

the Reporter

the chest pain conundrum

By Laura Hale Brockway and Barbara Rose

Case 1

A 45-year-old female presented to a small, regional emergency room with complaints of chest pain. The patient reported pain radiating into her back and left shoulder and shortness of breath. She had a history of obesity, high blood pressure and cigarette smoking. The emergency room physician ordered an EKG, which revealed a normal sinus rhythm. The physician ordered a GI cocktail, Pepcid, and released the patient two hours after arrival. The patient returned to the ER the following day with similar complaints of chest pain and excessive gas. She was examined by a physician assistant who ordered a GI cocktail. The patient improved after 15 minutes. She was given a prescription for Zantac and told to see her primary care physician in several days. Early the next morning, the patient returned to the ER via ambulance due to chest pain and difficulty breathing. The physician assistant was again called in to treat her. During the cardiac work-up, the patient relapsed into severe respiratory distress. Resuscitation efforts were unsuccessful and the patient died. An autopsy concluded the cause of death to be acute myocardial infarction.

The patient's family filed suit against the physician, the PA and the hospital. Allegations included failure to diagnose and failure to properly monitor. In reviewing the case, consulting physicians were critical of the care provided by the physician and the PA, for whom the physician was responsible. It was determined that the EKG from the first visit, which was originally read as normal,

showed some abnormalities. There was no EKG on the second visit.

Additionally, the patient was given a GI cocktail at each visit, which did not ultimately resolve her symptoms. Arguably, there were three opportunities for the physician and the PA to diagnose and treat the patient's condition. Given these circumstances, the case was settled with the consent of the physician for an amount in the low six-figures.

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Case 2

A 53-year old woman presented to her family physician complaining of heartburn all night for the past two nights, with no relief from antacids. She reported the pain radiating down her right arm and tightness in her back. The patient had been seeing this physician for four years, had a history of hypertension, a cholesterol count of 223, and “heartburn for years.” A chest x-ray taken three months earlier had shown no evidence of acute cardiopulmonary disease. The patient had a family history of heart disease. Her father died at age 49 and her brother at age 59, both from heart disease.

The physician’s assessment was persistent reflux. He refilled her Zantac and referred her to a gastroenterologist for an esophageal gastroduodenoscopy. At 4 a.m. the following morning, the patient called the physician complaining of chest and back pain since midnight. She reported tightness in her back and spine, mild nausea and was slightly pale. The physician recommended the patient take her husband’s hydrocodone and 3 Zantacs. She was to call back if not better. That afternoon, the patient came to the physician’s office. Four EKGs were done which suggested an anterior myocardial infarction, probably present since that morning. The patient was sent to a local hospital for cardiac enzymes and other diagnostic studies. Upon admission to the hospital, she was taken for an emergency cardiac catheterization. During the procedure, the cardiologist performed a balloon angioplasty and stent of the proximal left anterior descending artery. His assessment was coronary artery disease with 95 percent concentric stenosis of the proximal left anterior descending artery. In his history of the patient, the cardiologist rhetorically asked “acute myocardial infarction — the question is when did this begin and is it still active?” An echocardiogram performed seven months later revealed hypokinesis and an ejection fraction of 37 percent.

In her suit against the family physician, the patient alleged failure to diagnose and treat her condition, failure to refer to a cardiologist, and failure to refer to the nearest ER during the after hours phone call. The patient claimed these actions led to her acute myocardial infarction resulting in loss of heart function. Defense experts evaluating this case were critical of the family physician’s actions, specifically his failure to note and assess the patient’s multiple cardiac risk factors. The family physician should have questioned the patient further regarding the nature of her chest pain, and should have considered doing an EKG during the office visit. Further, given her symptoms and risk factors, the patient should have been directed to the ER during the 4 a.m. phone call. However, there was also some speculation as to whether or not a full cardiac work up (either during the visit or in the months before) would have prevented the MI. Defense experts also argued that the MI began around midnight, when the patient began experiencing pain, and was well progressed by the time she contacted her physician at 4 a.m. This case was taken to trial, and the jury found in favor of the plaintiff. The verdict was in the high six figure range.

Chest pain

Chest pain is a common clinical problem and the most frequent reason for urgent office visits, after abdominal

pain.¹ But, as these cases illustrate, patients whose chief complaint is chest pain present a “diagnostic and therapeutic challenge” to physicians.

It has been widely acknowledged that many patients with chest pain or related symptoms have conditions unrelated to coronary artery disease. Of the 600,000 patients who undergo cardiac catheterization each year, 30 percent are found to have normal coronary arteries. The esophagus is found to be the source of chest pain in 20 to 60 percent of patients with normal angiograms.²

“Many other patients will have a noninvasive cardiac evaluation that is considered to exclude coronary artery disease, leaving at least 450,000 new patients with unexplained chest pain seen annually in the United States.”³

And while many cases of chest pain are the result of gastrointestinal disorders, it is still important to note that many life-threatening patient conditions can masquerade as chronic heartburn or gastroesophageal reflux disease (GERD).

“The diagnoses for patients with chest pain range from minor disease processes such as chest wall strain or indigestion to life-threatening conditions such as acute myocardial infarction (AMI) or aortic dissection. Not only does missing a life-threatening condition result in potential serious morbidity and mortality to the patient, but this represents a frequent cause of malpractice suits . . .”⁴

According to closed claim data from the Physician Insurers Association of America, the most common patient condition associated with claims against family and internal medicine physicians was AMI. The most prevalent misadventure for both specialties was error in diagnosis. Of these claims, AMI was the most prevalent condition incorrectly diagnosed by family physicians. For internal medicine physicians, AMI was the second most prevalent condition misdiagnosed.

AMI was also the most frequent and expensive medical condition seen in claims against emergency room physicians. The majority of AMI claims reported a misadventure of error in diagnosis. The second most frequent condition for emergency department claims was an aortic aneurysm. Both conditions may present with symptoms that mimic heartburn or GERD. (PIAA data is based on malpractice claims reviewed from 1985 to 2001.)⁵

In addition to myocardial infarction, TMLT has seen cases of a ruptured abdominal aortic aneurysm and an aortic dissection in which symptoms were originally diagnosed as “gastric in origin.”

Difficulties in diagnosis

Studies have demonstrated that even experienced physicians cannot easily differentiate cardiac and non-cardiac causes of chest pain. “One study has shown that 25% of patients with chest pain evaluated by a cardiologist were misdiagnosed for coronary artery disease clinically compared to angiographic findings.”⁶

According to the American College of Cardiology/American Heart Association guidelines, the first and most important step in evaluating patients with chest pain is obtaining a detailed history of the pain. “Five components are typically considered: quality, location, duration of pain, factors that provoke pain, and factors that relieve pain.” The guidelines state that angina is never sharp or stabbing, usually does not change with position, is generally precipitated by exertion or emotional stress and lasts minutes in duration.⁷

In cases of aortic dissection, the pain is sudden and severe. Patients often describe a “ripping,” “cutting,” or “tearing.” “The chest pain in acute myocardial infarction is said to be more gradual in onset and more heavy or crushing in character than the immediately intense tearing quality of aortic dissection.”⁸

Case 1 illustrates another common caveat in assessing patients with chest pain — the nondiagnostic EKG. “The 12-lead EKG is the standard assessment for possible ACS (acute coronary syndromes). It is fast and economical, but an initial EKG is at best only 50% sensitive for detection of AMI. Normal EKGs, or confounding and atypical patterns all can distract the physician from diagnosing a true ACS in progress.”⁹

According to several studies, one to 15 percent of patients with normal EKGs at initial presentation to the ED are ultimately diagnosed with acute myocardial infarctions.¹⁰ “Clearly, the initial EKG carries helpful diagnostic information but should be viewed as inadequate to rule out the possibility of AMI completely. Most authors recommend serial EKGs to improve sensitivity in patients who have near-normal initial EKGs.”¹¹

Physicians should also be aware that clinical history does not always safely distinguish coronary from esophageal pain. “Gastroesophageal reflux disease (GERD) may be triggered by exercise and may cause exertional chest pain that mimics angina pectoris, even during exercise testing. The presence of other esophageal symptoms such as heartburn, dysphagia, regurgitation, or odynophagia suggests an esophageal etiology but does not confirm it. Other features that suggest an esophageal origin for the pain include pain that lasts for > 2-3 h, pain that does not radiate laterally, meal-related pain, pain that is relieved by antacids or pain that awakens the patient.”¹²

Diagnostic difficulties are compounded by the fact that a patient may have coronary artery disease and esophageal disease concurrently. Given the predominance of both conditions in the United States, the likelihood that a patient could have both is high. Thus, a definitive diagnosis becomes even more difficult.

“Unfortunately, as many as 50% of patients with cardiac pain also have one or more symptoms of esophageal pain. This overlap exists because the prevalence of both cardiac disease and GERD increases as people grow older. Therefore, both problems may coexist, may complicate the diagnostic evaluation and may interact in producing chest pain. Nevertheless, the clinician must always first exclude anginal chest pain, as the consequences of missing heart disease — when compared to GERD — are much more deadly to the patient.”¹³

“Because of the difficulty in differentiating cardiac from esophageal pain, a thorough cardiac evaluation is recommended as the initial approach in patients with recurring substernal pain. The nature of the workup is determined by numerous factors, including the patient’s age and other cardiac risk factors. Although a noninvasive workup with an electrocardiogram, exercise testing and perhaps echocardiography is sufficient to rule out cardiac disease in a young person (age < 40 yr), the gold standard remains coronary angiography.”¹⁴

Algorithms demonstrating diagnostic and therapeutic approaches to patients with chest pain are widespread in the medical literature. All algorithms reviewed for this article agreed that coronary artery disease should first be excluded when diagnosing and treating patients with chest pain.

Non-cardiac or unexplained chest pain

Once coronary artery disease has been ruled out, physicians often focus on other etiologies. “The cornerstone in evaluating patients with UCP (unexplained chest pain) in whom cardiac disease has been excluded is a thorough history and physical examination. This should be centered on ruling out diseases of the upper GI tract, biliary tree, chest wall and pulmonary system that can manifest as chest pain.”¹⁵

Among patients with non-cardiac chest pain, GERD has been implicated in 23 to 80 percent of these cases.¹⁶

“Confirming the esophagus as the source of pain in these patients may require upper endoscopy, ambulatory 24-hour esophageal pH monitoring, esophageal manometry, esophageal balloon distention or other less commonly used tests. These studies are invasive, costly and not always readily available in the primary care setting. More significantly, when the results are positive, these tests correlate only with NCCP (non-cardiac chest pain) symptoms; when the results are negative, they do not rule out the esophagus as the cause of the pain.”¹⁷ While ambulatory pH monitoring is considered the diagnostic gold standard for patients with GERD, recent studies have demonstrated a role for omeprazole, a proton pump inhibitor, in the diagnosis of GERD. “Because of the efficacy of omeprazole in relieving reflux symptoms, failure to respond to this proton pump inhibitor warrants investigation of other possible causes for a patient’s symptoms.”¹⁸

Although GERD is believed to be the main cause of non-cardiac chest pain, other non-gastrointestinal causes have been cited in the literature. These include microvascular angina, psychiatric disorders such as panic attack, and mitral valve prolapse.¹⁹ While these are most likely less common causes of non-cardiac chest pain than GERD, they can still create a diagnostic dilemma.

“Ultimately, the answer to the vexing — and expensive — problem of recurring unexplained chest pain is an ‘old-fashioned’ clinical approach, with early patient education and evaluation, followed by carefully chosen therapy and follow-up reinforcement.”²⁰

Risk management considerations

Common features in cases of missed myocardial infarction in the ED correlated with litigation. They include failure to take and record a careful history, misinterpretation of the EKG, failure to recognize atypical presentations, reluctance to admit patients with vague or suspicious symptoms, misguided use of laboratory evidence, and the inadequacy of the physician’s ED training and experience.²¹ A comprehensive history and assessment of a patient’s cardiac risk factors are the foundation for detecting cardiac symptoms. The family history is an integral part in determining risk. Primary and emergency physicians may, when in doubt, consider new complaints of undiagnosed chest pain as cardiac in nature until proven otherwise.

The first case illustrates a patient with demographics that may not give rise to the suspicion of coronary symptoms. The patient was young and female. “Despite public perception and current trends in funding priorities for clinical research, cardiovascular disease is the number one killer of women in the U.S.”²²

Physicians in the ED and office-based practices face complex and difficult challenges when evaluating patients with chest pain. Misdiagnosis of ACS does

“result in potentially catastrophic and subsequently litigious outcomes.”²³ The competing forces of the physician’s desire to find a correct diagnosis versus the emphasis of cost containment has led to the American College of Emergency Physicians implementation of chest pain evaluation units (CPEU) for patients presenting to the ED with chest pain.

It is not uncommon for the ED in small hospitals to be staffed with physicians who did not complete a residency in emergency medicine. The physician in the first case also employed a PA and assumed vicarious liability for his actions when covering the ED. Hospital administrators, their employees, and the physicians who staff these small emergency departments are at no less risk in regard to patient expectations for a competent medical examination and appropriate intervention. When a patient returns to the ED or contacts his/her physician again with complaints indicative of cardiac or gastroesophageal symptoms, that provides an additional opportunity for those on duty to look further.

As with all closed claims, the outcome is known and those reviewing the case have hindsight to their advantage. Accurate and timely documentation of patient complaints, a comprehensive patient and family history, appropriate medical examination and tests, basis for treatment decisions and follow up, along with patient education and acknowledgment of understanding create the foundation for a complete medical record. The medical record serves as the basis for defending a physician and if complete and accurate can make the difference. Whether an ED record or one created in the office based practice, all encounters with the patient should be complete and timely and include phone contacts during and after hours.

Sources

1. Lawrence L. National Center for Health Statistics. *Detailed diagnosis and procedures for patients discharged from short stay hospitals, United States*. 1984. U.S. Department of Health and Human Services, 1986: Vital and Health Statistics, series 13:86.
2. Nevens F, Janssens J, Piessens J, et al. The contribution of gastroesophageal reflux to chest pain in patients referred on an elective basis to a cardiac unit for suspected myocardial ischemia. *Dig Dis Sci*. 1991; 36:229-35.
3. Katz PO. Approach to the patient with unexplained chest pain. *Semin Gastrointest Dis*. 2001 Jan; 12 (1): 38-45.
4. Clinical policy: critical issues in the evaluation and management of adult patients presenting with suspected acute myocar-

5. A risk management review of malpractice claims: General and Family Practice, Internal Medicine. 2002. PIAA. Rockville, MD.
6. Katz PO, Castell, DO. Approach to the patient with unexplained chest pain. *Am J Gastroenterol*. 2000 Aug; 95 (8 Suppl): S4-8.
7. ACC/AHA 2002 Guideline Update for the Management of Patients with Chronic Stable Angina. November 17, 2002.
8. Chen K, Varon J, Wenker OC, Judge DK, Fromm RE Jr, Sternbach, GL. Acute thoracic aortic dissection: the basics. *J Emerg Med*. 1997 Nov-Dec; 15(6): 859-67.
9. Ghaemmaghami CA, Brady WJ Jr. Pitfalls in the emergency department diagnosis of acute myocardial infarction. *Emerg Med Clin North Am*. 2001 May; 19(2): 351-69.
10. Burt CW. Summary statistics for acute cardiac ischemia and chest pain visits to United States EDs, 1995-1996. *Am J Emerg Med*. 1999 17: 552-559.
11. Ghaemmaghami CA, Brady WJ Jr. Pitfalls in the emergency department diagnosis of acute myocardial infarction. *Emerg Med Clin North Am*. 2001 May; 19(2): 351-69.
12. Katz PO, Castell, DO. Approach to the patient with unexplained chest pain. *Am J Gastroenterol*. 2000 Aug; 95 (8 Suppl): S4-8.
13. Richter, JE. Chest pain and gastroesophageal reflux disease. *J Clin Gastroenterol*. 2000; 30 (Suppl.): S39-41.
- 14-15. Katz PO, Castell, DO. Approach to the patient with unexplained chest pain. *Am J Gastroenterol*. 2000 Aug; 95 (8 Suppl): S4-8.
- 16-17. Pandak WM, Arezo S, Everett S, et al. Short course of Omeprazole: a better first diagnostic approach to noncardiac chest pain than endoscopy, manometry or 24-hour esophageal pH monitoring. *J Clin Gastroenterol*. 2002; 35:307-314.
18. Scott M, Gelhot AR. Gastroesophageal reflux disease: diagnosis and management. *Am Fam Physician*. 1999 Mar 1: 59(5): 1161-1199.
19. Borzecki AM, Pedrosa MC, Prashker MJ. Should noncardiac chest pain be treated empirically? A cost-effectiveness analysis. *Arch Intern Med*. 2000 Mar 27; 160(6): 844-52.
20. Botoman VA. Noncardiac chest pain. *J Clin Gastroenterol*. 2002 Jan; 34 (1): 6-14.
21. Rusnak, RA, Stair, TO, Hansen K, et al: Litigation against the emergency physician; common features in cases of missed MI. *Ann Emergency Med*. 18: 1029-1034, 1989.
22. Ghaemmaghami CA, Brady WJ Jr. Pitfalls in the emergency department diagnosis of acute myocardial infarction. *Emerg Med Clin North Am*. 2001 May; 19(2): 351-69.
23. Clinical policy: critical issues in the evaluation and management of adult patients presenting with suspected acute myocardial infarction or unstable angina. American College of Emergency Physicians. 2000.

HIPAA reminder



The Privacy Rule compliance deadline has passed but other HIPAA regulation deadlines are still to come. The compliance date for the Transaction and Code Sets is October 16, 2003. If your office filed for an extension last year, you should be working on implementation of that plan. If no extension was filed, your billing operation is considered HIPAA compliant. The final Security Rule has been published and compliance is expected by April 21, 2005. We encourage all offices to continue educating themselves on these federal regulations.

Helpful web sites: www.cms.gov
www.hipaadvisory.com

Don't make me sue you!

Why patients sue physicians



Objectives

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

1. Discuss the primary reasons patients file lawsuits against physicians.
2. Identify 4 factors that may influence a physician's risk for claims.
3. Recognize practical strategies to avoid litigation and enhance defensibility in the event of a lawsuit.

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 sponsor continuing medical education for physicians. TMLT takes responsibility for the content, quality and scientific integrity of this CME activity.

TMLT designates this continuing medical education activity as meeting the criteria for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians should claim only those hours 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 article in its entirety 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 forms 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 June 10, 2003, and expires on June 10, 2005.

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

According to a 1999 survey conducted by *Medical Economics*, the majority of physicians who have never been sued attribute that fact to an effective physician-patient relationship based on sound communication and shared respect. This result is also reflected in conversation with TMLT policyholders who have practiced many years and never been sued. This article will explore both the reasons patients may decide to file a claim against their physician(s) and those factors influencing a patient's decision not to sue.

Who is likely to sue his/her physician?

Myths abound regarding who is more likely to file a medical malpractice claim. Generalizations are held, without empirical data, that patients with lower levels of education or those who are unemployed or without health insurance are more likely to file a lawsuit. There is no published research proving a correlation between socio-economic status, educational level, or employment status and the decision to sue. Those with higher educational levels may routinely seek preventive care, spend more on their health care and have inflated expectations of their health care providers.

Why do patients sue their physician(s)?

If physicians are asked, they often identify unrealistic patient expectations as the underlying cause of malpractice suits. M. Beth Krugler, attorney, mediator and licensed professional counselor, conducted a survey of Texas attorneys whose average experience in medical malpractice was 14 years. Fifty-two percent of those participating were primarily affiliated with the plaintiff bar and 48 percent with the defense bar. Plaintiff and defense counsel were asked which issues motivate most plaintiffs to file a suit and to rank those reasons. Both cited physician indifference or perceived indifference and the patient "left looking for answers" regarding what went wrong as the top two reasons. Anger at the situation and an allegation of inadequate information prior to care with an unexpected outcome are inextricably connected to the patient looking for answers. Technical error relates to improper performance of a procedure, iatrogenic injury, equipment failure/injury, and wrong site surgery. Mounting medical bills leading to frustration with the health care provider requesting payment and perhaps planning referral to a collection agency coupled with unexpected treatment results may provoke a patient to seek legal counsel. Patient anger at an HMO for denial of services may negatively affect the physician-patient relationship. Hopes of "winning the lottery" may be more prevalent in class action suits involving medication recalls and product liability where media coverage is extensive. A failure or delay in referral or consultation is linked to the allegation of failure to diagnose and treat in a timely manner. Number six, other, included reasons such as friend or family member urging contact with an attorney.

Case study

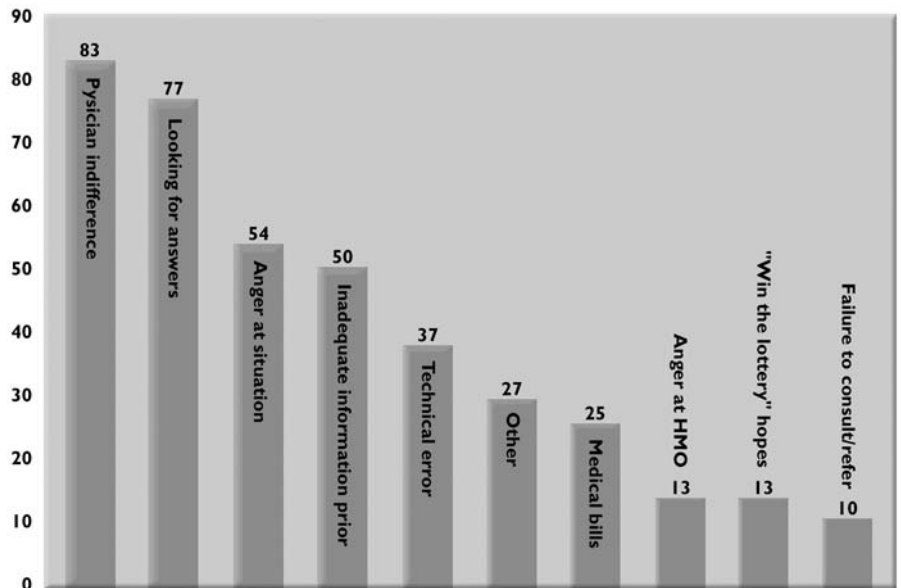
Clinical presentation

A 47-year-old male, who had been seeing his family practitioner (the defendant in this case) for four years, presented with complaints of chest pain. The patient stated that he had experienced the pain for two to three months, and it seemed to be related to his occupation as a carpenter. Upon examination, his blood pressure was 168/100, he had no shortness of breath or pain at rest. No other symptoms were evident at this time. Current medical history was remarkable for insulin-dependent diabetes, hypertension, alcohol abuse and arthritis. At this visit a diagnosis of atypical chest pain was made.

Physician action

A thallium stress test was recommended and a referral made to a cardiologist. Results

Why do patients sue their physicians?



of the stress test were forwarded to the family physician and indicated there were ST ischemic changes. After reviewing the test, the physician sent a letter to the consulting cardiologist asking that he also evaluate the patient, and give his clinical impression. The cardiologist responded by letter that only the treadmill test had been authorized, but he would be pleased to evaluate the patient. A referral was made for a cardiology consult and the patient was seen. During review of this case, it was discovered the consultant's report was not in the patient's record at the primary practice. The defendant could not explain why the report was not in the record.

On subsequent visits to the defendant's office, the plaintiff's hypertension had not resolved and medication changes were made. The patient remained free of chest pain during these appointments until a visit when he complained of epigastric pain radiating to his throat. An assessment of this new symptom was not documented in the medical record. Two weeks later the patient was found dead by his wife. The autopsy revealed coronary artery sclerosis, myocardial scarring and cardiomegaly.

Allegations

Allegations in the case included failure to follow up on diagnostic exam and failure to properly assess patient's complaints.

Case analysis

As the ordering physician, the family practitioner was ultimately responsible for

obtaining the cardiologist's completed report. Every office can develop a referral follow up process to track receipt of consultant reports and act on the absence of those not received in a timely manner. Consultant reviewers were critical of the physician for not getting the report. There was also criticism of the fact that no EKG was done on the patient's last visit and no documentation of a cardiac assessment. Since the patient was hypertensive, diabetic, and experiencing episodes of angina, the experts reviewing this case stated most physicians would have ordered more comprehensive tests based on the risk factors and symptoms. It was felt that the family physician had the final opportunity to prevent this patient's death. With the defendant's consent, this case was settled for \$100,000. Was this physician indifferent? Not likely, but perceptions such as this are difficult to overcome. The spouse and children were angry and looking for answers.

According to an article in the *Archives of Internal Medicine*, there is a problematic physician-patient relationship in 70 percent of all medical malpractice cases. Either the physician appeared not to care, did not listen or did not spend enough time with the patient. When patients sue a physician, they may be inclined to enhance their lawsuit with claims that the defendant was insensitive, in a hurry and failed to communicate effectively regarding their condition.

Patients with unexpected outcomes may allege they received inadequate information prior to surgery and other procedures as well

as treatment regimens including medications with known risks. Effective education and comprehensive informed consent with detailed documentation of these processes may defend the physician or prevent a lawsuit from having any merit. The patient with realistic expectations and demonstrated understanding of follow up instructions, both clearly documented, may be less likely to file a lawsuit. The combination of a bad outcome and patient dissatisfaction is a recipe for litigation.

Case study

Clinical presentation

For several months a truck driver in his early 20s had been experiencing short spells of detachment from reality as well as brief periods of dizziness which came and went without known cause. Two grand mal seizures were experienced by the patient four weeks apart. He did not seek medical care until the second seizure occurred and the patient presented to the emergency department. A skull x-ray was done, IV Dilantin administered and a referral made to a neurologist for an appointment two days later.

Physician action

The neurologist admitted the patient to the hospital with a provisional diagnosis of convulsive disorder of unknown origin. The patient reported a closed head injury one year earlier with no loss of consciousness. There was no evidence of infectious disease process of the central or peripheral nervous systems relating to present symptoms. The patient had no known drug allergies and no family history of nervous system diseases.

The neurological examination found a well nourished, well developed male who was cooperative, oriented times three, and whose vital signs were within normal limits. Neurological examination of the head did not disclose the presence of external injury or deformation. Encephalogram did not reveal any shifting of the midline structures. His neck had fair range of motion with no signs of injury. The cranial nerves, motor system, sensory system, and cerebellar system were intact. The patient had fair range of motion in his back and straight leg raises were to 90 degrees bilaterally. Skull and chest x-rays were normal. Doppler studies indicated bilateral normal carotid circulation. The Dilantin level was 4.7, which is not within therapeutic range. Some cardiac arrhythmias were noted on the EKG. Long term EEG monitoring was normal. Seizure disorder of unknown etiology was diagnosed and Dilantin 400 mg prescribed at bed time. The patient was discharged after an inpatient stay

of five days with an appointment in the physician's office in three days and discharge instructions to stay home and not return to work.

When seen in the neurologist's office, the patient was instructed to continue the Dilantin with an emphasis on medication compliance and this was documented in the medical record. A release to return to his regular work duties without any restrictions was issued for the patient. An entry in the medical record stated "discussed with employer," but the details of the information were not included. No limitation on driving a truck was mentioned in the record nor were the Department of Public Safety guidelines concerning operation of a motor vehicle after diagnosis of seizures.

At a follow up appointment three weeks later, the patient reported no seizure activity in the interim. Dilantin was continued and his next appointment scheduled in six months. That appointment was not kept and it was later determined the Dilantin had not been refilled on schedule. One month after the missed appointment, the patient experienced a seizure while driving a cement truck, drifted into the oncoming lane, and struck two vehicles. The patient and one driver suffered minor injuries but there were two fatalities in the other vehicle. The families of the victims brought suit against the neurologist.

Allegations

Allegations in the case included failure to advise the patient not to drive and to warn of the dangers in doing so, and negligent release of the patient to return to work and drive.

Case analysis

A physician has a duty to inform his patients of the nature of their diagnosis and advise them of any activities that may be hazardous to their condition or pose a danger to others. Failure to do so may result in the physician being found negligent and liable for injury not only to the patient but also for patient actions that result in harm to others. A patient warned of the possibility of injury if he/she continues to drive or operate dangerous machinery can be held negligent with respect to the safety of others as well as himself/herself. The physician who conscientiously instructs the patient and documents this in the medical record is unlikely to be found responsible for the actions of that person and may aid in the defense of a malpractice claim. Extra steps must be taken if guidelines from the Department of Public Safety are applicable to a patient's condition. According to the federal code, CFR 391.14

(Physical Qualifications for Drivers) §391.41 (b) 8 (Epilepsy), persons may not be qualified to drive if they have 1) a medical history of epilepsy; 2) a current clinical diagnosis of epilepsy; or 3) are taking antiseizure medication.

Patients warned of the dangers of driving or operating machinery may be found negligent with respect to the safety of others and themselves. Physicians who clearly document in the medical record that their obligation to educate and inform patients has been fulfilled are unlikely to be held accountable for patients' actions. In making a decision regarding return to work, it is important to understand the patient's job duties. Then specific warnings and instructions given to the patient and employer can be written for them with a copy included in the medical record. Because this patient's return to work form and medical record lacked adequate documentation regarding driving and no report had been made to the Department of Public Safety or the Medical Advisory Board, the decision was made to settle this claim.

Note: Texas Department of Public Safety (DPS) rules provide that certain physical or mental conditions, the extent of which cannot be determined by DPS, are referred to the Medical Advisory Board for further evaluation. The Board assists the DPS in determining whether an applicant for a driver's license or a licensed driver is capable of safely operating a motor vehicle. Conditions for referral include, but are not limited to eye diseases, cardiovascular diseases, diabetes mellitus, respiratory conditions, impairment of upper or lower extremities, neurological disorders, mental or emotional disorders, drug or alcohol abuse, and musculoskeletal disorders. A physician licensed to practice medicine in Texas may voluntarily inform the Medical Advisory Board of the DPS orally or in writing, of the full name, date of birth, and address of a patient over 15 years of age who the physician has diagnosed as having one of these conditions. The release of this information to the Medical Advisory Board is an exception to the patient-physician privilege.

Who is likely to get sued?

Studies conducted to identify the profile of physicians who are sued have not revealed consistent criteria. However, research has reliably shown that the area of medical specialization does correlate to a certain degree with the likelihood of being sued. Dr. G.B. Hickson's research on this topic for 15 years has identified four factors influencing a physician's risk for generating claims of malpractice. These include physician specialty, the number of unsolicited complaints they receive, their productivity and gender. The study analyzed data from 6,000 physi-

cians in 11 institutions reflecting a variety of settings including academic, urban and rural.

The table at the bottom of the page shows the national closed claim data of the PIAA's Data Sharing Project from 1985 through 2000.

Historically, surgeons and obstetricians have been sued more frequently than other physicians. These specialties are usually considered as having more risk. However, the influence of managed care may be reflected in the chart with the appearance of internal medicine, family practice and pediatrics in the top six based on number of claims. The primary care physician in health care today has an expanded role in the management of his/her patients. With the impetus to control costs and constraints of in network care, the time and energy required to do the right thing for the patient can be significant. Responding to denials of medical services for the patient who legitimately needs that specialist, test, procedure, etc., or perhaps, not making the referral or ordering the test, may lead to more frequent allegations of physician failure to diagnose.

In analyzing data compiled from unsolicited complaints, Dr. Hickson found that 9 percent of physicians account for 50 percent of complaints. His latest study replicated this outcome with 8 percent of physicians involved in 48 percent of all medical malpractice claims. In interviewing those who claimed injury, communication, care and treatment concerns, access and availability, and the "humaneness" of the physician, were identified as the primary categories prompting legal action. Dr. Hickson's research indicates an adverse event or unexpected outcome by itself may not prompt a lawsuit. However, if you add a pre-existing adversarial relationship or one that deteriorates after an adverse event, the likelihood of a claim increases.

Although more research needs to be done regarding the significance of physician productivity as a factor, one may surmise that the more patients a physician treats, the higher the risk for a lawsuit. Dr. Hickson believes more than numbers are involved and may reflect a physician's need to see more patients than others with evidence of a personality type. Does it describe the workaholic or one for whom economic security is paramount? Does this factor have a link to poor reimbursement for medical services thus creating the necessity to schedule more patients? The "more the better" philosophy may spell problems for a physician as it translates into less time with the patient, and decreased accessibility thus planting the seeds for patient dissatisfaction and complaints.

There is no empirical data to explain why men are more likely to be sued than women.

Speculation includes: the female physicians in the study may be better communicators; the women were less likely to practice disciplines known to have high risk for malpractice claims (ob/gyn the exception); or patients may be less likely to sue a woman.

What are reasons for patients not suing their physicians?

Of the trial attorneys participating in M. Beth Krugler's survey, 90 percent were aware of a case(s) where the patient/family decided not to file a lawsuit when the situation may have supported a finding of negligence on the part of the physician. Survey participants were asked to list reasons a suit was not filed. The following were cited in order of prevalence:

1. relationship with physician/perceived integrity of the physician;
2. no desire to prolong the pain; wanting to move on with their lives;
3. personal philosophy/religious beliefs;
4. damages insufficient to justify litigation;
5. inter-family conflict regarding decision to sue;
6. intimidated to sue physicians/health care providers;
7. need for future medical care and concern suit could jeopardize future treatment (Tie) lack of trust in the legal system;
8. plaintiff not wanting to risk "airing dirty laundry."

The number one reason reinforces the opening statement in this article. Physicians who have never been sued consistently cite an effective physician-patient relationship built on communication and shared respect. Compassion enhances competency and trust in a therapeutic interaction between patient and physician.

In 1990, the Texas Medical Association (TMA) asked physicians who had practiced for 20 years or more without a malpractice suit to describe their strategies for managing patient relationships. More than 200 physicians responded to the survey. Their responses along with information from interviews of malpractice plaintiffs compiled the following profile of the physician least likely to be sued:

- She lets the patient know that physician and staff are genuinely concerned about the patient's welfare. Nothing predisposes a patient to sue faster than the impression that the physician does not like or does not care about him.
- He never forgets that even the best doctors are fallible human beings, not earth-bound deities. Physician arrogance offends every segment of the population except one: malpractice plaintiff's lawyers. They love it because juries despise it.
- She makes sure that the staff treats all patients with dignity and respect at all times, even when the patient does not reciprocate.
- He ensures that all phone calls are returned as promptly as possible and that patients never feel left to fend for themselves.

Who is sued and what is the outcome?

Specialty	Number of claims	% closed w/payment	Average payout
Ob/gyn (surgical)	22,980	36%	\$235,059
Internal medicine	21,591	27%	\$169,381
Family/general practice	19,043	36%	\$132,356
General surgery	17,974	35%	\$151,810
Orthopaedic surgery	16,440	30%	\$138,799
Pediatrics	5,022	29%	\$232,499
ENT	2,654	32%	\$167,855
Neurology	2,607	22%	\$266,881
Cardiovascular (no surgery)	2,402	19%	\$199,378
Emergency medicine	2,337	29%	\$144,092
Gynecology	1,904	32%	\$117,343
Dermatology	1,854	31%	\$94,347
Gastroenterology	1,286	21%	\$147,234

- She listens to the patient carefully without presuming that she already knows what the patient is trying to say or that it is not important.

- He educates the patient about the plan of treatment, potential risks involved, and alternatives that are available. The physician solicits and answers the patient's questions, then allows him/her to decide, without coercion, whether to accept the recommended treatment.

- She immediately and honestly accepts responsibility for her own mistakes, apologizes, and makes amends whenever appropriate.

- He makes sure that the patient understands all charges billed, offers to negotiate any disputed charges, and makes allowances when emergencies or hard times make it difficult for patients to pay.

- She exchanges information with other health care providers involved in the patient's care.

- He maintains a legible chart with current and carefully documented recommendations and prescriptions as well as the patient's noncompliance or refusal to accept treatment.

- Above all, the physician remembers that he/she is first and foremost the patient's advocate and places the patient's best interests above all other considerations.

James E. Schutte, PhD, author of *Preventing Medical Malpractice Suits*, describes this profile as not that of a "super-doctor but of a conscientious practitioner who maintains the standard of patient care to which physicians have always been held accountable." These are the tools of highly effective physicians.

Situations where a suit was not filed (Excerpts from Dr. Schutte's book, *Preventing Medical Malpractice Suits*):

An obvious case of negligence does not always provoke a lawsuit as long as the patient is treated properly, kept informed, and values the relationship with his physician. Consider the case of a general surgeon who left forceps inside a patient during a cholecystectomy. The oversight was discovered from a postoperative x-ray. This potentially disastrous situation was handled honestly and quickly. The physician showed his patient the x-ray and proclaimed: "George, you have my favorite pair of forceps still inside you. Now I'm not blaming you. I know you didn't mean to keep them. But frankly, I can't practice without them. So if you will let me get them back, I won't charge you for any of my services, including the first surgery. Not only that, but I will give you another three days' vacation — all expenses

paid! — in this splendid hospital." According to this physician, "George just laughed and said he could use another three days of rest. Not only did he not sue me, but he is still my patient."

A hospital administrator reports a case involving a family practitioner on staff for many years. This physician had been caring for a 40-year-old diabetic for 20 years. The patient was married and a father of five. His diabetes had never been adequately controlled and the patient expired in the emergency department from an insulin reaction. The administrator feared the worst scenario and notified the risk management staff to prepare for a possible lawsuit. Meanwhile the patient's family sent a floral arrangement to the physician with gratitude for all he had done over the years and requested he attend the funeral. A few days after the funeral, a plaintiff's lawyer contacted the family and suggested they might have grounds for a malpractice suit against the family physician. Not only did the family angrily refuse the attorney's suggestion, they threatened to sue the hospital for deliberate infliction of emotional pain as they were convinced someone at the hospital had leaked the patient's death to the attorney. The widow was furious with the hospital administrator and asked: "how could I dare betray the closest friend my husband and I ever had."

Conclusion

Laying the foundation for building patient satisfaction is not a complicated art. It requires awareness, trust, and a commitment to the tenet that patients are often fearful, vulnerable, and in need of affirmation of their humanness in a depersonalized world. The physician is no less human and having that in common with his/her patients should serve as the foundation for mutual respect. Perfection is not achievable in life and physicians may build a relationship with patients based on trust that has been earned without discounting human frailty. Educating patients and consenting patients with current information about the risks, benefits, and alternatives of recommended medical or surgical procedures, coupled with disclosure of unexpected outcomes, may not end unrealistic expectations and suits against physicians. Perhaps these practices will result in a decrease in the 80 percent of malpractice claims that have no merit. If fewer patients seek legal counsel due to perceived physician indifference and a quest for answers regarding their medical care, suits may decline.

Sources

1. Crane, Mark. Malpractice Wars. *Medical Economics*. July 26, 1999.
2. Krugler MB. *Was It Something I Said? Analyzing the Underlying Psychology of Litigation*. 1999.
3. Beckman HB, Markakis KM, Lushman AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med*. 1994; 154:1365-1370.
4. Meyers AR. Lumping it: the hidden denominator of the medical malpractice crisis. *AJPH*. 1987; 77: 1544-1548.
5. Hickson GB, Clayton EW, Entman SS, Miller CS, Githens PB, Whetten-Goldstein K, Sloan FA. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA*. 1994; 272:1583-1587.
6. Hickson GB, Clayton EW, Githens PB, Sloan F. Factors that prompted families to file medical malpractice claims following perinatal injuries. *JAMA*. 1992; 267: 1359-1363.
7. Physician Insurers Association of America. PIAA research notes: primary care managers focus on Internal Medicine & General & Family Practice. Winter 2002.
8. Robeznieks A. Being open may avoid lawsuits. *American Medical News*. June 10, 2002; 13-16.
9. Howard CH, Leonard JP. *The anatomy of a medical malpractice lawsuit*. Holland & Knight, LLP. October 9, 2001.
10. Greenwald, LM. Patient satisfaction: a measure of risk management success. ProMutual Group. Boston. 1999
11. Schutte, JE. *Preventing Medical Malpractice Suits*. Hogrefe & Huber Publishers, 1995.

CME test questions

Instructions: Using black ink, read each question, select the best answer, and then clearly mark your selection. When you have completed the test, please fax it to the TMLT risk management department, attention Natalie Gilmore (512) 425-5996. A certificate of completion will be mailed to the address you provide below.

1. Reasons patients file lawsuits according to a survey of Texas attorneys include:
 - a. unrealistic expectations and hopes of "winning the lottery"
 - b. looking for answers and physician indifference
 - c. failure to consult or refer
 - d. both b and c

2. The PIAA Data Sharing Project revealed the largest payouts in claims against:
 - a. pediatricians
 - b. neurologists
 - c. internal medicine
 - d. obstetrics/gynecology

3. Physicians who have had lawsuits filed against them have:
 - a. good luck
 - b. an effective physician
 - c. shared respect and respect for others
 - d. both b and c

4. Factors that may increase the risk of a lawsuit include:
 - a. gender
 - b. unsolicited commercial solicitations
 - c. physician specialization
 - d. all of the above

CME evaluation form

Please complete the following questions.

1. The objectives for this activity are:
2. The material will be helpful to me in my practice.
3. Did you perceive any commercial interest in this activity?
4. How long did it take you to complete this activity?
5. On a scale of 1 to 5, how effective was this activity in meeting the objectives?
6. Suggestions for improvement:
7. Suggestions for future activities:

Expired CME

- 1.25 hrs
- 4 5

8. What will you do differently in your medical practice after reading this article?

Contact information

Name _____ Phone _____

Address _____

Email (to have your certificate emailed) _____

The Reporter will feature a bimonthly column to answer your most frequently asked questions about asset protection. We invite you to email or write Ken Vanway with your questions, ken@vanway.org or Law Office of Ken H. Vanway, P.C., First Commercial Bank, 1110 RR 620 South, Suite B, Austin, Texas 78734.

The information provided in this article is not to be construed as legal advice and should not be relied upon without specific consultation with a professional.

The perfect corporate structure — Part 1

Why incorporate — advantages and disadvantages

You can create a corporation for your medical practice and become an employee of your own professional corporation and thus attain some asset protection and income tax benefits. Only by being incorporated can you take advantage of the income tax advantages, including deductions for:

1. Life insurance
2. Health insurance
3. Disability income
4. Account Receivables factoring/leveraging
5. Equity Disability Trusts (EDT)
6. Malpractice Equity Trusts (MET),
7. Captive Insurance Companies (CIC)
8. ExTRA plan
9. Pension rescue
10. Long term care
11. Life annuity
12. PEO model

While incorporation does not protect your personal assets from your own medical malpractice, it **does offer the following benefits:**

1. Protection from claims against your employees, associates or partners
2. Protection from contractual and employee claims
3. Protection of income via “corporate wages paid” under Texas Homestead
4. Tax and fringe benefit planning

The disadvantages of incorporation are:

1. Cost of incorporation, typically \$1,500
2. More complex corporate tax return than the Schedule C
3. Annual minutes of shareholder/directors meetings
4. Observing corporate formalities

Texas Professional Association (P.A.) Act

Incorporated medical practices are regulated under a special Texas statute called the Professional Association act or PA due to the position of the Texas Medical Association, which concluded that “the inherent relationship between doctor and patient should not be practiced through a ‘pure’ corporation entity.” The PA Act was therefore

designed to provide for the noncorporate association of doctors, and was originally interpreted to apply only to individuals licensed to practice medicine by the Texas State Board of Medical Examiners. Professional service means service that requires license but cannot be performed by corporation. The PA Act in its present form includes podiatrists, dentists, medical doctors and osteopaths. Doctors of medicine and osteopathy and podiatrists may co-own an association.

In 1999, the PA Act was amended to allow professionals in related mental health fields to form an association that is jointly owned by those practitioners such as psychologists, clinical social workers, professional counselors, and marriage and family therapists.

You can form a PA for a single physician with that single physician serving as the sole Shareholder, Director and Officer. Only licensed professionals may own stock in the PA. Physicians remain personally liable for their own malpractice but are not personally liable for actions of partners, associates,

employees, staff, or contractual liability. However, the Act explicitly states that a shareholder of a PA shall have no duty to supervise the manner or means whereby the officers or employees of the corporation perform their respective duties. Shareholders of professional corporations have no greater liability in the role of shareholders than do shareholders of other business corporations.

The PA corporation (but not the individual shareholders, officers, or directors) will be jointly and severally liable with the officer, employee, or agent rendering professional service for such professional errors, omissions, negligence, incompetence, or malfeasance on the part of such officer, employee, or agent when such officer, employee, or agent is in the course of his or her employment for the corporation. **Therefore, do not leave assets in the corporation!** Utilize asset protection strategies to insulate your cash operating account, medical equipment and accounts receivable from malpractice judgments, especially if you practice in a multi-physician PA or if you have one or more full or part-time employees.

A PA operates with Articles of Association, Bylaws, Board of Director(s), shareholder(s), and officer(s). The original articles of association, as well as annual statements, must be filed with the Secretary of State. This provision preserves professional ethical standards and assures that the corporate form will not be used as a device to limit the liability of the professional to patients or clients.

Part 2 in the next issue will cover C corporation versus S corporation versus LLC (limited liability company; the perfect corporate structure for multiple physician practices; and tax and fringe benefit planning opportunities.

Protecting your assets from lawsuits

By Ken H. Vanway, P.C., attorney at law, senior partner, Vanway, Thrash & Associates



About the author

Ken H. Vanway is board certified in Estate Planning and Probate Law — Texas Board of Legal Specialization. Ken has more than 20 years experience. His firm practices in many areas of estate planning and lawsuit protection including wills, living trusts, insurance trusts, family partnerships, charitable trusts, private foundations and asset protection. For more information, please visit his web site, at www.estateplanning.com/kenvanway.

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In case you missed it . . .

- Risk Alert information is now on www.tmlt.org. Visit TMLT's home page and click on the "Risk Alert" icon for the latest news on problems discovered with medicines and other health related products. Currently, read the latest on Prempro.

- Did you receive your Business Associate Agreement from TMLT in April? Make sure you are HIPAA compliant. If you have not already mailed back your Business Associates Agreement, please take a moment and do so now. If you need another copy of the agreement you can locate it at www.tmlt.org in the application kit. It is important that you provide us with your printed name and phone number on the agreement, as well as your signature. We all know that signatures alone can be difficult to read so please help us identify your agreement by completing the form.

- The legislative debate continues and

according to press releases by TAPA, there are provisions in both the House and Senate versions of House Bill 4 that TAPA supports and those with which it disagrees. TAPA supports a hard cap of \$250,000 on non-economic damages which applies to every health care professional. TAPA does not support the waiver of the cap in 12-0 jury verdicts. The Department of Insurance has reported that the \$250,000 hard cap should allow a 12 percent savings in medical liability premium while another actuarial study commissioned by the TMA reports that the Senate version would provide less than 5 percent premium savings.

TAPA is also committed to the non-economic damage cap constitutional amendment, periodic payment, and collateral source reform. It is notable that, although the Medical Injury Compensation and Reform Act (MICRA) brought quick relief to California, its effect on liability premiums has been most pronounced and long-lasting

since the California Supreme Court declared the law constitutional. Finally, TAPA supports an immediate effective date for this legislation, a provision that is contained in the Senate version of the Bill.

Editor's note: The 78th Legislative Session may have concluded by the time you read this issue of the Reporter. The July-August issue will provide an update on the outcome of the session and how physicians will be affected.

- Get up to date news on TMLT financial reports. The 2002 TMLT Annual Report is being prepared and will be mailed or emailed to you in early June. The report will also be posted on the TMLT web site.

- *The Reporter* is also available on the TMLT web site under Publications. If you are currently receiving a print copy and change your address, please notify us of your new address by emailing laura-brockway@tmlt.org.