extensively as they attend trials and mediations all across the state. If they are out of the office, their voicemail message gives instructions for a caller to follow. "No policyholder who is involved in a claim or lawsuit should be without information from his or her claim supervisor, even if it's just that the call will be returned as soon as possible. This is our work standard," says Sue Mills, assistant vice president claim operations.

TMLT claim supervisors are well aware that a policyholder involved in litigation is anxious for information about the case. Primarily, status reports are delivered directly to the policyholder from the defense attorney on the case. The frequency of communication often depends on the complexity of the case. Day to day communications concerning responsive pleadings, hearing reports, depositions, motions, etc. should come from the defense attorney. Questions on settlements or demands can be directed to the claim supervisor. According to Canant-Finch, "If the communication is up to us, we'll make every effort to be responsive." The claim supervisor and defense attorneys work together as a team to keep the policyholder informed.

Claim supervisors are regular attendees in courtrooms throughout the state. While scheduling does not permit them to attend every day of every trial, they review each case and are in court providing support and guidance to the physician involved and valuable information for the defense counsel during critical phases of a trial.

Bob Fields, executive vice president of claim operations, points out, "The claim supervisors are also in touch with the plaintiff attorney quite frequently. Remember that we have a history of

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closed claim study

Failure to diagnose malignant melanoma

by Barbara Rose, Senior Risk Management Representative

The following closed claim study is based on an actual malpractice claim 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 physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Clinical presentation

A 58-year-old man presented to his family physician for evaluation of a lesion on his back. The man was a long-time patient of this physician. The patient denied prior skin problems by verbal history and intake patient questionnaire at annual physicals in 1994, 1997 and April 1999. This visit occurred in September 1999.

Physician action

The physician found "a 2 cm annular café colored nevus over the midline of his back. There is a small area of darkening of the periphery." The medical record said the patient claimed it had been present for a year, and had not changed, bled or itched. The physician's impression was "benign compound nevus." The physician offered to remove the nevus, but the patient opted against removal. This offer and the patient's declination were not noted in the medical record.

The patient returned in December 1999 and asked the family physician to remove the lesion. The physician performed a shave biopsy and removed what was charted as a "1 cm annular seborrheic appearing lesion." The pathologist diagnosed Clark's level three, 2.82 mm thick malignant melanoma with significant horizontal as well as vertical growth. The patient was referred to a general surgeon and underwent wide excision and lymph node mapping. A left lymph node was found to be positive for metastatic melanoma cells. Dissection of the left inguinal femoral nodes was done and followed with adjuvant IV interferon therapy. Current medical records

from the patient's oncologist reflect a 40 percent chance of survival.

Allegations

- Failure to timely diagnose malignant melanoma
- Failure to order lab work, biopsy and/or tests to diagnose a cancerous tumor
- Failure to timely refer to a specialist for evaluation of the lesion

Contrary to the medical record, the patient claimed he complained of the back lesion at the 1997 visit and the April 1999 visit. He also alleged the family physician was negligent for not excising the lesion at the September 1999 visit. It was further alleged that diagnosis and treatment of the lesion on either the April or September 1999 visits could have prevented metastasis and resulted in an improved 5-year survival rate.

Legal principle

One of the main issues in this case was the discrepancy between the patient and the physician regarding the April 1999 visit. The physician's medical records for this visit were extremely meticulous, including a detailed patient questionnaire and a full two-page narrative review mailed to the patient with a letter containing recommendations on managing his other medical problems. The patient also did not indicate skin problems on the patient questionnaire for this visit. It was hard to believe that despite his copious records, the physician failed to chart a skin lesion complaint in April 1999.

Of particular concern in this case was the physician's diagnosis of the lesion in September 1999. The physician testified that he thought the lesion was benign. However, most expert consultants believed the lesion was malignant at that visit, based on the description of the lesion in the patient's medical record. The patient deferred removal of the lesion with the physician's approval. The plaintiff's experts argued that the physician's failure to refer the patient to a dermatologist or to perform a biopsy in April or September demon-

strated he had insufficient knowledge of melanoma. The physician did not document that he offered to remove the lesion in September 1999. Such a note would have been helpful to the defense of this case.

Defense experts were supportive of the physician's decision not to remove a lesion he felt was clinically insignificant. Clinical recognition of skin cancer, including melanoma, is difficult, not precise and it is uncommon in general practice. However, there was criticism of the family physician's inconsistent descriptions of the lesions in September 1999 and December 1999. It was believed this would strengthen the plaintiff's argument that the patient should have been referred to a dermatologist.

This case came down to an alleged delay in diagnosis of three months. Although it is unlikely that a 3-month delay caused any significant change in the outcome or treatment of the patient's melanoma, it has become increasingly difficult to get a jury to focus on this in cancer cases.

Disposition

This case settled before trial with the physician's consent. TMLT paid \$625,000 on behalf of the defendant family physician. The expert support for the plaintiff, the distinct polarity in the memory of the physician and the patient, and the sympathetic nature of the damages were major factors in the settlement.

Risk management considerations

Because the primary care physician in today's health care system is perceived as the director and coordinator of care and patient expectations are often unrealistic, allegations of failure to diagnose and treat in a timely manner are on the increase, particularly with diagnoses of cancer. Several processes associated with prudent risk management can be identified in this claim.

Document, document, document! What physician does not tire of hearing this? The harsh reality is if not documented, absolute

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closed claim study . . . *continued from page 7*

proof is not possible, and the defense of the physician is compromised. Documenting everything relevant to patient care and decision making is necessary for excellent records as well as the opportunity to defend a physician. It is dangerous to rely on memory. Missing or incomplete documentation creates a sympathetic bias toward the patient at a jury trial. This physician did not document his offer to remove the lesion earlier and the patient's refusal in response. Just as informed consent is required for the performance of procedures, acknowledgment of informed refusal of treatment should also be a routine part of physician practice and documentation.

Retrospective review of any case provides an unfair advantage for the reviewer. Neither plaintiff nor defendant physician consultants disputed the difficulty in the clinical recognition of melanoma. Primary care physicians face a multitude of complex patient conditions, and knowing when to refer is a key component of their practice. Early referral to a dermatologist might have made a difference in the diagnosis and treatment of this patient's melanoma.

through the maze . . . *continued from page 6*

working opposite these plaintiff attorneys. Sometimes we've worked on dozens of cases involving them. In other words, we have a history with them and lots of experience. This knowledge helps us immensely during the course of a trial."

Jill McLain, vice president of claim operations, asserts "TMLT is the only carrier consistently attending trials on the physician's behalf and watching closely to react to everything that's happening. We try to attend the jury selection whenever possible. And after the trial, we try to talk with members of the jury to find out from them what made the difference in their decision. We become attuned to nuances throughout the litigation process that defense counsel just doesn't have the opportunity to observe, and that's valuable information to have."

Regardless of the outcome of their case, policyholders who have gone through the process have written letters to their claim supervisor expressing gratitude for the genuine care and support shown to them during this difficult time

in their careers. One physician wrote Bob Fields about his experience with the claim supervisor, "I cannot tell you how much he was a comfort to me. From the very first time that I picked up the phone to call him and tell him that I had been served notice, he was always reassuring at any point in time. He even gave me his telephone number if I needed to call him early in the morning. He gave me a direct line to him. He made everything very easy, and he showed great professionalism . . . he kept me informed about everything."

When not dealing with a specific case, the primary purpose of the claim supervisor's relationship with defense counsel is to ensure adherence to TMLT's litigation standards. TMLT disseminates litigation guidelines to defense attorneys to help ensure that the quality of service we expect to provide our policyholders is met.

TMLT's claim philosophy is to defend doctors, not pay non-meritorious claims. Aggressively defending non-meritorious claims helps us protect your reputation and the TMLT claim supervisor plays a key role in this process.