

the Reporter

Case study

In October 1997, a 44-year-old African American man came to his family physician with a 3-day history of rectal bleeding. Anoscopy revealed a torn internal hemorrhoid and a double contrast barium enema showed diverticulosis. The patient returned to the family physician eight months later and reported continued rectal bleeding. At this visit, the patient alleged the physician told him that the rectal bleeding was due to his diverticulosis and was not life threatening. For this reason (according to the patient), the patient never reported continued rectal bleeding to the physician, despite numerous office visits and opportunities to do so.

In February 2001, the patient came to the physician's office with rectal bleeding and severe abdominal complaints. The family physician referred the patient to a gastroenterologist. Colonoscopy and later surgery revealed Stage IV colon cancer with metastasis to the liver. The patient underwent colon resection and chemotherapy but his prognosis was very poor.



Failure to diagnose colorectal cancer

By Laura Brockway

A suit was filed against the family physician alleging failure to fully evaluate symptoms suggestive of colon cancer and delay in diagnosing colon cancer. In reviewing this case, defense consultants stated a double contrast barium enema was inadequate to investigate the patient's rectal bleeding in 1997. The standard of care required either colonoscopy or sigmoidoscopy. The physician was also unable to testify that he had inquired about continued rectal bleeding when he saw the patient in June 1998. The consultants felt the standard of care required the physician to inquire about the previous rectal bleeding instead of relying on the patient to report a continued problem.

The standard of care issues and the sympathetic nature of the patient's condition created considerable weakness for the defense of this case. With the consent of the family physician, this case was settled for an amount in the high six figures.

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Colorectal cancer

Colorectal cancer is the third most common form of cancer in the United States and is the second leading cause of cancer deaths. The American Cancer Society estimates that 146,940 new cases of colorectal cancer will be diagnosed in 2004. Colorectal cancer is expected to cause about 56,730 deaths during 2004, accounting for about 10 percent of cancer deaths. In the U.S., the incidence of colorectal cancer is increasing, while the mortality rate is decreasing.¹

Most colorectal cancers can be surgically cured, especially if they are small, have not metastasized and are detected before they are symptomatic. Current survival rates indicate 90 percent of those diagnosed early are cured.¹ This early cure rate prompted medical specialty societies and government health agencies to recommend screening protocols for all adults. "Colorectal cancer lends itself to screening because it is a common and serious disease; it has readily identifiable and slow-growing precursor lesions; once developed, it advances slowly through the various stages; and recommended screening tests are available."²

Claim experience

Failure or delay in diagnosing colorectal cancer is a leading cause of litigation against physicians. It is also one of the most expensive types of claims. Through 2002, more than 1,700 colorectal cancer claims were reported to the Physicians Insurers Association of America (PIAA) Data Sharing Project. Total indemnity on these claims was \$137 million and related claim expenses totaled \$26 million. The most frequent misadventure in colon cancer claims was that of error in diagnosis, accounting for 46.8 percent of colorectal cancer claims. The physician specialty with the highest number of colorectal cancer claims is internal medicine, representing 30.7 percent of paid claims.

In 1991, the PIAA conducted a Colon Cancer Study, reviewing data from 151 claims closed that year. The report found that in 97 percent of those cases, delays in diagnosis were most commonly caused by:

- failure to perform an examination
- failure to respond to patient complaints
- error in interpretation of barium enema results.³

Other issues that make these cases difficult to defend include differing national screening guidelines, screening versus diagnostic testing, and the public perception that colonoscopy is 100 percent accurate in detecting colon cancer.

Screening guidelines

Colorectal cancer screening is done on patients who do not have any signs or symptoms that may indicate cancer. If symptoms exist, diagnostic work-up rather than screening should be completed.³

Most prominent colorectal cancer screening guidelines (including those from the American Cancer Society and the American Gastroenterological Association) differ regarding which screening options should be offered to which patients. All the guidelines state that colonoscopy, flexible sigmoidoscopy and fecal occult blood testing are all cost-effective screening alternatives.

"With respect to colon cancer screening, although prominent colon cancer screening guidelines may differ, the most important message is that virtually all respected guidelines suggest screening is necessary. There could be a courtroom debate about the details of screening (which test at which age and level of risk). A provider arguing the details of one respected screening guideline versus another, however, is in a much better position than the provider who has never performed colon screening, nor documented the recommendation to screen."⁴

The American Cancer Society recommends screening men and

women at average risk for colorectal cancer beginning at age 50 with one of the following testing options:

- FOBT annually
- flexible sigmoidoscopy every five years
- annual FOBT plus flexible sigmoidoscopy every five years (preferred over either above option)
- double-contrast barium enema every five years
- colonoscopy every 10 years

Screening guidelines recommend that patients at increased risk for developing colorectal cancer undergo screening earlier and more frequently. These patients include anyone with a strong history of colorectal cancer or polyps, a known history of hereditary colorectal symptoms, a personal history of colorectal cancer or adenomatous polyps or a personal history of inflammatory bowel disease. The American Cancer Society does not recommend digital rectal exam as a stand-alone screening test for colorectal cancer.¹ Similar recommendations are issued by the American College of Surgeons, the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians.⁵

In 2003, the American Gastroenterological Association issued new screening guidelines stressing the importance of family history in colon cancer. According to the guidelines, patients with a positive family history of colorectal cancer may need to be screened as early as age 20 to 25 for the disease.⁶

"The recommendations have expanded the responsibility for colon cancer screening to a wider group of physicians, such as ob/gyns. Previously, ob/gyns have treated healthy patients in the childbearing years, prior to the age of previously recommended colon cancer screening. Quite often they serve as the primary care physician for these patients. Now, they have an added responsibility to assess these patients for risk factors for colon cancer."³

Regardless of the screening method used, document that the patient was informed of the need to undergo the screening procedure. Even if the patient refuses, this note will aid in defending against a "failure to screen" claim. Discuss with the patient that no screening test, even colonoscopy, will pick up every cancer or precancerous polyp, but any screening is better than no screening at all.

Research indicates overall compliance with colon cancer screening continues to be poor. Data from the Centers for Disease Control and Prevention indicates that only 30 to 40 percent of people at risk for colorectal cancer in the United States are being screened by any test.⁷ According to the National Health Survey, only 30 percent of responders older than 50 years of age admitted to having an FOBT during the past two years and only 20 percent had a screening endoscopy during the previous three years.⁸ In a study published in the *American Journal of Gastroenterology*, physicians, nurses and their spouses were invited by letter to undergo a free screening colonoscopy. Less than 15 percent accepted.⁹

"Our greatest challenge is not choosing among the many options for screening. Rather, we must somehow overcome the barriers that too often result in no screening. A common reason patients give for not being screened is 'My doctor never told me to.' In the final analysis, any test is better than none, and the best test is one that gets done."¹⁰

Symptomatic patients

In general, colorectal cancer does not exhibit clinical signs in its early stages. As the disease progresses, rectal bleeding is often the first symptom. Therefore, blood in the stool, either occult or gross, is a strong indication for colon evaluation in patients at risk for colorectal cancer.

"Bleeding should not be attributed to hemorrhoids without a complete colon examination. In general, patients who are at risk for colorectal cancer should have either a colonoscopy or a flexible sigmoidoscopy and double-contrast barium enema to evaluate a complaint of blood in the stool. Colonoscopy is the preferable test

when the suspicion of colorectal cancer is present. A flexible sigmoidoscopy and barium enema is preferred when working up isolated symptoms of abdominal pain, diarrhea, constipation, and a change in bowel habits.”⁵

Colonoscopy

“Often in clinical studies, colonoscopy is considered the ‘gold standard’ against which all other diagnostic modalities are measured. However, although colonoscopy clearly is the most accurate method available for detecting polyps and cancer, it should never be considered 100 percent sensitive and specific (i.e., a gold standard) in clinical practice. Competently performed colonoscopy clearly misses many polyps and occasional cancers.”¹¹

Colonoscopy clearly has a number of advantages over other screening methods. It allows for the removal of polyps throughout the entire colon as well as the biopsy of lesions suggestive of cancer. However, there have been no controlled trials evaluating the effectiveness of screening colonoscopy in the reduction of colorectal cancer mortality in the average risk population. Studies have also demonstrated that missing adenomas is “essentially universal to conventional colonoscopy.”¹¹ In a tandem colonoscopy study published in *Gastroenterology*, Rex et al. reported that large polyps (greater than 1 cm) were rarely missed but adenomas less than 5 mm in size were missed at a rate of 27 percent.¹²

The procedure itself is not without risk. The incidence of complications during colonoscopy is: 1 in 1,000 patients suffer perforation; 3 in 1,000 suffer major hemorrhage; and 1 to 3 in 10,000 die as a result of the procedure.⁸

“Any reasonable person in America today knows that periodic screening including colonoscopies every now and then should free them from a colon cancer death. Likewise, that same reasonable person knows that people who are screened should not have colon cancer or, worse yet, die from the disease. In reality, the medical establishment has again fallen victim to its own hyped publicity. Organized medicine overstates its ability to reduce and eliminate colon cancer from the population. We cannot eradicate colon cancer by screening. Colon cancer will be no more when its ‘cause’ is defined and it is eradicated.”¹³

Risk management considerations

Physicians can consider the following guidelines to help reduce liability in the area of colorectal cancer screening and diagnosis:

1. Stay current with clinical practice standards that are applicable to your patient population.
2. Screen your patients for colon cancer following a reasonable authoritative guideline.
3. Have an informed consent discussion and include the risks, benefits, alternatives, and limitations of screening and the procedures involved. Document informed consent, and if appropriate, informed refusal.
4. Assess and document your patients’ family histories for hereditary risk factors, with special care toward ascertaining hereditary nonpolyposis colon cancer and familial adenomatous polyposis.
5. Recommend that patients contact family members who are at significant increased risk for colon cancer.
6. If the preparation for flexible sigmoidoscopy or colonoscopy is inadequate, repeat the procedure.
7. Document cecal intubation and careful withdrawal techniques in the colonoscopy report.
8. Recommend appropriate follow-up, and consider implementing a patient reminder system.
9. Document informed consent, refusal, procedures, and follow-up recommendations.
10. Ensure adequate support systems, particularly patient reminder systems.^{3, 4, 11}



PIAA closed claim data (1985-2002)

Colon cancer claims by top 5 physician specialties

Internal Medicine
General surgery
General practitioner/family physician
Radiology
Gastroenterology

Colon cancer claims by top 5 misadventures

Errors in diagnosis
No medical misadventure
Improper performance
Not performed
Failure to supervise

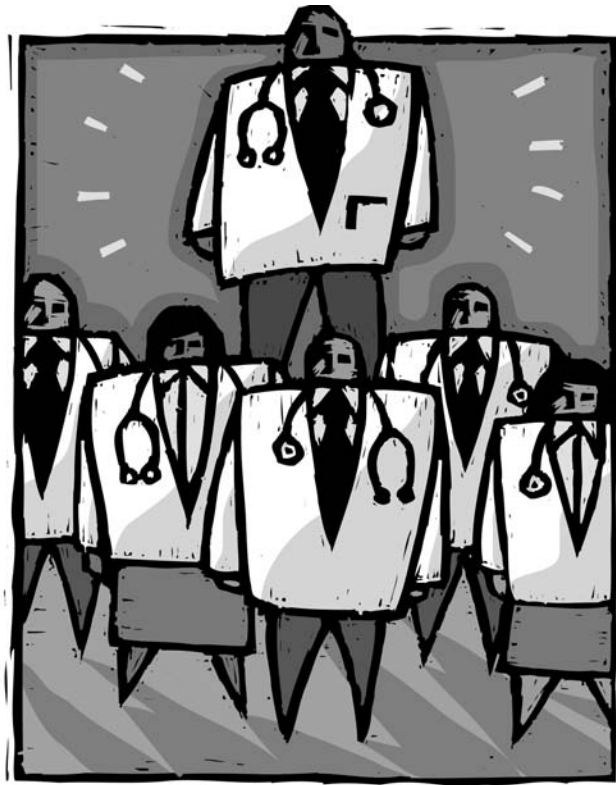
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Shared patient/shared liability

treating patients who see multiple physicians



Objectives

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

1. Recognize the challenges inherent in caring for a patient with multiple physicians.
2. Identify the need to inform and include patients in treatment decisions.
3. Acknowledge the need to communicate with all members of the health care team.
4. Evaluate your commitment to the role of patient advocate.

Course author

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Disclosure

Barbara Rose 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 one 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 August 1, 2004, and expires on August 1, 2006. Please note this CME activity does **not** meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

Many medical malpractice claims against physicians involve more than one physician being named in the suit. When filing suit,

plaintiff's attorneys often include every physician who treated the plaintiff when the alleged negligence or malpractice occurred. According to recent claim data, approximately one-third of TMLT claims involve more than one defendant physician.

A current search for empirical data or published articles regarding the inherent challenges that arise when patients are treated by multiple physicians is sparse. However, a review of TMLT claims demonstrates the following common scenarios.

- Pre- and postoperative management of routine medications that require adjustment (e.g., coumadin, aspirin, insulin) can prove challenging. Which physician assumes oversight and informs the patient, verifies patient understanding, and coordinates changes in the medication regimen?

- Polypharmacy in the treatment of the elderly who may be routinely followed by a primary care physician and perhaps a cardiologist, endocrinologist, gastroenterologist, psychiatrist, etc. The combination of a primary care physician and any number of consultants is common in health care today. Who is in charge? Who is coordinating the delivery of safe, quality care? (The reader is no doubt inclined to say "where is patient accountability?" This will be addressed later in the article.)

- Admitting hospital patients to the care of a hospitalist with consults in pulmonology, cardiology, and neurology. In these cases, physicians were rescinding the orders of other doctors involved in the patients' care. More than one hospitalist saw the patient due to scheduling and compounded the challenges of communication and coordination of care.

- The patient with chronic pain who is desperate to find relief often seeks care from multiple physicians.

Closed claim studies

To more fully explore these issues, we present three closed claim studies.

Case 1 — Failure to communicate

The first closed claim study illustrates what happened when a patient was seen by multiple physicians and no one assumed the responsibility for communication among those involved in diagnosis and treatment.

Clinical presentation

A 34-year-old woman, who reported right mandible and tooth pain for six months, was referred to an oral surgeon for a possible root canal. The surgeon obtained x-rays that revealed a cyst or abscess in the right mandible under the gum line.

Physician action

The patient was referred to a facial plastic surgeon who performed a biopsy of the cyst. The specimen was sent to a local pathology lab where the slides were prepared by one of the group's histotechnologists. The pathologist, the defendant in this case, interpreted the slides as containing "atypical small cell infiltrate." She further commented in the medical record "the histologic and immunohistochemical findings suggest the possibility of a small cell carcinoma with neuroendocrine features." It was later discovered the slides had been contaminated by another patient's specimen read earlier by the defendant pathologist.

During her deposition, the pathologist testified she was concerned about the atypical cells, and that she wanted to make sure the clinical information fit with what she saw on the slides. She called office staff for the group and asked them to review the pathology reports from the day she read the patient's slides to see if any other reports indicated small cell carcinoma. She was told that there were no other small cell carcinomas processed that day. The patient's slides were then sent to an out-of-state pathology laboratory and were interpreted as showing metastatic small cell neuroendocrine carcinoma of primary lung origin.

The plastic surgeon conferred with the defendant pathologist, who recommended a mediastinal biopsy and a rebiopsy of the cyst in the jaw because she felt this was very unusual. The rebiopsy was never done, and the pathologist's recommendation was not put in writing. According to testimony from all parties, the patient was never told of the need for a rebiopsy.

The plastic surgeon explained the biopsy results to the patient and she was referred to an oncologist. The patient underwent a CT scan of her head, abdomen and pelvis and a body bone scan, all found to be unremarkable. A CT scan of the chest revealed a 3 x 2 cm soft tissue mass near the ascending aorta, described as worrisome for neoplasm.

The oncologist questioned the diagnosis of small cell carcinoma, stating in the med-

ical record "tumor board review of her history and scans still is not definitive." The patient did have a mediastinal mass, but the oncologist indicated this could also be a normal thymus. He requested that the patient undergo a PET scan. In deposition, the oncologist stated that he planned to inform the patient of the need to rebiopsy the jaw cyst, but was unable to specifically recall discussing this with the patient. There was no mention of a rebiopsy in the medical record.

At this point, the oncologist went out of town and left instructions with his partners that if the PET scan came back as normal thymus to refer the patient to an otolaryngologist. The PET scan found the mediastinal mass was consistent with normal thymus and did not reveal any abnormalities in the mandibular region. Based on these results, the patient was referred to an otolaryngologist.

This physician had the patient's pathology slides reviewed by another pathologist, who concurred that they revealed metastatic small cell carcinoma. This pathologist recommended that a clinical correlation be made, but he did not specifically mention a rebiopsy. A CT scan of the neck and larynx did not show any masses in the soft tissues of the neck, but did show complete opacification of the right maxillary sinus. There were no other suspicious masses in the nasopharynx, oropharynx, hypopharynx, or larynx. The radiologist could not identify any lesions in the oral cavity, mandibular glands, thyroid glands, and no enlarged lymph nodes.

Despite the negative findings, the otolaryngologist recommended surgical removal of the lesion because he felt the cancer would not respond well to chemotherapy. He performed a right hemimandibulectomy, lymph node dissection, tracheostomy with reconstruction utilizing a left fibula free-flap and right neck dissection. The pathology on the specimen came back as normal for bone, teeth and other tissue and negative for tumor.

After these findings, the defendant pathologist was contacted and asked to check all the specimens and reports from the day she interpreted the patient's biopsy. The pathologist had a technician check the reports and again, it was reported that there were no records reflecting small cell carcinoma processed that day. The pathologist then rechecked all the reports herself and discovered there had been another patient who had undergone a lymph node biopsy that showed metastatic small cell carcinoma

of the lung origin. This report had also been generated by the defendant pathologist.

Interviews with office staff later revealed a possible explanation for why the small cell carcinoma case was not found initially. The patient's specimens were processed over the weekend but were not reported until Wednesday. The small cell carcinoma slides were processed over the weekend, but were reported out on Monday. Therefore, since office personnel were looking for cases reported on the same date, they would not have found the small cell carcinoma.

Since the initial surgery, the patient has undergone several reconstructive procedures to rebuild the mandible and re-implant teeth. The patient's face was disfigured due to the resection. The patient had been told she had a very aggressive form of cancer and had notified her family, including her two young children, that she was going to die.

Allegations

The patient filed a lawsuit against the pathologist and the pathology group, alleging improper interpretation of the biopsy specimen.

Legal implications

The cross-contamination of the pathology slides did occur and this exposure fell to the pathology group regarding their handling of the tissue specimen. The contamination most likely occurred during the processing of the specimen into a paraffin block or during the creation of the slides. It was alleged by the plaintiff's experts that the pathology group fell below the standard of care in not discovering the cross-contamination when it was first suspected by the pathologist.

Regarding the liability of the pathologist, the plaintiff's expert did not express any opinions as to whether the pathologist appropriately read the pathology slides, and he even acknowledged that contaminations can occur. The plaintiffs alleged the pathologist fell below the standard of care when she herself did not investigate the possibility of cross contamination and assigned office personnel to check the pathology reports. The investigation should have been conducted either by the pathologist or by experienced lab technicians or medical transcriptionists.

Defense experts felt the pathologist appropriately interpreted the slides, such as they were, and that it was appropriate to

request office personnel to conduct the search of the records as long as they were qualified to understand the terminology. It was also helpful to the defense that two other pathology labs reviewed the patient's slides and did not mention any suspicion of contamination. However, the defense of the case was weakened because it was the pathologist herself who had reviewed and reported the other small cell carcinoma case. The question being, why didn't the pathologist recall this seemingly rare diagnosis?

Also of issue in this case was the otolaryngologist's decision to proceed with radical surgery when there were still questions about the patient's diagnosis. In his deposition, the otolaryngologist stated that he knew the oncologist was questioning the diagnosis and that there was no clinical-pathological correlation between the slides and the patient's condition. He testified this did not make any difference because he had pathology slides with metastatic small cell carcinoma.

Disposition

This case was settled with the consent of the pathologist and the pathology group for an amount in the high six figures. Defense experts were concerned that a jury would not understand why the pathologist did not look for evidence of contamination herself, and why she did not recall reviewing another slide revealing a small cell carcinoma. These concerns, along with the patient's disfigurement and mental anguish, were major factors in the decision to settle this case.

Risk management considerations

Documenting the recommendation for a second biopsy and it being done may have prevented this unnecessary surgery and the subsequent suit. When a patient's condition and care involves multiple physicians, some with differing opinions, it is advantageous for one physician to function as the primary coordinator with all the medical information available. This patient went from an oral surgeon to a plastic surgeon who biopsied the mandibular cyst. The specimen was interpreted by the defendant pathologist, and the plastic surgeon then referred the patient to an oncologist who then recommended a consult with an otolaryngologist. This physician had the slides reviewed by another pathologist who con-

curred with metastatic small cell carcinoma but also recommended clinical correlation.

The defendant pathologist, upon conferring with the plastic surgeon, recommended a second biopsy of the cyst but did not document this exchange in writing. Though pathologists may not routinely establish a direct patient-physician relationship, it is important for them to document every interaction regarding a patient.

In retrospect, relying on office personnel to search for patient reports with the same diagnosis was inadvisable. Had the defendant taken the time to focus on this search, the other report with this diagnosis may have been identified and contamination suspected.

Case 2 — Failure to diagnose and refer

The second study serves as a harsh reminder of the need to have "fail-safe" systems in place.

Presentation and physician action

A 49-year-old woman came to a plastic surgeon for blepharoplasty. The patient had been cleared for surgery by her primary care physician. As part of the preoperative clearance, a chest x-ray was taken. The radiologist who interpreted the x-ray noted a 2.5 x 3 cm lung mass and suggested a CT scan. The eyelid surgery proceeded and was uneventful.

Thirteen months later, the patient visited another physician, complaining of a chronic cough and shortness of breath. A chest x-ray revealed a large mass in the left lung diagnosed as lung cancer in an advanced stage. The plaintiff died several months later.

A lawsuit was filed against the plastic surgeon, the primary care physician and radiologist alleging: failure to diagnose lung cancer in a timely manner; failure to act on an abnormal chest x-ray and refer in a timely manner; and failure to obtain a biopsy to identify the nature of the lung mass.

Legal implications

Three physicians had exposure in this case. Did one physician have more exposure or responsibility? Each had the opportunity to act on the abnormal chest x-ray in a timely manner. Did the radiologist take the time to personally notify the family physician who ordered the study? He apparently did not. Did the primary care physician who cleared this patient for surgery read the radiologist's report? One may surmise that he did not. Did the plastic sur-

geon, who had a copy of the report in his record, review it? He did not, and in deposition indicated his reliance on the preoperative clearance performed by the family physician. Three physicians, each with the opportunity to act quickly and assertively on an abnormal study “dropped the ball.”

Disposition

Both the plastic surgeon and the radiologist were eventually dropped from the claim. The family physician, who was not a TMLT policyholder, settled the claim for an amount within his policy limits.

Risk management considerations

The physician who orders a test may have a system in place to track the receipt of reports, to track the review of reports and to ensure a response with the appropriate follow up and action for continuity of care. Physicians are advised to initial and date test reports and document their actions as verification of what was done. The primary responsibility for this abnormal report “falling through the cracks” was placed on the family physician who ordered it as part of preoperative clearance.

A physician who receives a report, whether solicited or not, is also advised to verify it has been reviewed. In this case, the abnormal chest x-ray report was sent to the surgeon. He did not review it, but the report was filed in the medical record. Because this report was in the surgeon’s office record, he was included in the suit.

The radiologist who interpreted the chest film had the opportunity to call the ordering physician and give an oral report. The CT scan could have been ordered, and perhaps the outcome for this patient would have been different. Though radiologists generally do not have established physician-patient relationships, their commitment to quality care and to their colleagues who order imaging studies is reflected in timely notification when viewing an abnormal study.

Case 3 — Who is in charge?

Who is to assume the role of patient ombudsman or patient care coordinator? At the center of this challenge is the art of successful communication between referring physician and specialist, primary doctor to hospitalist, specialist to specialist, surgeon to anesthesiologist, etc. The following case describes another claim involving two physician defendants.

Presentation

An 18-year-old woman first came to her obstetrician for prenatal care on October 9, at approximately 11 weeks gestation. On January 3, an initial sonogram revealed a normal pregnancy. One month later, a 3-hour glucose tolerance test showed a blood glucose level of 327.

Physician action

The patient was admitted to the hospital for treatment and control of her gestational diabetes. An internal medicine physician was called in to evaluate and manage her diabetes. The patient was discharged three days later with her blood sugar under control, and after receiving appropriate diabetic education (regarding accuchecks and diet.) The discharge plan included scheduled appointments with the obstetrician and internist. Four days later, the patient came to the internist for a review of diabetic education, which included blood sugar checks three times a day and dietary guidelines. Her next appointment was scheduled one week later. This appointment was not kept and no attempt was made to contact the patient. The obstetrician was not notified of the patient’s failure to keep the appointment.

Routine prenatal appointments with the obstetrician were kept on February 25, March 11, March 25, and April 1. During this time the patient reported she was performing accuchecks, and the readings were within normal limits. She was not asked and did not acknowledge that she had not seen the internal medicine specialist since February 9. At her April 8th appointment, the patient reported lack of movement. No fetal heart tones could be detected, and she was admitted to labor and delivery. A sonogram confirmed fetal demise.

Allegation

The primary allegation was failure to properly manage the patient’s gestational diabetes. Both the IM physician and the obstetrician were named in the lawsuit.

Legal implications

Damages were primarily noneconomic and were based upon the value of a stillborn child. Physicians reviewing this case were critical of the obstetrician’s lack of follow up to ensure the diabetes was being monitored and treated. The consultants indicated that the obstetrician was primarily responsible for the patient’s overall care during

pregnancy. The internal medicine physician was held accountable for not attempting to contact the patient when she did not keep her appointment and for failing to notify the obstetrician.

No one disputed the fact that the patient had responsibility for her prenatal care and to keep all her appointments. As such, there was some potential for contributory negligence on the part of the plaintiff. However, based upon the assumptions made by the doctors and the lack of communication, a proportionate finding of liability against both physicians was deemed likely.

Disposition

Mediation and negotiation were conducted with the two defendant physicians. An agreement was reached on behalf of both physicians for a settlement in the low six figures.

Risk management considerations

Every practice may benefit from an established system in place to follow up with patients who fail to keep appointments. Document the “no show” in the patient record and attempt to reach the patient. Document the call to the patient. If the nature of the patient’s condition is such that continuity of care is essential, call again and document again. If indicated, a letter documenting the efforts to reach the patient and the need for follow up can be sent, and a copy of the letter placed in the record. In this claim, communication between physicians was a significant weakness and exposed both to a difficult defense.

Patient accountability and shared decision making

All patients need to be actively involved in their health care and their role is “to ask questions that result in your physician giving you the information you need to make an informed decision as to your treatment.”¹ Many patients are not involved and do not ask appropriate questions. The reasons can include fear, educational level, illiteracy, language and cultural barriers. The ultimate responsibility to determine if a patient has enough information to make an informed decision about treatment choices rests with the physician.

To determine how well physicians inform patients and involve them in clinical decision making, researchers audiotaped patient

encounters and analyzed the decision making process. The study, entitled “Informed decision making in outpatient practice: time to get back to basics” supported the premise that physicians have the responsibility to inform and educate patients so they can participate in their own treatment.

The study analyzed 3,552 clinical decisions involving 59 primary care physicians (internal medicine and family practice) and 65 surgeons (general and orthopaedic). “A decision was defined as a verbal commitment to a definitive course of action.”¹

The authors defined informed decision making to include these 7 elements:

- discussion of the patient’s role in decision making;
- discussion of the nature of the decision;
- discussion of alternatives;
- discussion of the benefits and risks of the alternatives;
- discussion of uncertainties associated with the decision;
- assessment of the patient’s understanding of the decision; and
- exploration of the patient’s preferences.¹

Clinical decisions were then classified as basic, intermediate or complex. An example of a “basic” decision would be the decision to have a laboratory test. An “intermediate” decision would be the decision to change the dosage of a current medication or to begin a new medication. A “complex” decision would be the decision to be screened for prostate cancer.

Based on this criteria, the study found that 9 percent of the decisions analyzed met the criteria for completeness of informed decision making. Further, 17 percent of basic decisions were considered complete and 0.5 percent (representing one patient) of complex decisions were considered complete.

The authors identified two effects of a low result in informed decisions, “inadequate efforts to foster patient involvement in decision making may impair the patient-physician relationship; and the mounting evidence that inadequate patient involvement may interfere with patient acceptance of treatment and adherence with medical regimens.”¹

In a related editorial published with the study, Michael J. Barry, MD stated, “the absence of a shared decision making strategy may contribute to the widespread variations in rates of medical treatment for many conditions. For example, it may be that the

choice of one treatment over another or of no treatment is driven by physician rather than by patient choices.” Dr. Barry further stated “the results of the study present a challenge to the medical profession to embrace the shared decision making concept in their day-to-day practice.”²

Multiple physicians and the elderly

Another great challenge in the delivery of health care today, and one worthy of a separate article, will be mentioned briefly. Senior citizens who see multiple physicians and use multiple pharmacies place themselves “at a higher risk than ever before for overmedication and potentially harmful drug interactions. In 2002 one in four seniors was treated by four or more physicians and used four or more pharmacies to fill their prescriptions.”³

At each visit, patients are asked about all medications in their regimen. A patient’s active participation and accurate information about his or her medication profile, as well as communication among physicians, is critical to prevent medication errors and unintended outcomes. For the patient who is a poor historian or who experiences cognitive changes, ask that they “brown bag” all medications and bring them to the visit. A second option is to request that a family member make a complete list and send it with the patient.

Limiting exposure and risk management

“Once the doctor-patient relationship is established, a doctor remains at least partially liable for the patient’s care, no matter how many other doctors become involved. Subsequent physicians, by establishing doctor-patient relationships of their own, assume a share of the liability for treatment.”⁴ Shared liability may extend to shared advocacy, but without one physician assuming the role of coordinator and communicator with the entire health care team, patient care may be compromised.

Since Hippocrates, the physician-patient relationship has been defined as a fiduciary one, as a relationship founded in trust. “When a patient seeks a physician’s help and the physician agrees to give that help, a special covenant is made. The physician agrees to become the patient’s advocate, to protect the patient’s best interests.”⁵ Whether a physician is the first, second,

third, or last doctor of record for a patient, this relationship based on trust is the heart of the matter. This relationship should ensure there are one or more knowledgeable professionals committed to the patient’s interest. The role as patient advocate is the foundation of the physician’s profession.

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CME test questions

Instructions: Using black ink, read each question, select the best answer, and then clearly mark your selection. Please fax the completed test to the risk management department, attention Rebecca Deones 512-425-5996. You can also mail the test to the TMLT risk management department, attention Rebecca Deones, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide below.

- 1. TMLT's data demonstrate that approximately two-thirds of claims have more than one defendant physician.
 - a. true
 - b. false
- 2. The study titled "In" of the following:
 - a. 0.5 percent of cor
 - b. 9 percent of decis
 - c. 17 percent of bas
 - d. a and c.
- 3. The physician who
 - a. track receipt of th
 - b. review the result
 - c. act on the results
 - d. wait for the patie
 - e. a, b and c
- 4. Patients who do no
 - a. true
 - b. fa
- 5. In 2002, one in fou
 - a. one physician



CME evaluation form

Please complete the fo

- 1. The objectives for th
- 2. The material will be
- 3. Did you perceive an Yes No
- 4. How long did it tak 1.25 hrs
- 5. On a scale of 1 to 5, the effectiveness of this activity as it pertains to your practice? 1 2 3 4 5
- 6. What will you do differently in your medical practice after reading this article?

7. Suggestions for course improvement are:

8. Suggestions for future topics include:

Contact information

Name _____ Phone _____

Address _____ TMLT policyholder? Yes No

Email address (to have your certificate emailed) Please print legibly. We cannot email your certificate if we cannot read your email address.

Grid of 25 empty boxes for email address input.

risk management consult

Q: Should all the members of my staff sign or initial their entries in the medical record?

Answer: Yes. Every author in the medical record should acknowledge ownership of his/her notes. Keep a current master signature log with the full names and initials of the physician(s) and each staff person with authority to document in the record. If any physicians or staff have the same initials, full last names should be used to avoid confusion. If signature stamps are used, policy should dictate that only the owner of the stamp uses it. Signature stamps create potential problems and are not recommended. All entries should clearly identify who participated in each patient visit and who was responsible for entering the information.

Q. My partner dictated a note in a patient's record about the inadequate technique of a radiology technician resulting in a film of poor quality. I have concerns regarding this type of information in the patient record. How do you advise handling this situation?

Answer: It is inappropriate to include personnel matters in the patient record. These situations are best handled by reporting them to the department manager, proper administrative staff, human resource department, etc. In the event of litigation, information in the medical record regarding an employee's poor performance may be used by a plaintiff's attorney to support claims of negligence.

Q. I am too busy to review all my dictation. Is it acceptable to use a stamp "Dictated but not read" to reflect this?

Answer: No. Use of a stamp with this message is discouraged. It may indicate your work is incomplete with respect to that particular patient and does not reflect the thoroughness

you wish to exhibit in your records. Physicians are advised to read and initial their dictation to ensure accuracy. You are held responsible for the content of all dictation, patient letters, consultations — everything you write.

Physicians have been embarrassed to later discover errors that were dangerous or ridiculous. Consider the following entries from actual medical records:

- "the patient had a baloney amputation in 1989" (a below-the-knee amputation)
- "patient had a pabst beer today." (a pap smear)
- "the patient was found in the bathroom without a purse." (without a pulse)

While these entries were embarrassing, the following entries resulted in problems defending malpractice claims:

- "patient history: had no carcinoma, no family history." (This patient had a history of adenocarcinoma.)
- "CMS normal, swelling now present." (This patient had a fresh cast and swelling was not present. However, compartment syndrome developed two days later and the typographical error made it appear the physician missed the early signs.)

Signing off on all entries in the medical record is essential for many reasons. Most third-party payers require it. Follow up treatment questions cannot be answered if the provider is not identified. Internal quality improvement activities require a clinician's identity. As the above examples demonstrate, it may be critical in defending a malpractice claim years later. It is not enough to assume that everyone knows your handwriting, dictation, etc.

Q. What is physician responsibility when delegating tasks to unlicensed staff?

Answer: Standing delegation orders may be authorized for the performance of acts and duties which do not require the exercise of independent medical judgment (TSBME Standing Delegation Orders, Chapter 193),

provided that you are satisfied with the competence of the staff, with due regard to patient safety and in keeping with sound medical practice. Unlicensed staff can be trained to perform some tasks associated with the delivery of patient care. However, some tasks are inappropriate to delegate and the accountability for the competent performance of those tasks remains with the physician.

In determining appropriate utilization of unlicensed personnel, the physician is to evaluate the capabilities of the staff member, the complexity of the task, and the amount of supervision required. Employers can be held liable for negligent delegation if they:

- delegate a task they know or should know the person does not have the training or experience to do;
- do not provide the supervision the employer knows or should know is needed; or
- delegate tasks contrary to the medical or nurse practice act.

Q. A pharmacist called to verify a patient's prescription and we discovered a prescription pad had been stolen and the patient was attempting a forgery. May I terminate this patient from my practice?

Answer: Yes you may. Send the patient a letter terminating the relationship via certified and first class mail. File a copy of the letter in the record and also the return receipt for the certified letter. Additionally, review the management of prescription pads in the practice. Keep them with you while seeing patients and secure them at other times. Do not give patients, family members, visitors to the practice, or staff the opportunity to steal a blank prescription.

Please email your risk management consult questions to barbara-rose@tmlt.org.

closed claim study

Failure to diagnose and treat osteosarcoma

by Barbara Rose and Laura Brockway

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. The ultimate goal in presenting this case is to help physicians practice safe medicine. 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 to emphasize the issues of the case.

Presentation

A 16-year-old girl came to the emergency department complaining of pain in her right lower leg. She reported that she had hit her leg just below the knee and that her leg became bruised and swollen and continued to hurt. The nurse noted an 8 cm swollen area just below the right knee. An x-ray of the lower leg was ordered and read by the on-call radiologist. His impression was "poorly defined area of increased density with evidence of cortical erosion and soft tissue ossification in the proximal right tibia which could represent a primary bone neoplasm such as osteogenic sarcoma. Further evaluation is recommended." The patient was told to follow up with her family physician.

Two days later, the patient and her mother came to their family physician's office. The patient reported continued leg pain. In the chart for this office visit, the physician noted he had spoken with the ED radiologist and the radiologist said the patient had "a probable tumor of the right tibia, probably an osteosarcoma." On exam, the physician reported a 4- to 6-cm diameter area of swelling over the proximal tibia. His impression was "probably osteosarcoma," and he referred the patient to an orthopaedic surgeon.

Physician action

Five days later, the patient was seen by an orthopaedic surgeon (the defendant in

this case). He reviewed the emergency room x-rays and ordered new x-rays. His impression was the patient had a subtle fracture of the proximal tibia with some evidence of healing, i.e., a periosteal bone reaction. He put the patient's leg in a cylinder cast that was to stay on for six weeks. The patient was to return in four weeks. He noted in the chart that the patient had been told that "there could be a tumor there," and he stated, "I do not see evidence of that."

When the patient returned four weeks later, she complained of increased pain and tenderness. She also reported having been kicked in the leg a few days before the office visit. X-rays taken that day revealed "abundant calcific reaction in the soft tissues that has not been present previously." The physician noted the patient was developing a hypertrophic calcification, and he placed her leg in a knee immobilizer. He prescribed Vioxx and told the patient to return in two weeks.

As scheduled, the patient returned and continued to complain of pain in the right leg. Upon exam, the physician found minimal tenderness below the right knee, but the area was "firm and somewhat enlarged." After reviewing the x-rays taken that day, the physician stated, "fracture of the proximal tibia has healed. Heterotopic ossification is noted. It is increasing." He prescribed Indocin and asked the patient to return in three weeks.

Three weeks later, the patient returned and reported continued pain. When he examined the patient, he noted a palpable mass just below the knee. X-rays were again taken and the physician interpreted them as showing heterotopic ossification of the proximal right tibia. The patient was instructed to continue taking Indocin and return in one month. The patient never returned to this physician.

Three weeks after her final appointment with the orthopaedic surgeon, the patient visited another family physician in a neigh-

boring town. She complained of leg swelling and pain. The family physician ordered an MRI that was performed two days later. The radiologist stated that the findings from the MRI were "highly suggestive of osteosarcoma." He recommended a tertiary care referral, and discussed these results with the family physician and the orthopaedic surgeon.

The patient was ultimately seen by an orthopaedic oncologist. A biopsy confirmed osteosarcoma and a CT scan revealed bilateral pulmonary metastasis, with as many as eight pulmonary nodules. Although the leg tumor was reduced 95 percent with initial chemotherapy, the oncologist recommended an above the knee amputation in an effort to rid the leg of cancer. The amputation was performed without incident. The patient has subsequently undergone three operations to remove the nodules from her lungs and has been through four cycles of chemotherapy. Her prognosis is very grave.

Allegations

The plaintiff alleged the orthopaedic surgeon was negligent in failing to diagnose osteosarcoma, resulting in a 16-year-old girl having her leg amputated above the knee. There were no allegations that a more timely diagnosis would have increased the patient's chance for survival. The damages revolved strictly around the loss of the leg.

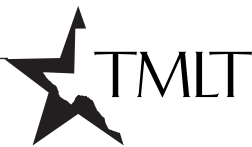
Legal implications

TMLT was unable to locate expert testimony completely supportive of the defendant's care. The defendant himself conceded that he missed the diagnosis and repeatedly expressed his desire to have the case resolved.

There was great debate among the physicians consulted — three general orthopaedic surgeons and two orthopaedic oncologists — as to when the physician should have become suspicious and

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the Reporter



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ordered additional testing. The orthopaedic oncologists stated that additional testing should have been ordered on the patient's first visit based on the radiologist's suspicion of tumor. The two orthopaedic surgeons stated that additional testing was not required at initial presentation, but was necessary when the patient continued to complain of pain after the casting. None of the experts were supportive of the defendant's care after the second visit when findings inconsistent with fracture and heterotopic ossification were present.

One of the main issues for the defense became whether or not an earlier diagnosis would have allowed for a limb salvaging procedure instead of amputation. The patient's orthopaedic oncologist testified that he could have saved the patient's leg if the defendant had made a more timely diagnosis. This opinion was based on his review of the x-ray taken at the emergency department. However, the oncologist admitted on cross-examination that he had never recommended a leg salvage procedure based solely upon plain films. He stated

that CTs and MRIs are necessary to evaluate the size of the tumor and the involvement of the vessels and nerves. The defense was able to locate an expert who testified that the patient's leg was not salvageable. His opinion was also based on the emergency department x-ray. The issue of limb salvage became one of "dueling experts," and it was impossible to definitively state whether the patient was a candidate for limb salvage surgery when she first saw the defendant.

Disposition

With the consent of the orthopaedic surgeon, this case was settled for an amount in the mid-six figures. The lack of a completely supportive defense expert, the subsequent treator's criticism of the defendant, and the sympathetic nature of the patient's condition were all factors in the decision to settle this case.

Risk management considerations

In retrospect, as the series of medical care visits started for this patient, one still cannot ignore the words on the first x-ray report "... could represent a primary bone neoplasm such as osteogenic sarcoma.

Further evaluation is recommended." Several actions did not occur. The emergency department did not contact the family physician to request an order for more imaging studies. Once seen by her family physician and referred to the defendant, the primary care physician did not call the orthopaedic surgeon and share his concerns regarding the x-ray findings. This report was in the orthopaedic surgeon's medical record of the plaintiff. It was not evident the report had been reviewed as there were no physician's initials, date, or comments regarding the findings and impression.

Contemplating prudent practice and risk management in this claim revealed two issues. Communication between physicians was a weakness and became the foundation for exposure and liability when this unfortunate outcome occurred. The need for every practice to have a follow up system to ensure that all reports are reviewed and acted on in a timely manner was evident.

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