

the Reporter

10 things that get physicians sued

By Laura Brockway

Not all medical liability suits filed against physicians are prompted by medical errors. Patients often cite interpersonal aspects of care, such as poor communication or feeling rushed, as central to the decision to initiate litigation.¹

"Patients do not necessarily file lawsuits because they believe they were harmed by a medical error. They sue because they believe they were harmed by a medical error and something else happened during their care," says Jane Holeman, vice president of risk management at TMLT.

This article will describe ten common errors that can increase the risk of a malpractice suit, and offer risk management techniques to address these issues.

1 Failing to listen to patients, spend adequate time with them, and communicate empathetically with them

Research on why patients sue physicians has repeatedly shown that basic interpersonal skills such as listening and showing respect can be just as important as clinical skills in preventing lawsuits.¹ However, given the time and economic constraints placed on physicians, it is easy to see how these skills can become overlooked.

"Eye contact and attentive listening are important and can go a long way toward building a relationship with the patient," says Jill McLain, vice president of claim operations. "And patients who have a good relationship with their doctors will be less likely to sue if a bad outcome occurs."

According to Holeman, a key factor in patient satisfaction involves the quality of time spent with the physician, not just the quantity. "Short visits

can be effective if the physician will sit down, listen to the patient, and ask the appropriate questions. If the physician spends the entire visit with his or her hand on the doorknob, the patient may feel rushed and may not give complete information to the physician. This is inefficient for everyone," Holeman says.

But many physicians rightfully ask, "how can I improve a patient's perception of a satisfactory visit when time is limited?" Holeman offers the following tips.

- Schedule appointment time based on patients' needs.
- During the appointment, spend time connecting with patients via non-medical conversation.
- Before patients are in the exam room, have them complete a form (see sample on page 3) that prompts them to state the reason for their visit.

2 Maintaining illegible or incomplete documentation

Accurate, legible, and complete documentation can be the best defense against a malpractice claim. What would your medical records look like to another physician, a plaintiff's attorney, or a jury? Poor documentation practices can impede care and may signal to the patient that the physician is careless or does not care to follow the patient closely.

"Poor documentation alone will not generally send a patient to an attorney, but could lead to a suit once the attorney sees the records," McLain says. "Poor documentation also makes the case more difficult to defend."

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Physicians should also be aware that the Texas Medical Board can discipline physicians if their medical records are incomplete or illegible. The rules for medical records as governed by the TMB include the word “legible” in their description of an adequate medical record. The TMB rules for medical records are as follows:

“165.1. Medical Records

(a) Contents of Medical Record. Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an “adequate medical record” should meet the following standards:

- (1) The documentation of each patient encounter should include:
 - (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - (B) an assessment, clinical impression, or diagnosis;
 - (C) plan for care (including discharge plan if appropriate); and
 - (D) the date and legible identity of the observer.
- (2) Past and present diagnoses should be accessible to the treating and/or consulting physician.
- (3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
- (4) The patient’s progress, including response to treatment, change in diagnosis, and patient’s non-compliance should be documented.
- (5) Relevant risk factors should be identified.
- (6) The written plan for care should include when appropriate:
 - (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
 - (B) any referrals and consultations;
 - (C) patient/family education; and,
 - (D) specific instructions for follow up.
- (7) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
- (8) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
- (9) Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient’s medical records.
- (10) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient’s status. Paragraphs (1)-(10) of this subsection may be modified to account for these variable circumstances in providing medical care.”²

Another documentation pitfall involves “correcting” medical records after an unexpected outcome or notice of a claim. Altering the medical record after the event — even if you believe the information will assist in your defense — is detrimental. Addendums to the medical record may be allowed if done in a timely manner and clearly identified. Include the date and time, a reference to

the date and time of the actual encounter, reason for the addendum, the added information, and author’s signature.

“Remember that part of good patient care is maintaining complete and legible documentation that is available for review by the primary physician and any consultants,” McLain says.

3 Allowing staff to treat patients poorly

These behaviors can include rudeness, insensitivity, or inattention to patients. Rude behavior by office staff and a bad outcome may be all it takes to initiate a lawsuit — even if the rudeness and the bad outcome have nothing to do with each other.

To address this problem, develop a policy and procedures manual for the practice. This manual can ensure that staff act in accordance with the policies in place. A policy and procedures manual can also reinforce staff accountability and serve as a staff orientation tool.

“Staff must be adequately trained and monitored,” Holeman says. “Make them aware of the policies and procedures through regular training. Document this training and address unacceptable behavior when you see it.” Maintain an office culture that is patient friendly.

To evaluate the “friendliness” of your practice, consider using patient satisfaction surveys or have a friend or colleague call or visit and report the experience to you.

4 Being inaccessible to patients

Perceived “inaccessibility” can occur when patients experience the following: long wait times for appointments; failure to return phone calls and messages; long automated phone messages when calling the office; and inattention during hospitalization.

“Such inaccessibility may be interpreted by patients that the physician does not care,” Holeman says. She urges physicians to have policies in place for returning patient phone calls. It is also important to tell patients what to expect regarding returned calls and to meet those expectations. Many practices use prompts that tell patients when they can expect returned phone calls.

“Long, automated phone messages and menus are by nature annoying, but in some practices they are necessary. If you must use such a message, give the caller the option to speak to a person early in the message,” Holeman says.

To minimize wait times for patient appointments, instruct staff on triaging and assigning priority appointments. “Scheduling every patient for the same brief visit can be inefficient for everyone. Staff can ask callers a set of standard questions and then schedule appropriate appointment times,” Holeman says. Patients who cannot be accommodated by the physician should be referred to another physician or to the emergency department (ED).

“The accessibility of the physician when a patient is in the hospital is another huge issue,” McLain says. “Family members may wait all day at the hospital to ask the doctor questions. When they do see the doctor, they often feel rushed and their questions are not fully answered.” This can be addressed by clear communication with the family about what to expect, when the physician will be there, or by arranging a time to talk to the family.

Failing to order and follow up on indicated tests

5 or delay in ordering such tests

Employ a tracking system to ensure that patients have obtained recommended tests. A tracking system can minimize exposure to allegations of failure to diagnose and treat and can lead to better patient care.

“Sometimes patients just need a reminder. Maybe they could not make it to the lab on the day of the appointment and then they forgot that they needed lab work. A tracking system can remind both patients and physicians that tests need to be completed,” McLain says.

According to Holeman, a tracking system does not need to be complicated. “It can be as simple as a box of index cards or a ‘tickler’ sheet that staff use to make phone calls. Also, some electronic medical records have a tracking feature that can be used. The important thing is to make tracking a routine procedure in your practice,” she says.

Along with tracking, have a written procedure for handling test results when they are received, and for following up on results that have not been received. This procedure should specify that test results are to be thoroughly reviewed before they are filed in a patient’s chart. Ideally, the reviewer should initial and date the reports and document what needs to be done.

Sometimes patients who have sued their physicians claim that test results were never communicated to them, or that the physician was delinquent in providing those results. Timely notifying patients of their test results should be a high priority. Routinely noting in the record that the patient was provided with those results, and including the date and initials of the person who contacted the patient, can help to prevent such allegations.

Failing to refer when appropriate, failure to track referrals, and failure to communicate with referring physicians

6 While it is true that patients have a duty to comply with their physicians’ recommendations, including following through with referrals, it is not uncommon for them to claim that the physician either did not stress the importance or did not explain the reason for the referral. In fact, they sometimes claim that they were given an option, as opposed to a recommendation, to see a consultant.

Implementing a system to track referrals can improve patient care and reduce liability exposure. The system can provide a method for: verifying that the patient keeps the appointment; confirming receipt of the consultant report; prompting a call to the consultant if a report is not received; making sure the physician sees the report; and arranging for a follow-up appointment if necessary. If the patient fails to keep the appointment with the specialist, the staff can then contact the patient with a reminder of the importance of following through with that recommendation. These steps should be documented in the patient’s chart.

As with reports of test results, written procedures for handling consultant reports can prevent problems and improve patient compliance. Initialing and dating reports after careful review can provide useful documentation if a lawsuit is filed.

“Another problem we see frequently involves communication between physicians. While written communication will often suffice, there are some situations in which a discussion needs to take place,” says McLain. “It is also important to document your discussions with other physicians and any joint treatment plans resulting from

Today’s visit

Patient’s name _____

Date of birth _____

Main reason for today’s visit:

Other concerns I would like to discuss if there is time:

Please check all that apply:

- _____ I have prescriptions that need to be refilled
- _____ I need a school or work excuse
- _____ I need a referral for my insurance company
- _____ I need the attached forms filled out

This form can help prompt patients to state the reason for their visit.

the referral.”

7 Inappropriately prescribing medications

When patients experience adverse reactions to or lack of benefit from prescribed medications, lawsuits can result. These suits allege such errors as: failing to check the patient’s chart when prescribing medication; prescribing improper dosages; failing to consider and advise patients of potential side effects or interactions with other drugs; prescribing drugs outside the physician’s specialty; and prescribing drugs for non-patients.

Given the significant amount of direct-to-consumer advertising of prescription and over-the-counter drugs, physicians frequently receive requests from patients for drugs they have seen advertised. Physicians would be well advised to resist patient pressure for drugs with which they are not familiar. There are a number of information sources available. Physicians who use reliable sources to educate themselves about the drugs they prescribe will be better able to explain their rationale if they should be sued individually, or as a part of mass tort litigation. When possible, it is helpful to provide the patient with information about the drug, and to document discussions and any handouts given. Documenting the information provided can be helpful if the physician’s actions must be defended in litigation.

To avoid allegations related to improper prescribing, consider the following guidelines.

- Check the patient’s medical record when prescribing or refilling a medication. Request that the patient come for an office visit, if appropriate, before authorizing a refill.
- In the patient’s chart, record medications and allergies in a central location. Update this information at each visit.
- Be familiar with the drug prescribed. Refer the patient to a specialist if he or she requires a drug that is outside your scope of practice.
- When prescribing drugs off-label or in dosages exceeding those recommended, document your rationale. Also document that you discussed the risks and

benefits of the treatment with the patient.

- When a patient calls with complaints of unusual symptoms, the prescribing physician should be alerted.
- If a pharmacy calls to question a prescription, check the original order.
- Make sure handwritten prescriptions are legible and that dosages are correctly noted.

Improper care of patients during emergency situations

8 Treating patients by phone when an examination is warranted can be risky. Patients can be poor historians and may inaccurately describe their symptoms. Additionally, the physician cannot assess the patient's appearance, body language, or symptoms by phone.

"Treating patients over the phone is not a problem per se. In some cases it may be appropriate. Careful judgment should be used when deciding whether phone advice and treatment is sufficient," Holeman says. "When possible, check the chart. Determine if the patient has ever experienced this problem before? When was the patient last seen in the office? Is this a recurring issue for the patient?"

Implement written protocols for telephone triage that include:

- which staff members can answer patient questions;
- specific questions to ask the caller;
- when to notify the physician; and
- which calls warrant a visit to the office or ED.

Document the patient's request, symptoms, and any advice given. If the patient is told to go to the ED, document this directive in the medical record.

Another situation that warrants discussion involves interaction between treating physicians and the caregivers in ED. "We have received a number of claims in which plaintiffs alleged that the patient's primary care physician or specialist inappropriately relied on the ED physician or resident because the physician did not want to come to the hospital," McLain says.

Other claims involving emergency care have alleged lack of adequate communication between the physicians at the hospital, such as emergency physicians or residents, and others such as radiologists or specialists.

When contacted by an ED physician, documenting any advice given over the phone can later serve to correct any confusion about what was communicated. The ED physician is probably documenting the conversation, but sometimes that documentation is inconsistent with the recollection of the physician calling in. Additionally, if you are asked to fax copies of medical records or reports, confirm that the ED received the materials. Document the confirmation in the medical record.

Failing to obtain informed consent

9 Informed consent is not a piece of paper. It is a discussion between the patient and the physician regarding the risks and benefits of a procedure, treatment, test, or medication," Holeman says.

In Texas, informed consent is governed by statute and is overseen by the Texas Medical Disclosure Panel (TMDP). The panel includes six physicians and three attorneys who review all treatments and procedures to determine which procedures require informed consent and which do not. Procedures and treatments are then assigned to

a list. Those requiring disclosure of risks and benefits are put on List A. Those that do not require disclosure of specific risks are identified in List B. The panel periodically examines new treatments or procedures and assigns them to one of the lists. The lists, TMDP rules and forms can be viewed at Title 25, Texas Administrative Code, Part 7 at www.sos.tx.us/tac/index.shtml.

When offering any treatment or procedure to a patient, the physician must make these determinations:

- if the treatment or procedure appears on List A, then disclosure specified by the panel must be followed;
- if the treatment or procedure appears on List B, no specified disclosure is legally required;
- if the treatment or procedure does not appear on either List A or List B, the physician must then disclose all material and inherent risks which could influence a patient in making decisions.

"It is also important to realize that informed consent is a non-delegable duty. The physician is responsible for discussing the risks and benefits and obtaining consent," Holeman says. "A signed form is not a substitute for a detailed discussion."

Additionally, it is important to note that, by statute, the TMPD may not require disclosure of the risks of certain surgeries, procedures or medications. However it is best to disclose those risks that a reasonable person would want to know in making the decision.

A final piece of advice regarding informed consent — document the discussion in the medical record. The notes should indicate that the patient was informed of the risks, benefits, and alternatives of the offered treatment, and that the patient expressed a desire to proceed.

Allowing noncompliant patients to take charge

10 These situations can include a patient leaving the ED when the physician suggests admission or a patient leaving the hospital before his or her condition is stabilized.

"Physicians should resist attempts by patients to talk them into anything other than what their best medical judgment deems appropriate," says McLain.

Physician recommendations and patient noncompliance should be objectively and adequately documented. If a patient suffers a bad outcome as the result of his or her noncompliance, they may try to shift the blame to the physician. "Patients often claim that the physician did not explain the severity of their condition or the potential consequences of going against medical advice. Thorough, contemporaneous documentation can help dispel these allegations," says McLain.

Another risk management strategy for these situations includes requiring that the patient sign informed refusal or "Against Medical Advice" forms.

References

1. Ambady N, et al. Surgeon's tone of voice: a clue to malpractice history. *Surgery*. 2002; 132:1; 5-9.
2. Texas Medical Board. Board Rules Chapter 165.1-165.5 Medical Records. Available at <http://www.tmb.state.tx.us/rules/rules/165.php>.

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tmlt perspective

TMLT announces rate reductions, declares 20% dividend

TMLT declares 20% dividend and reduces rates by 7.5% effective January 2007

The Board of Governors of Texas Medical Liability Trust (TMLT) has declared a 20% dividend amounting to approximately \$35 million for 2006 effective January 1, 2007 for renewing TMLT policyholders. Dividends will be credited to each policyholder's premium as a lump sum when his or her policy renews in 2007.

In addition, the Trust will be reducing rates 7.5% for all specialties across the state beginning January 1, 2007. Current TMLT policyholders will receive this rate decrease when their policy renews.

TMLT has now reduced annual rates four times since the passage of House Bill 4 and Proposition 12—12% in 2004; 5% in 2005; 5% in 2006; and now 7.5% in 2007, a total of 29.5% in four years. By the end of 2007, TMLT's rate reductions, since 2004 will amount to nearly \$139 million and returned dividends of 25% will amount to nearly \$45 million. Since the passage of Prop 12 and medical liability reform of 2003, TMLT policyholders will have realized cumulative savings of over \$180 million.

Non-meritorious claims intake is down as a result of the medical liability reform achievements in 2003. "TMLT believes the legal environment will continue to improve as long as 2003 tort reform measures remain in effect," says acting president and CEO Bob Fields.

Chairman Dr. Dennis Factor states, "Because of TMLT's recent earnings and strong surplus position, physician policyholders can share in the organization's success in the form of rate reductions and dividends." TMLT currently insures about 13,800 Texas physicians.

TMLT offers fall CME program

In October, the TMLT Risk Management department will offer the Fall seminar series "Double Jeopardy: Problem Patients and Frustrated Physicians." The seminar will discuss how to manage problematic patient

behaviors and will include case examples, audience participation, and demonstrations by the speakers. The seminars are led by health law attorneys Sarah Fontenot, JD and James Gilman, JD.

Upon completion of this program, participants should be able to:

- identify communication issues related to patient noncompliance, inappropriate behavior, and potential ethical dilemmas;
- examine physician responses to patients who question medical judgment and list proactive strategies to manage these situations in the future;
- recognize physician interactions with patients that precipitate inappropriate patient reactions such as anger, withdrawal or dependence;
- discuss termination of the physician-patient relationship, specific procedures, and associated legal issues.

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 3 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

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

TMLT policyholders who complete this program will earn a 3% discount (maximum \$1,000) that will be applied to their next eligible policy period.

Course dates and locations are:

- Austin — Tuesday, October 3
- Houston — Thursday, October 5
- Fort Worth — Tuesday, October 10
- San Antonio — Tuesday, October 17
- Dallas — Thursday, October 19

The dinner and program will run from 6:30-9:30 p.m. Registration begins at 6 p.m. The registration fee is \$25 for TMLT policyholders and \$35 for non-TMLT policyholders. For additional information or to register, please contact Natalie Gilmore at natalie-gilmore@tmlt.org. or (800) 580-8658 ext. 5911.

Please register no later than one week before each seminar.

You've Been Sued DVD now available

You've Been Sued: Successfully Navigating the Litigation Process, TMLT's first DVD-based CME program is now available to physicians upon request.

This course — led by physician Howard Marcus, MD and attorney Dan Ballard, JD — discusses strategies that are essential to the successful defense of a medical malpractice lawsuit. The DVD includes discussions related to legal principles involved in medical liability cases, reenactments of actual physician depositions, effective risk management practices, and the emotional impact of a lawsuit on physicians and their families.

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 3 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

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

TMLT policyholders who complete this program will earn a 3% discount (maximum \$1,000) that will be applied to their next eligible policy period.

The *You've Been Sued* DVD is available at no cost to physicians. However, to earn CME credit, TMLT policyholders will be charged a \$25 registration fee. Non-TMLT policyholders will be charged a \$35 registration fee.

To request *You've Been Sued*, please contact Natalie Gilmore at (800) 580-8658 ext. 5911 or send email to natalie-gilmore@tmlt.org.

TMLT Memorial Scholarship

Winning Essays

The case study — delay in diagnosing epidural abscess

Presentation

Upon referral from his family physician, a 41-year-old man came to a free standing diagnostic center for an MRI of the lumbar spine. The patient had a history of chronic back pain that was not responding to conservative measures. The technician completed the MRI after the center's two radiologists had left for the day.

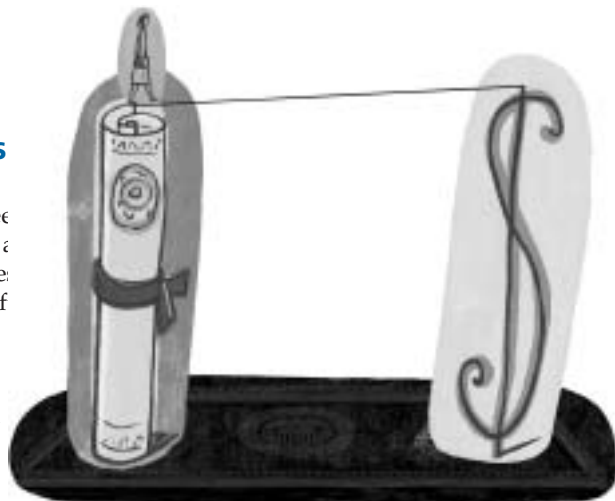
Physician action

The next morning, a Friday, radiologist 1 reviewed the MRI and described a mass consistent with an epidural hematoma or osteomyelitis. Based on the fact that the fluid collection in the epidural space was well defined, the radiologist believed it was more likely a tumor in the bony area. The radiologist was further swayed by the patient's history of "chronic" back pain, which favored a tumor rather than an acute infectious process. Radiologist 1 filled out a request for additional views, as well as a Gadolinium study to examine the bony structure, all to be taken within 72 hours. He instructed staff at the center to contact the patient, and have him return for the additional studies. Radiologist 1 did not directly contact the patient or the referring physician. At noon that day, radiologist 1 went home with the flu and did not return to the office on Saturday.

The diagnostic center staff attempted to contact the patient at the phone numbers supplied by his referring physician, but were unsuccessful. They then called the family physician's office, and were told the telephone numbers that had been provided to them were the only numbers they had for the patient. Interestingly, the patient information sheet completed by the patient when he registered at the diagnostic center contained his current working telephone numbers. Staff never checked that sheet or attempted to contact the patient at those phone numbers.

At 10 a.m. on Saturday, the patient came to the emergency department (ED) of a regional hospital with complaints of back pain with radiation down his legs. ED staff called the radiology center for the results of the MRI. Radiologist 1 was called at his home by a center employee. He advised this employee to locate the films and have his partner on duty, radiologist 2, review the films. Radiologist 2 reviewed the films and testified that he prepared a handwritten, preliminary fax report to be sent to the ED. In this report, he said there was a heterogeneous cystic mass located from L4 to S1 on the left and that a Gadolinium study was needed. Radiologist 2 then gave the report to an employee who faxed it to the ED and later called to confirm it had been received. This preliminary report is not in the files at the diagnostic center and is not in the hospital chart. The ED physician and ED personnel deny receiving a faxed report from the center. They allege receiving only an oral report of an MRI with findings of degenerative disease and a mild diffuse posterior disc bulge, along with foraminal stenosis and a compression fracture. Based on his evaluation of the patient and the results of the MRI, the ED physician diagnosed back pain and herniated disc. The patient was discharged home from the ED.

The patient returned to the ED at 9 a.m. on Sunday complaining of not being able to move or feel his legs. The patient was treated by the same ED physician, who ordered a lumbar spine MRI. The MRI was read by the hospital radiologist, who reported a "hematoma (spinal) epidural." A neurosurgeon



was consulted, and took the patient to the OR. He performed an emergency decompression of the epidural space and noted a “large collection of what appeared to be an organized clot on the posterior aspect of the thecal sac” and a “well organized and fibrous-type clot of blood . . . also associated with this some pockets of what appear to be purulent matter and a material consistent with epidural abscess with hematoma.”

When radiologist 1 returned to his office on Monday, he became aware that the patient had not returned to the diagnostic center for additional testing, had been seen at the ED, and had undergone surgery. It was at this time and with this information that radiologist 1 dictated his MRI report. The MRI report is dated Thursday (indicating the date of the study) with a transcription date of Monday. He then called in the report to the referring family physician.

The patient was ultimately diagnosed with cauda equina syndrome and secondary incomplete paraplegia. He has limited motor function in his legs, but can walk with the help of a walker. The patient was also diagnosed with neurogenic bowel and bladder, and does experience nocturnal incontinence.

Allegations

A lawsuit was filed against the two radiologists, the diagnostic center, the ED physician, and the hospital.

Legal implications

The plaintiff retained a credible expert who testified that the lesion radiologically appeared to be an abscess, which represented an emergent condition requiring immediate communication with the patient and referring physician.

During his deposition, radiologist 1 testified that he believed that the patient had a neoplasm. Because the patient had not reported any neurological symptoms, and because the patient reported the problem to be chronic rather than acute, radiologist 1 did not consider the patient’s condition “emergent.” Further, radiologist 1 testified that he would have called the family physician directly to inform him of the results if the additional studies had been completed.

Defense radiology experts were supportive of radiologist 1’s interpretation of the MRI. Both experts testified that the findings on the MRI were not emergent, and that radiologist 1 was not required to call the family physician on Friday to alert him that he found something suspicious for which he was conducting additional studies. One expert, who has written extensively on American College of Radiology’s practice guidelines for communication, supported radiologist 1’s decision not to call the referring physician. Radiologist 1 felt the study was incomplete and that there would be no danger to the patient in waiting a couple of days to obtain additional contrast studies.

Other defense radiology consultants were not entirely supportive and felt the lesion represented an abscess instead of a solid lesion. One expert pointed out that a note contained in the patient information sheet completed by the patient when he came to the diagnostic center indicated “history of chronic back pain, weakness in left leg, no trauma.” To this expert, “weakness in the left leg” indicated neurologic compromise. When coupled with the finding on the MRI, the radiologist should have called the family physician immediately. Another radiologist, who was supportive of the interpretation of the MRI and the belief that it was neoplastic disease, believed radiologist 1 should have advised the family physician of the finding because radiologists never know the full clinical picture of a patient.

The family physician testified that if radiologist 1 had called him on Friday to report the preliminary findings, he would have agreed with the decision to obtain additional studies. However, the family physician said he would also have called the patient to inform him of the findings and check on his condition. He further testified that had he been contacted on Friday, he would have arranged for a neurosurgical consultation, but not on an emergent basis.

Disposition

This case was complicated by communication errors committed by staff at the diagnostic center, a “lost” radiology report, and finger pointing among the defendants. Based on these factors, the case against radiologist 1 was settled before trial. Radiologist 2, the diagnostic center, and the hospital settled their cases before trial. The outcome of the suit against the ED physician is unknown.

And the recipients are . . .

In 2006, 48 students from 8 Texas medical schools applied for the TMLT Memorial Scholarships. The TMLT Board of Governors reviewed the submissions, and we are now proud to introduce the recipients of the 2006 TMLT Memorial Scholarships:

D’Andrea Michelle Anders, a fourth-year student at the University of Texas Medical Branch at Galveston;

John Spencer Chiara, a third-year student at Texas Tech University Health Science Center School of Medicine;

Jessica Dalby, a third-year student at Baylor College of Medicine;

Tara Hagopian, a third-year student at the University of North Texas Health Science Center’s Texas College of Osteopathic Medicine;

Chad D. Housewright, a fourth-year student at Texas A&M University System Health Science Center College of Medicine;

Eric Jon Larsen, a fourth-year student at University of Texas Medical School at Houston;

Joshua Delbert Mitchell, a third-year student at the University of Texas Southwestern Medical School;

Stephanie Watson, a third-year student at University of Texas Medical School at San Antonio.

The \$5,000 scholarships were awarded to one student at each Texas medical school. Recipients were chosen based on academic achievement, financial need, and essay. For the essay portion, students were asked to write risk management considerations for a closed claim study provided by TMLT.

Risk management considerations

By John Spencer Chiara

“**T**his case represents two types of errors that can lead to medical mistakes: systems breakdowns that lead to communication failure and misdiagnosis. While the latter often assumes the limelight, it is difficult to eliminate and, at least in this case, is not as serious as might be assumed. The former is completely avoidable and in this case led to both the damages and assignment of liability. Failure to communicate findings in a timely fashion is the crux of this case.

Initially, although the family practice doctor provided a short explanation, it would have been preferable for him to include a detailed list of the symptoms that led to the referral for an MRI. This would have better guided Radiologist #1, who is not a clinician, in understanding both the severity of the condition and urgency of timely diagnosis and treatment.

The next error, and with out any question the most critical, was made by Radiologist #1. Failure to dictate his report of the MRI the day the study was made, regardless of his impression of the urgency of the condition, is the key to this case. If he had dictated the report when he reviewed the study he could have substantially reduced his liability, because the ED physician would have had easy access to a report indicating some type of mass lesion. Even with the mistaken diagnosis of a neoplasm, the ED physician would have known that there was a potentially expanding lesion threatening the spinal cord. The ED physician would have then been able to seek a neurosurgical consult and saved at least some of the patient's function. Misdiagnosing an abscess as a neoplastic lesion is probably a pardonable error, but not when that diagnosis, as flawed as it was, was not made available to the ED physician.

The true harm in this case occurred because the ED physician did not have access to the information regarding the previously identified lesion. It is debatable whether the patient or family physician should have been contacted, since it is unclear how their actions would have been different or contributed to a better outcome. The best way to have protected the patient and reduced liability would have been for the first radiologist to dictate and report his findings at the time they were made. Making information available to subsequent doctors would have enabled each of them, in turn, to apply their knowledge and experience as the events unfolded. Misdiagnosis will occur from time to time and is a product of an imperfect science being practiced by imperfect people. Nevertheless, with proper and timely communication of findings, the diagnostic error would have been of much less consequence and may not have resulted in tragedy for the patient.

“**O**ne of the most frightening things about becoming a physician stems from the fact that we must accept the reality that lawsuits are inevitable. No matter how exemplary our performance is as physicians, there will come a time when we miss a diagnosis or just make the wrong decision about a patient's condition. As future physicians, we will be expected to serve as team leaders regardless of what field of medicine we choose to pursue. This is one of the greatest advantages to being a physician, but if the team doesn't function efficiently, it can also be one of the greatest disadvantages.

A hardworking dependable staff can help a good physician be an excellent physician, but the opposite is true of a nondependable staff. The staff at the diagnostic center failed to contact the patient when his contact information was readily available and may have even failed to fax the second radiologist's preliminary report to the ED. These actions are totally inexcusable and because the two radiologists trusted that these things had been done, they became liable for things that were in a sense beyond their control.

The outcome of this case may not have been so tragic if the physicians had used better judgment when they were given the opportunity to make decisions about the patient's care. The first radiologist's initial interpretation of the films indicated that the patient's condition was serious enough to warrant further studies; therefore, until the worse case scenario had been ruled out, he should have had a heightened level of concern for the patient. I do feel that he should have contacted the referring physician to obtain information about the patient that would

have helped him make a more informed decision. It is difficult to comment on the second radiologist's role in this case because there is a question of whether a report was ever really generated. If in fact he did review the films and prepare a handwritten preliminary fax report to be sent to the emergency department, I find no fault with him. If I were the ED physician, again, I would have wanted to rule out worse case scenarios before I discharged the patient. If I were not able to obtain the films from the outside diagnostic center or talk to the radiologist myself, I would have re-ordered studies.

This case clearly demonstrates how a breakdown in the team structure can lead to disastrous consequences for patients. Consequently, there are a number of lessons to be learned. Worse case scenarios should always be ruled out, and the members of medical teams should try to make informed decisions so the welfare of patients is not compromised. It's unfortunate that the patient in this case suffered permanent disability. My only hope is that the defendants learned as much as I have learned and will make wiser decisions when caring for future patients.

Risk management considerations By Stephanie Watson

“**T**his case represents a regrettable end to a common problem in medicine. With no less than 12 people involved in handling this patient's information in only 3 days, one can easily see the room for error in communication. The major problem is with hand-off of information, when a physician or their staff transfers information to each other. Richard Croteau, JCAHO's executive director of strategic initiatives states, “2/3 of our sentinel events (leading to patient morbidity and mortality) are due to errors in communication, and most of that is at hand-offs.”

This case is not an isolated event in which punishing these physicians will solve the problem. At many points in this patient's weekend, these physicians and their staff made mistakes in judgment about how to proceed, but I do not believe they did so maliciously, as most physicians do not. They acted in ways that made their day easier, by making less phone calls, writing less notes, and having co-workers take over responsibilities. This is human nature and must be prevented by systems in place to make it harder for us to make these errors.

The first communication breakdown comes when radiologist 1 read the initial MRI, but did not call the family physician with the abnormal result. Even though it was read as non-urgent, a policy should be in place to be sure the reading is documented and the FP knows about the abnormal MRI and the plan for follow up studies. Next, when radiologist 1 went home sick, someone else in the office could have been informed of the patient's status and could have read and dictated a report on the initial MRI instead of the report being dictated after the weekend of ED visits revealed the true diagnosis.

When the staff of the diagnostic center could not reach the patient and the FP's office was called, the new contact information provided by the patient

could not be used because it was not entered into the patient's chart. The FP's office needs a system to ensure this information is promptly entered. If the patient was informed of the abnormal MRI he could have used this information at the emergency department. Furthermore, since the FP's office was called, the physician could have been informed at that time.

When radiologist 2 prepared the MRI report and his staff faxed it, another breakdown of communication occurred. The ED physician claims he got an oral report of DJD and disc herniation, which he used as grounds to discharge the patient, but radiologist 2 claims he sent a report of cystic changes. Somehow the diagnostic center's fax did not get to the ED and the ED got the wrong report orally. Nothing is in writing, no one followed up his or her reports, and this miscommunication contributed to the patient's current condition. Systems to double check names, ID numbers, and receipt of reports as well as physician read-backs of reports and redundancies in retrieving and submitting information could have changed the outcome of this case.

Risk management considerations

By Jessica Dalby

“This case report, rife with problems, demonstrates the consequences of human fallibility. Threats to patient safety are often covered up, rather than discussed, in our culture of blame and shame. Such behavior only builds huge obstacles that impeded the creation and implementation of safer protocols. Creating an environment in which professionals can freely discuss problems and prevention methods is the key for risk management.

The greatest failure of the physicians implicated in this case lies in poor communication skills. The lack of communication between radiologist 1 and the referring physician and the failure of radiologist 2 to speak directly with the ED physician are both examples where a five minute phone conversation could have greatly improved the patient's outcome. Good medical practice is deeply rooted in effective communication, both in the doctor-patient relationship, between doctors, and among other professionals. As a medical student, you toil for hours to prepare the perfect patient presentation for your attending because you know that the differential a doctor considers is heavily influenced by the way in which the case is presented. Thus, effective communication is a vital skill learned in medical school that must be practiced effectively throughout a physician's career. Effective communication comprises two parts, what is spoken and what is heard. Thus an effective communicator must not only speak clearly, but must ensure that his words are interpreted correctly. The conversation between the diagnostic center and the ED clearly failed to meet this definition.

Several different scenarios in this case would have benefited from improved protocols, providing additional safety checks. Specifically, a policy needed to be in place in which no MRIs were done at the diagnostic center without at least preliminary review by a radiologist the very same day. Also, the failure of the diagnostic center staff in contacting the patient, when his current phone numbers were listed in their files, could have been avoided had the staff followed a set protocol to actually look at their paperwork. The next preventable failure is seen when radiologist 2 prepares a handwritten preliminary report for the ED, yet doesn't file it with the patient's chart. A simple protocol to ensure better record-keeping, such as saving all faxed reports, could have saved the physician from a hearsay battle with the ED, who would also have benefited from better record keeping. Finally the failure by radiologist 1 to dictate his report immediately allowed subsequent events to sway his dictation, which is ethically questionable. Had a protocol existed requiring dictation within 48 hours, the physician would have avoided this sticky situation.

To ensure patient safety requires a lot of effort by everyone involved, from the office assistant to the technician to the physician. Therefore, patient safety reviews, in which staff can point out problem areas and plans can be made to correct those issues, are critical to the smooth operation of a practice. We should strive to create a medical culture in which everyone learns from mistakes of the past to ensure a higher quality of patient care in the future.

Risk management considerations

By Tara Hagopian

“In retrospect, the risk management considerations in this case seem reasonably apparent. Lack of communication, poor attention to detail and dated documentation procedures by the physicians and their staff gave rise to the malpractice lawsuit. While hindsight is 20/20, physicians must practice medicine in an anticipatory manner to mitigate risk to themselves and to their patients. An opportunity was present at some point for each physician to change the outcome of this case, however reliance on the dependability of other people contributed to the ineffective treatment of the patient. Had modern technology designs been applied here, as well as in many other cases, there is a chance that the patient would have experienced enhanced continuity of care and the burden on the physicians to provide this level of care would have been reduced.

This case was plagued by simple mistakes from the beginning. Radiologist 1 should have initially contacted the referring physician even though he felt the study was incomplete due to the fact that he did not know the patient's complete history and also to simply reduce his liability. Had the radiologist and his staff paid closer attention to the patient's chart, they may have first noticed the weakness in left leg coupled with back pain which would have necessitated immediate action including contacting the refer-

ring physician, and second, the staff would have been able to contact the patient at his current phone number. To prevent this type of error the clinic could implement procedures that include entering patient information in an electronic chart upon arrival where the new phone number and patient history may not have been so easily overlooked.

Other mistakes include the failure of Radiologist 2 to document the fax he sent and failure of the ED physician to request the MRI from the clinic or request a new one the first time the patient came to the ED. Electronically sending the fax, or at least making a copy of it as well as a transmission report for the patient file would have greatly reduced liability for Radiologist 2. The ED physician in an effort to reduce his liability should have requested the MRI, which could have very easily been emailed had new technology been in place, or at the very least should have checked for weakness in the patient which would have prevented the patient from being discharged so that he could be treated immediately.

In times such as these when medical malpractice suits are high, physicians must take extra care in treating patients to reduce personal liability. This case demonstrates how anticipatory action, attention to detail and good communication and documentation are essential elements in the practice of medicine. The use of technology to facilitate better communication and documentation could have provided improved continuity of care as well as decreased the risk to all parties involved.

interpretations. Also a set of protocols should have been in place to contact the patient and the referring physician in the event that further evaluation would be needed. Guidelines should have been enforced to dictate diagnostic reports in a timely fashion. Furthermore, the staff should have verified contact numbers prior to performing diagnostic studies.

One must note that poor documentation was paramount in this case. Some physicians live by the adage "if it was not documented, it was not done." The written medical record must reflect the date, time, involved parties, actions taken, and the results of any events. Radiologist 2 should have submitted a written preliminary report to the medical record with a summary of the transmission of the report to the ED physician. The radiology staff should have also documented the conversation with radiologist 1, the transmission of the report to the ED, and verification of receipt including the name of the person spoken with and the time received.

Although defense experts testified that there were no derelict proceedings, few would argue that the physicians had a duty to this patient. Several acts of commission and omission led to this unfortunate trail of events. These actions could have been avoided and may have been directly related to the damage suffered by this patient.

Risk management considerations

By Chad D. Housewright

“We are simply a sum of our decisions. Often in medical malpractice claims a trail of poor decisions can be observed. The essential elements of establishing medical malpractice are summarized by the “4 Ds” which can assist in navigating this trail. The physician has a *duty* to provide adequate care for the patient. There must be an obvious *dereliction* of this duty. Furthermore, *damage* must be suffered that is *directly* caused by the physician’s derelict actions. This case demonstrates these elements.

Although not a pursuant in the claim, some would argue that the family physician failed in a few areas. He could have provided the patient with anticipatory guidance and education on possible outcomes, warning signs, and agreed upon instruction to contact the physician in the event these were noted. This would have been helpful since the physician was familiar with the patient and could assist the ED physicians in directing care. The family physician should also be well versed on the practice patterns of referral institutions and be aware of the possibility that diagnostic testing may be performed in the absence of a radiologist and thus interpretation of such tests would be delayed.

On the other hand, radiologist 1 may have been a victim of distraction as he unfortunately succumbed to the flu. Life events will occur in medical practice, but pre-established guidelines can act as a safety net in these circumstances. Radiologist 1 could have notified a covering physician of pending diagnostic

Risk management considerations

By Eric Jon Larsen

“All of the problematic situations presented by this case represent times when the people most responsible, the physicians, have not performed and/or deferred duties to their staff and peers which they should have performed themselves.

The first chronological error that took place in this patient's care was made by Radiologist 1. By not including the referring physician and/or patient in the discussion of the initial radiological findings, he/she restricted the use of a wealthy resource of background knowledge that may have shifted his/her thinking away from an initial exclusion of an infectious process. The first mistake that many doctors make is thinking that their patients can't understand what is happening to them, thus excluding them from discussions of the findings until they have read the studies and an "educated" diagnosis is agreed upon beforehand. By having the patient brought into the discussion, they can add clarification to the sensory information needed to pinpoint the diagnosis (eg. weakness in his left leg in this case).

The second error made by Radiologist 1 was that he/she did not read the Patient Information Sheet filled out during registration at the diagnostic center. By filling out this initial form, most patients feel that any concerns marked on this form have been addressed and they forget to re-mention it during their interaction with the physician. Since Radiologist 1 did not read this form before trying to interpret the MRI, he/she missed a vital clue that would have prevented an infectious process from being erroneously excluded from the list of possible diagnoses. This critical error caused the patient's illness to be categorized as non-emergent and placed the patient at risk for improper management. Also, since staff did not read the Patient Information Sheet either, contact with the patient was further compromised.

Where Radiologist 2 came under criticism in this case was regarding the missing report that he/she gave to an employee to fax to the ED. Instead of handing over the master copy of any document to someone not responsible for the patient's care, the doctor should have provided multiple copies to be placed in the chart, given to the patient, to be faxed and for the diagnostic center's permanent files. Without this written proof that the physician was acting in the patient's best interest, there is no support for his/her actions when under scrutiny by the legal system. Radiologist 2 also stated that they called to verify that the faxed document was received, but never stated by whom. He/she should have talked to the ED physician directly and given an oral report to corroborate the written findings. This would have relieved any legal responsibility regarding inadequate care by Radiologist 2.

While it may be cumbersome and time-consuming for doctors to micro-manage every aspect of a patient's care, this is the expectation placed on them by their patients as well as society. We are entrusted with their health and it is what we would expect if/when we ever become patients ourselves.

Risk management considerations

By Joshua Delbert Mitchell

“You can delegate authority, but you can't delegate responsibility,” is a mantra that the army has long expressed to remind its leaders that they are ultimately accountable for results. It is an awesome responsibility to be a leader in the military where you can routinely make decisions that affect your soldier's lives. It is very similar to the responsibility of a physician, in whose hands a patient places his life and well-being. Similar to the battle drills and operating procedures the military uses to minimize risks and casualties in peace and war, established and rehearsed protocols can also help minimize risks and litigation in medicine. The current case study poignantly points out the medical and legal consequences of deficiencies in established protocol and lack of proper management accountability.

Prior to any patient treatment, a standard system for managing patient information and communication of diagnostic imaging findings should be established and disseminated to all office workers, to include physicians, of the referral center. A copy of the protocol should always be readily available, and a radiologist or office manager must routinely re-evaluate the standard courses of action to ensure they are understood and followed. If such a system

were in place, the referral center could have avoided many of the unfortunate mistakes in this case.

Specifically, a standard protocol should include promptly inputting patient information into a central database and routinely double-checking the patient's most recent information sheet when attempting patient contact. It should include notifying the supervisor if, after following these guidelines, the patient still cannot be reached. It should include meticulous record keeping of all findings as well as the time, place, and person to which the findings were relayed. It is especially important to record the person that received diagnostic communications transmitted through facsimiles, which do not readily ensure that the intended party received the information sent.

Poor supervision added to the problems of the diagnostic center. The radiologist instructed his staff to contact the patient for follow-up studies, but the patient would have been better served through direct notification by the radiologist. The radiologist knew best the nuances of the patient's case, could answer the patient's questions, and could confirm with the patient the chronicity of his symptoms that were key to the preliminary diagnosis. The radiologist also arguably has an ethical responsibility to keep the physician and patient informed, even prior to follow-up studies, since the differential diagnosis includes processes that can be severe and debilitating.

While mistakes will always be made in patient care, the physician should strive to eliminate those that are due to a simple lack of precision and oversight. Litigation will only be minimized if one combines standard communication procedures and record keeping with good diagnostic and medical management skills. It is the duty of the physician to ensure all of these things happen, for it is the physician that is ultimately responsible for the patient's well-being, just as military leaders are ultimately responsible for their soldier's lives.



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medical liability update

Federal legislation creates patient safety organizations

by Jessica Beinart, JD

A new source of protection for health care providers and a way for those providers to enhance patient safety was recently created in the Patient Safety and Quality Improvement Act of 2005.

Provisions of the legislation

After years of debate and proposed legislation — at the state and federal level — on July 29, 2005, President Bush signed The Patient Safety and Quality Improvement Act of 2005. When signing the Act, President Bush said “[t]his is a common-sense law that gives legal protections to health professionals who report their practices to patient safety organizations. By providing critical information about medical procedures, doctors and nurses can help others learn from their experiences.”

The Act provides a vehicle to report medical errors to a Patient Safety Organization (PSO) voluntarily and without fear of legal reprisal. PSOs collect reports of medical errors and patient safety work product that are voluntarily submitted by health care providers for inclusion in a database. PSOs analyze the data.¹ The Department of Health and Human Services (HHS), through the Agency for Healthcare Research and Quality (AHRQ), will accumulate all data from PSOs and analyze it on a national level.²

A review of definitions under the Act is necessary to understand the protections and services provided by a PSO. A PSO accepts all patient safety work product, including data, reports, records, memoranda, analyses, written or oral statements that are assembled or developed by a provider for reporting to a PSO and are reported to that PSO.³ PSOs cannot protect medical records, billing and discharge information, original patient or provider records, or information collected, maintained, or developed separately, or that exists separately, from a patient safety organization.⁴ PSOs contract with providers, including physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, hospitals, nursing

facilities, outpatient rehabilitation facilities, home health agencies, hospice programs, renal dialysis facilities, ambulatory surgical centers, pharmacies, physician or health care practitioner’s offices, long term care facilities, behavior health residential treatment facilities, clinical laboratories, health centers, psychologists, certified social workers, registered dietitians or nutrition professionals, physical or occupational therapists, pharmacists or any other individual or entity licensed or otherwise authorized under state law to provide health care services.⁵

Reported information is privileged

The Act delineates a powerful privilege when reporting to a PSO. Patient safety work product reported to a PSO is not subject to federal, state, or local civil, criminal, or administrative subpoena or proceedings.⁶ Patient safety work product reported to a PSO is not subject to disclosure under the Freedom of Information Act, Title 5 U.S.C. Section 552.⁷ Reports to a PSO cannot be admitted as evidence or otherwise in civil, criminal, or administrative proceeding, except in a criminal proceeding after a court makes an in camera determination that the information is material to the proceeding or if the information relates to the commission of a crime and disclosure becomes necessary for criminal law enforcement purposes.⁸ Patient safety work product reported to a PSO will not be used in disciplinary proceeding against a provider who reported the information.⁹ PSOs maintain all HIPAA confidentiality protections.¹⁰ The Act assesses a civil monetary penalty up to \$10,000 per occurrence if privacy is breached when reporting to a PSO.¹¹

A comparison to Texas privileges shows the value of the Act. The physician-patient communication privilege is waived when the patient puts his or her health at issue in a lawsuit or a proceeding against a physician, including disciplinary proceedings brought by the Texas Medical Board.¹² The hospital committee privilege maintains a

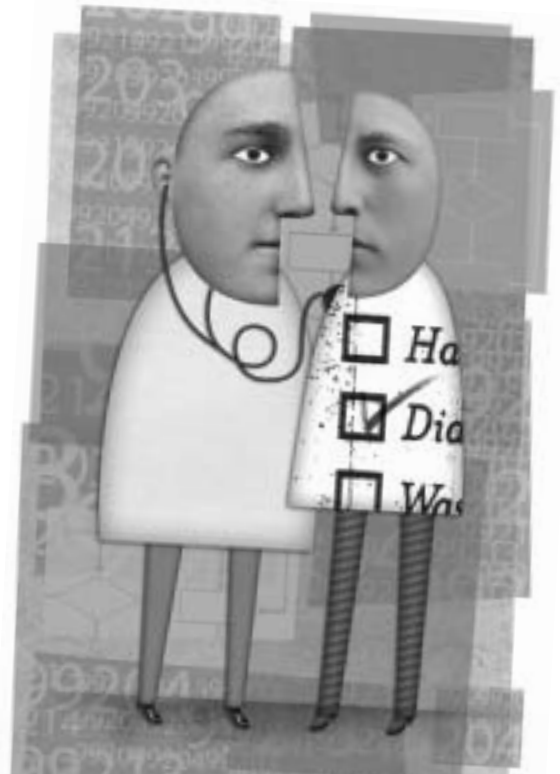
privilege for records and proceedings of medical committees, but not for information that is routinely generated by the hospital or gratuitously submitted to the committee.¹³ The peer review privilege maintains confidentiality of records, reports, evaluations, and recommendations received, maintained, or developed by a peer review committee, but disclosure can be authorized by law, if the action investigated is based on malice, anti-competitive actions, or civil rights proceedings under 42 U.S.C. Section 1983 or if disclosure is to another medical peer review committee, an appropriate state or federal agency, a national accreditation body or the state licensing board of another state.¹⁴

For more information on PSOs, please visit the web site of the Agency for Healthcare Research and Quality at www.ahrq.gov/qual/psact.htm.

References

1. 42 U.S.C. Section 299b-21(5),(6); 42 U.S.C. Section 299b-24. The Secretary of Health and Human Services shall establish criteria for certification as a PSO and maintain a list of entities certified under the Act.
2. 42 U.S.C. Section 299b-23
3. Patient Safety Work Product is defined in 42 U.S.C. Section 299b-21(7)(A)
4. 42 U.S.C. Section 299b-21(7)(B)
5. 42 U.S.C. Section 299b-21 (8)
6. 42 U.S.C. Section 299b-22(a)
7. 42 U.S.C. Section 299b-22(a)
8. 42 U.S.C. Section 299b-22(a)(c)
9. 42 U.S.C. Section 299b-22(a)
10. 42 U.S.C. Section 299b-22(g)(i)
11. 42 U.S.C. Section 299b-22(f)
12. Tex. Rule Ev. 509(c); Occ. Code Section 159.003.
13. Health & Safety Code Section 161.032.
14. Occ. Code Section 160.007.

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Caring for patients with diabetes

Objectives

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

1. Discuss the prevalence of diabetes mellitus in the United States.
2. Identify the types of complications patients with diabetes can develop.
3. Discuss the Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study.
4. List available resources to help develop and implement a comprehensive diabetes care plan.

Course author

Michele Luckie is a senior risk management representative at Texas Medical Liability Trust.

Disclosure

Michele Luckie 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

Texas Medical Liability Trust 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 3 *AMA PRA Category 1 Credits*.TM Physicians should only claim credit commensurate with the extent of their participation in the activity.

Ethics statement

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

Directions

Please read the entire article and answer the CME test questions. 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.

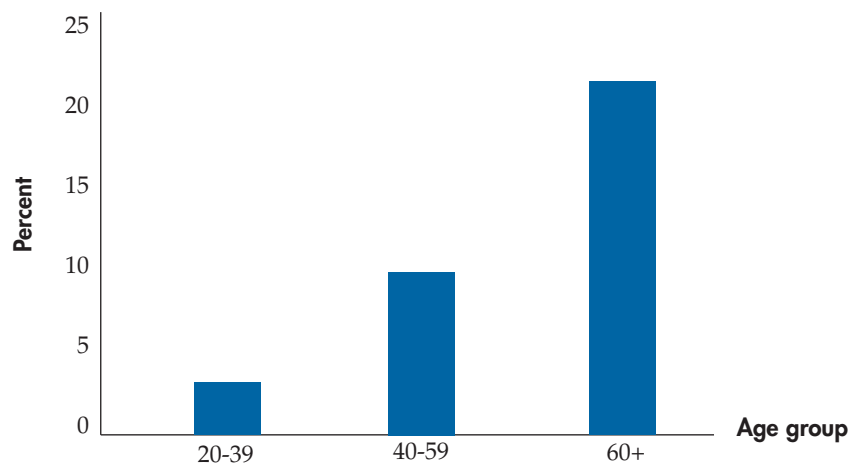
Release/review date

This activity is released on October 2, 2006 and expires on October 2, 2008. Please note this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

Introduction

Diabetes is the fifth deadliest disease in the United States, and it has no cure. In fact, diabetes has become so insidious — striking more people than ever and at earlier ages — that medical and nutrition experts say it has reached pandemic levels. Currently, an estimated 20.8 million children and adults in the U.S., or 7% of the population, have diabetes. ¹

Estimated total prevalence of diabetes in people aged 20 years or older, by age group — United States, 2005



Source: 1999-2002 National Health and Nutrition Examination Survey estimates of total prevalence (both diagnosed and undiagnosed) were projected to year 2005.

Nearly every physician must deal with some issue related to diabetes and its complications. Worldwide, hundreds of millions of families cope with the personal and economic tolls of this disease. Governments and businesses stagger under the escalating costs of health insurance and lost productivity.

Statistics

Prevalence of diabetes in the U.S. is likely to increase for several reasons. First, a large segment of the population is aging. Also, Hispanics/Latinos and other minority groups at increased risk for developing diabetes make up the fastest-growing segment of the U.S. population. Finally, Americans are increasingly overweight and sedentary. According to recent estimates from the Centers for Disease Control and Prevention (CDC), if present trends continue, one in three Americans and one in two members of minority groups born in 2000 will develop diabetes in their lifetime. Each day, approximately 4,110 people are diagnosed with diabetes. The CDC also projects that the prevalence of diabetes in the U.S. will increase 165% by 2050.

These figures translate into an immense amount of money spent on caring for patients with diabetes. The American Diabetes Association (ADA) states the total annual economic cost of diabetes in 2002 was estimated to be

\$132 billion.² Direct medical expenditures totaled \$92 billion and comprised \$23.2 billion for diabetes care, \$24.6 billion for chronic diabetes-related complications, and \$44.1 billion for excess prevalence of general medical conditions. Indirect costs resulting from lost workdays, restricted activity days, mortality and permanent disability due to diabetes totaled \$40.8 billion.

The annual cost of health care per capita for people with diabetes rose from \$10,071 in 1997 to \$13,243 in 2002, an increase of more than 30%. Health care costs per capita for people without diabetes amounted to \$2,560 in 2002. One out of every 10 health care dollars spent in the United States is spent on diabetes and its complications.³

Types of diabetes

There are two common types of diabetes. Type 1 was previously called insulin-dependent diabetes mellitus (IDDM) or juvenile-onset diabetes. To survive, people with type 1 diabetes must have insulin delivered to their body by injection or pump. This form of diabetes usually strikes children and young adults, although disease onset can occur at any age. Risk factors for type 1 diabetes may be autoimmune, genetic, or environmental. There is no known method to prevent type 1 diabetes.⁴

Type 2 diabetes was previously called non-insulin dependent diabetes mellitus (NIDDM) or adult-onset diabetes. This type accounts for approximately 90-95% of all diagnosed cases of the disease. Type 2 diabetes is usually associated with older age, obesity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism or pre-diabetes, physical inactivity, and race/ethnicity. African Americans and Native Hawaiians or other Pacific Islanders are at particularly high risk for type 2 diabetes and its complications. Clinically based reports and regional studies suggest that type 2 diabetes in children and adolescents, although still rare, is being diagnosed more frequently.⁴

Before the discovery of insulin in 1921, everyone with type 1 diabetes died within a few years after diagnosis. Although insulin is not considered a cure, its discovery was the first major breakthrough in diabetes treatment.

Today, healthy eating, physical activity, and taking insulin are the basic therapies for type 1 diabetes. The amount of insulin must be balanced with food intake and daily activities. Blood glucose levels must be closely monitored through frequent blood glucose checking. People with diabetes also monitor blood glucose levels several times a year with a laboratory test called the A1C. Results of the A1C test reflect average blood glucose over a 2 to 3 month period. However, managing diabetes is more than keeping blood glucose levels under control — it is also important to manage blood pressure and cholesterol levels through healthy eating, physical activity, and use of medications (if needed). By doing so, those with diabetes can lower their risk of serious complications.

Complications of diabetes

Diabetes is associated with an increased risk for a number of serious, sometimes life-threatening complications.⁵ Proper diabetes management can reduce the risk. However many people are not even aware they have diabetes until they develop one of these complications.

Heart disease and stroke account for approximately 65% of deaths in diabetic patients. The risk for stroke is 2 to 4 times higher and the risk of death from stroke is 2.8 times higher among diabetic patients.

High blood pressure — about 73% of adults with diabetes have blood pressure greater than or equal to 130/80 mm Hg or take medications for hypertension.

Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year making diabetes the leading cause of blindness in adults 20-74 years of age.

Kidney disease — diabetes is the leading

cause of kidney failure, accounting for 44% of new cases in 2002. In 2002, 44,400 people with diabetes began treatment for end-stage renal disease.

Nervous system disease — about 60-70% of people with diabetes have mild to severe forms of nervous system damage. The results of such damage include impaired sensation or pain in the feet or hands, slowed digestion, carpal tunnel syndrome, and other nerve problems. Severe forms of diabetic nerve disease are a major contributing cause of lower-extremity amputations.

Amputations — more than 60% of non-traumatic lower-limb amputations occur in people with diabetes. The rate of amputations for people with diabetes is 10 times higher than for people without diabetes.

Dental disease — periodontal disease is more common in people with diabetes. Among young adults, those with diabetes have about twice the risk of those without diabetes. Almost one-third of people with diabetes have severe periodontal disease with loss of attachment of the gums to the teeth measuring 5 millimeters or more.

Complications of pregnancy — poorly controlled diabetes before conception and during the first trimester of pregnancy can cause major birth defects in 5-10% of pregnancies and spontaneous abortions in 15-20% of pregnancies. Poorly controlled diabetes in the second and third trimesters of pregnancy can result in excessively large babies, posing a risk to both mother and baby.

Sexual dysfunction — men with diabetes are two times as likely to experience erectile dysfunction as men without diabetes. Women with type 1 diabetes are twice as likely to experience sexual dysfunction compared with women without diabetes.

Other complications from uncontrolled diabetes can cause acute, life-threatening events, such as diabetic ketoacidosis and hyperosmolar (nonketotic) coma. People with diabetes are more susceptible to many other illnesses. Once they acquire these illnesses, they often have a poor prognosis. For example, they are more likely to die with pneumonia or influenza than people who do not have diabetes.

Closed claim study

The following closed claim summary reflects the medical challenges caused by a life-threatening complication of diabetes.

Presentation

A 28-year-old man came to his family physician for elevated blood pressure. The patient was scheduled for blood work (SMAC, CBC, TSH) the following business day. The

patient never returned for the blood work. One year later, the patient came back to the physician complaining of blurred vision, weakness, fatigue, weight loss, polydipsia, and polyuria.

Physician action

When the patient returned with the above complaints, his blood pressure was 148/90 mm Hg and heart rate 110 bpm. Urinalysis showed glucose of 1000, Ketone levels 160, specific gravity of 1.005, pH of 5.0. The physician obtained a Chem 21, CBC, and TSH.

The physician saw the patient three days later and discussed the results of the lab tests, including a glucose of 680; sodium of 129; chloride of 87; cholesterol of 600; and triglycerides of 4300. The CBC revealed Hgb of 15.2, Hct of 38.8, and WBC of 4,100 with a normal differential. Thyroid panel was normal.

The physician recommended hospitalization. However, the patient refused saying that he did not want to be hooked up to machines and poked by needles. The patient also indicated he could not afford medication and requested sample medications. The physician had samples of Amaryl, which he gave to the patient and instructed him to take one half tablet per day and follow-up in two weeks. He placed the patient on a sugar-free diet.

Two days later the patient was found dead in his home. Autopsy reports indicate the cause of death as diabetic ketoacidosis.

Allegations

The patient's family alleged that the physician violated the standard of care in that:

- lab values were not obtained "stat";
- the physician failed to admit the patient to the hospital and instead sent him home on a sugar-free diet;
- lab values were not monitored and/or the significance was not understood; and
- Amaryl is contraindicated in a patient with these lab findings.

Legal implications

It was felt the family physician's treatment in this case was below the standard of care. Consultants were critical of the decision not to hospitalize a patient with such an extremely elevated glucose level and possible ketoacidosis. They believed that the patient should have been immediately hospitalized and treated. Additionally, the physician should have been more aggressive in explaining the risks of not being hospitalized to the patient. All consultants were critical of the use of Amaryl for a patient with ketoacidosis.

Disposition

This case was settled on behalf of the family physician.

Risk management considerations

The first time the patient came to the office, the physician recommended lab work. The patient never returned to have the lab drawn. There was no attempt to contact the patient, and there was no entry in the medical record indicating that the patient failed to keep the appointment. It is recommended that protocols for follow-up on cancellations and no-shows be developed. This may assist in identifying patients whose conditions require a visit. By doing so, your patients are reminded that it is important to follow through with scheduled appointments. Documenting these attempts also demonstrates your efforts to contact patients should a problem subsequently occur.

As family physicians refer a large number of patients for diagnostic testing and referrals, it is critical to have a system in place to ensure that patients do not fall through the cracks. In this particular case, it is alleged that once the patient did return a year later and had lab work done, the results were not communicated in a stat fashion.

For patients who are referred for laboratory tests, diagnostic studies, or consultations, a tracking system is recommended to ensure the patient is seen and results are received in a timely manner. A "diary" system to determine if a patient is seen and that results are received is recommended. Additionally, physicians may decide to schedule test and consultant appointments for the patient, requesting the office be advised if the patient does not keep the appointment so this can be documented.

In this case, the physician alleged that the patient refused hospitalization. Additionally, the patient did not want a prescription for medication, but would agree to take available sample medication. Noncompliance or refusal of treatment should be documented in the patient's medical record. It is further recommended that a staff person, such as a nurse, witness the discussion and entry. Patient acknowledgement and understanding should be documented as well. Patients refusing medical treatment can also be asked to sign an informed refusal. Historically, patients have been successful in claims alleging they were not adequately informed regarding the benefits of a proposed treatment. They often state they would not have refused if they had been educated and informed regarding the benefits of treatment and the risk in refusing such treatment.

Why this patient was not hospitalized and

whether or not he understood the severity of his condition is open to conjecture. This article will continue with a review of two relevant studies and effective diabetes management.

Diabetes Control and Complications Trial

The importance of keeping levels of blood glucose, blood pressure and cholesterol as close to the normal range as safely possible was proven with the results of the Diabetes Control and Complications Trials (DCCT) in 1993.⁶ The DCCT was a clinical study conducted from 1983 to 1993 by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). The largest, most comprehensive diabetes study ever conducted, the DCCT involved 1,441 volunteers with type 1 diabetes and 29 medical centers in the United States and Canada. Volunteers had diabetes for at least 1 year but no longer than 15 years. They also were required to have no, or only early signs of, diabetic eye disease.

The study compared the effects of two treatment regimens — standard therapy and intensive control — on the complications of diabetes. Volunteers were randomly assigned to each treatment group.

The elements of the intensive management protocol were:

- testing blood glucose levels 4 or more times a day;
- four daily insulin injections or use of an insulin pump;
- adjustment of insulin doses according to food intake and exercise;
- a diet and exercise plan; and
- monthly visits to a health care team composed of a physician, nurse educator, dietitian, and behavioral therapist.

The study showed that keeping blood glucose levels as close to normal as possible slows the onset and progression of eye, kidney, and nerve diseases caused by diabetes. In fact, it demonstrated that any sustained lowering of blood glucose helps, even if the person has a history of poor control.

All DCCT participants were monitored for diabetic retinopathy. Study results showed that intensive therapy reduced the risk for developing retinopathy by 76%. In participants with some eye damage at the beginning of the study, intensive management slowed the progression of the disease by 54%.

Findings from the DCCT also showed that intensive treatment prevented the development and slowed the progression of diabetic kidney disease by 50%.

Study participants in the DCCT were also examined to detect the development of diabetic neuropathy. Study results showed the risk of nerve damage was reduced by 60% in

persons on intensive treatment.

DCCT participants were not expected to have many heart-related problems because their average age was only 27 when the study began. Nevertheless, they underwent cardiograms, blood pressure tests, and laboratory tests of blood fat levels to look for signs of cardiovascular disease. The study proved that volunteers on intensive treatment had significantly lower risks of developing high cholesterol.

While the benefits of intensive treatment were encouraging, there were also some risks associated with the therapy. The most significant side effect of intensive treatment was an increase in the risk for hypoglycemia episodes severe enough to require assistance from another person. Because of this risk, DCCT researchers do not recommend intensive therapy for children under age 13, people with heart disease or advanced complications, older adults, and people with a history of frequent severe hypoglycemia.

Persons in the intensive management group also gained a modest amount of weight, suggesting that intensive treatment may not be appropriate for people with diabetes who are overweight. DCCT researchers estimate that intensive management doubles the cost of managing diabetes because of increased visits to a health care professional and the need for more frequent blood testing at home. However, this cost is offset by the reduction in medical expenses related to long-term complications and by the improved quality of life of people with diabetes.

More recently, a follow-up study of DCCT participants showed that the ability of intensive control to lower complications related to diabetes has persisted more than 10 years after the trial ended. As the DCCT and other clinical trials have proven, complications from diabetes can be prevented with more intensive management.

The UK Prospective Diabetes Study

Similar to the DCCT, the United Kingdom Prospective Diabetes Study (UKPDS) was a unique, long-term clinical trial designed to find out how to treat people with type 2 diabetes to prevent complications and to maintain their health.⁷

UKPDS sought to answer these questions:

- Can the risk of complications in type 2 diabetes be reduced by intensive blood glucose control?
- In patients with high blood pressure, can the risk of complications be reduced by tight control of blood pressure?
- Does any specific treatment for type 2 diabetes or for high blood pressure confer any particular benefit?

The study demonstrated that the complications of diabetes can be prevented by better blood glucose control and improved blood pressure control than that usually achieved using existing treatments. These two approaches have now been shown to be the key to maintaining the health of patients.

Now it is known that the complications can be prevented with more intensive management. Those with type 2 diabetes need to be monitored regularly and may require additional treatments to maintain acceptable blood glucose and blood pressure control.

Screening programs should be considered to identify diabetes before it presents with symptoms so that early therapy can be initiated before the processes leading to complications can develop.

Gestational diabetes

Pregnant women who have never had diabetes but who have high blood sugar levels during pregnancy are said to have gestational diabetes mellitus (GDM). GDM affects about 8% of all pregnant women. There are approximately 135,000 cases of gestational diabetes in the U.S. each year.

Gestational diabetes affects the mother in late pregnancy after the baby's body has been formed, but while the baby is growing. Because of this, gestational diabetes does not cause the kinds of birth defects sometimes seen in babies whose mothers had diabetes before pregnancy.

Left untreated, gestational diabetes increases the risk of preeclampsia and preterm labor. Excessive glucose also crosses the placental barrier and causes macrosomia. Women with GDM have an increased risk of a difficult, instrumental-assisted delivery or a Cesarean delivery, usually because of the infant's size.

Babies with macrosomia face health problems of their own, including shoulder dystocia. Shoulder dystocia can cause Erb's palsy, which usually resolves within a few days or weeks, but in some cases may have lasting effects. More importantly, if the baby remains wedged during delivery, shoulder dystocia can lead to fetal hypoxia and death.

Due to the extra insulin made by the baby's pancreas, newborns may have very low blood glucose levels at birth and are also at higher risk for breathing problems. Babies with excess insulin become children who are at risk for obesity and adults who are at risk for type 2 diabetes.

Because of the potential harm to both the mother and baby caused by gestational diabetes, treatment usually begins quickly. Successful treatment of GDM depends on early detection and intervention. The American College of Obstetricians and Gynecologists

recommends universal screening of all pregnant women at 24–28 weeks gestation. The ADA recommends selective screening that excludes low-risk women. Low-risk women are those with a normal pre-pregnancy weight, no ethnic risk factors, and no family history of diabetes or personal history of difficult pregnancy.

The goal of treatment for gestational diabetes is to keep blood glucose levels equal to those of pregnant women who do not have gestational diabetes. Treatment for GDM includes special meal plans and scheduled physical activity. It may also include daily blood glucose testing and insulin injections.

While GDM usually disappears after pregnancy, as many as half of women diagnosed with GDM will develop type 2 diabetes within 5 years, according to published studies.⁸

Diabetes in children

“Type 2 diabetes mellitus is a new morbidity in children and adolescents. For pediatric patients, it heralds earlier onset of cardiovascular disease, retinopathy, nephropathy, and neuropathy with risk of impaired quality of life and premature death. The emergence of type 2 diabetes mellitus in young people is believed to be associated with changes in physical activity and nutrition that are ubiquitous in modern society.”⁹

The ADA recommends screening for children and youth at increased risk for the presence or development of type 2 diabetes. The criteria include:

- Overweight (BMI > 85th percentile for age and sex, weight for height > 85th percentile, or weight > 120% of ideal for height).
- Plus any two of the following risk factors:
 - family history of type 2 diabetes in first- or second-degree relative;
 - race/ethnicity (Native American, African American, Latino, Asian American, Pacific Islander);
 - signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, or PCOS); and
 - maternal history of diabetes or GDM.⁹

Effective diabetes management

More than 95% of diabetes care is carried out by the patient,¹¹ therefore it is critical that the patient be involved in devising their diabetes care plan. “Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Diabetes care is complex and requires that many issues,

beyond glycemic control, be addressed.”¹⁰

While the challenge of providing effective diabetes care can be a monumental task for physicians, comprehensive and practical resources are available.

The National Diabetes Education Program has launched a new online resource to help health care professionals organize their diabetes care. The web site — www.betterdiabetescare.nih.gov — provides information, models, links, resources and tools to help physicians design and implement effective health care systems for those with diabetes.

Additionally, the ADA has updated their *Standards of Medical Care in Diabetes — 2006*.¹¹ These standards offer a comprehensive review of the following:

- classification and diagnosis;
- screening for diabetes;
- detection and diagnosis of GDM;
- prevention/delay of type 2 diabetes;
- diabetes care;
- prevention and management of diabetes complications;
- diabetes care in specific populations;
 - children and adolescents
 - preconception care
 - older individuals
- diabetes care in specific settings;
 - in the hospital
 - in the school and day care setting
 - at diabetes camps
 - in correctional institutions
- hypoglycemia and employment/licensure;
- third-party reimbursement for diabetes care, self-management education, and supplies; and
- strategies for improving diabetes care.

The *Standards* are available at http://care.diabetesjournals.org/cgi/reprint/29/suppl_1/s4. It is recommended that physicians who treat or screen patients for diabetes be familiar with these standards.

The ADA also maintains a comprehensive web site for patients, available at <http://www.diabetes.org/home.jsp>.

Conclusion

Researchers continue to look for the cause of diabetes and ways to manage, prevent, or cure the disease. Earlier recognition of symptoms, combined with new medications and a team approach to tackling the disease, are helping people with diabetes live longer and healthier lives. At the level of the physician-patient relationship, the ongoing medical management of patients with diabetes presents great challenges to physicians in all aspects of their care. Remember to document comprehensive assessments, findings, plan

of care, patient education and informed choice(s), and level of compliance or noncompliance with the treatment regimen.

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CME test questions

Instructions: Using black ink, read each question, select the answer, and then clearly mark your selection. Please fax the completed test and evaluation forms to the Risk Management Department, attention Rebecca Henson 512-425-5996. You can also mail the test and evaluation forms to the TMLT Risk Management Department, attention Rebecca Henson, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide on the CME evaluation form.

1. It is estimated that 7% of the United States population has diabetes.

- True
- False

2. The CDC projects

- 56%
-

3. According to the A was

- \$44.1 billion

4. Which of the follo

- nervous system
- sexual dysfuncti
- dental disease
- all of the above

5. The Diabetes Con were both successfu

- True
- False

6. Left untreated ge

- macrosomia
- preeclampsia
- preterm labor
- all of the above



Statement of completion

I attest to having spent _____ hours in this CME activity.

Physician signature _____ Date _____

CME evaluation form

Please complete the following regarding the article, "Caring for Patients with Diabetes."
Please fax the completed evaluation with the CME test questions.

1. The objectives for this activity are:

2. The material will:

3. Did you perceive this activity as relevant to your practice?

Yes No

4. How long did it take to complete this activity?

0.5 hr

5. On a scale of 1 to 5, how relevant is this activity to your practice?

1 2 3 4 5

6. What will you do as a result of this activity?

7. Suggestions for future topics include:

8. Suggestions for future topics include:

Contact information

Name _____

Address _____

Phone _____

TMLT policyholder? Yes No



closed claim studies

Failure to diagnose colon cancer

by Barbara Rose and Laura Brockway

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

Presentation

A 47-year-old woman with a history of anal cancer and surgery three years earlier was referred to a gastroenterologist. She complained of vaginal bleeding with sexual intercourse and lower abdominal cramping.

Physician action

The first visit with the gastroenterologist occurred on November 6. He performed a rectal examination and found no masses. He ordered a CT scan to rule out recurrence of the anal mass, and indicated that he planned to perform a colonoscopy later. He charted that he planned a follow-up appointment, but the patient was not given an appointment date and she was not called to arrange a follow-up appointment.

The CT scan was completed on November 11, and the report was sent to the gastroenterologist's office. It stated, "a partially necrotic mass involving the left posterior wall of the rectum is suspected." The radiologist recommended confirmation with barium enema and/or colonoscopy. The mass was reported as being 4 cm in length, located 6 cm from the anus. While the gastroenterologist agreed that the report was received in his office, for unknown reasons, the patient was not contacted about the results or to arrange an appointment.

The patient returned to the gastroenterologist on May 29 complaining of a 3-

day history of lower abdominal pain, nausea, and frequent bowel movements. The gastroenterologist examined the patient and found her to be pale with no cardiovascular, chest, or abdominal abnormalities. His impression was possible recent small bowel obstruction, anemia, and need for a rectal examination. He planned to obtain a colonoscopy, CBC, repeat CT scan, and possible small bowel follow through. The gastroenterologist did not discuss the November 11 CT scan results with the patient or recommend the follow-up outlined by the radiologist.

The gastroenterologist's notes indicated a phone call to the patient on June 5 in which she reported feeling well, and a comment "awaiting colonoscopy." The gastroenterologist advised that he made this call to the patient after receiving some lab results. The patient was scheduled for a colonoscopy on June 18, but according to the patient, was not told she needed the colonoscopy urgently. The patient cancelled the June 18 colonoscopy due to travel plans.

The patient then tried to reschedule the colonoscopy in August, but was told they were not scheduling colonoscopies due to localized flooding of hospitals. The gastroenterologist next spoke to the patient by phone, and she reported loose stools and frequent bleeding. The chart note for this phone call stated "I do not know why she has delayed colonoscopy." According to the patient, the gastroenterologist became very angry with her during the phone conversation and yelled at her for not having the colonoscopy. Following that conversation, the patient decided to seek care from another gastroenterologist.

The patient saw another gastroenterologist on September 17. He examined her and found her abdomen distended and slightly tender. Her H & H was 6.7/21.9. Digital rectal exam revealed a palpable tumor that he described as fixed, circumferential and very firm. A CT scan performed on September 19 revealed a large rectal mass and lesion in the right lobe of the liver. (The liver lesion was not present on the November 11 CT

scan.) The rectal mass was reported as being larger than on the previous CT scan.

The patient was hospitalized, and a diverting colostomy was performed. The patient then underwent chemotherapy resulting in a reduction of the tumor size. Abdominal surgery occurred on March 29 consisting of resection of the distal sigmoid colon and rectum with hysterectomy, upper vaginal resection, and partial resection of the sacrum. A biopsy of the liver lesion did not indicate the presence of cancer.

At the time the claim was filed, the patient was doing well with no recurrence of cancer. However, she does have a permanent colostomy, loss of sexual function, and urinary incontinence.

Allegations

A lawsuit was filed against the gastroenterologist alleging negligence in failing to note and report the results of the CT scan. It was further alleged that the gastroenterologist's failure to initiate follow-up treatment resulted in the patient having to undergo more extensive surgery as a result of the delay in diagnosis.

Legal implications

The plaintiffs retained testimony from credible experts to support the allegations. Their gastroenterology expert stated that the defendant fell below the standard of care in failing to advise the patient of the CT scan findings and failing to perform or refer the patient for a biopsy of the mass. Also testifying for the plaintiffs was the patient's treating surgeon. He stated that the patient's surgery was much more extensive as a result of the delay, necessitating a hysterectomy, partial removal of the vagina, partial removal of the sacrum, and development of permanent urinary incontinence. He also testified that, although unable to support his opinion with literature, common sense

*continued on page 24
continued from page 22*

Failure to order pneumococcal vaccine

by Barbara Rose and Anna Tausin

Presentation

A 34-year-old man came to the emergency department (ED) following a motor vehicle accident. Tests revealed a ruptured spleen and several broken bones.

Physician action

A general surgeon, the defendant in this case, performed an exploratory laparotomy and splenectomy on the patient. An orthopaedic surgeon reduced the right ulna and left distal radius. Both surgeries went well and the patient remained in the hospital for 16 days. The general surgeon continued to see him, but he was primarily under the care of the orthopaedic surgeon.

The orthopaedic surgeon wrote the discharge orders, and indicated that the patient should follow up with the general surgeon. According to the general surgeon, before discharge he educated the patient about his susceptibility to infection and the need to obtain a pneumococcal vaccination from his primary care physician. This conversation was not documented in the hospital chart. However, it was the general surgeon's practice to have this conversation with all post-splenectomy patients. The patient did not follow up with the general surgeon.

Sixteen months after the splenectomy, the patient was seen in a local ED with flu-like symptoms. The ED record stated, "splenectomy status-post MVA? Immunization." A physician's assistant evaluated the patient and diagnosed bronchitis and a viral syndrome. The PA gave orders for the patient to follow up with his primary care physician in three days or return to the ED if his symptoms worsened. The PA later testified that he discussed with the patient the importance of receiving a pneumococcal vaccination. This conversation was not documented in the chart.

Three months after this ED visit, the patient was seen by his family physician for cold symptoms and severe neck pain. The family physician sent him to the ED. The patient was seen by an emergency medicine physician who performed a lumbar puncture. The results were normal. The patient was given prescriptions for Skelaxin, Vicodin, and Zithromax. The ED physician later testified that he told the patient about the need to obtain a pneumococcal vaccination. This discussion was not documented in the ED record.

Another three months passed and the patient again became ill with flu-like symptoms. He was taken to a local ED and then transferred to another hospital. The patient was diagnosed with overwhelming post-

splenectomy sepsis (OPSS). He developed disseminated intravascular coagulation, embolization of his extremities, and gangrene with necrosis of his digits. He required amputation of his fingers and toes and received extensive rehabilitation.

Allegations

A lawsuit was filed against the general surgeon alleging negligence in failing to provide the patient with a pneumococcal vaccination following spleen removal. The plaintiffs argued that the lack of vaccination caused the development of OPSS and resulted in irreversible, disabling, and disfiguring injuries. The hospital, the orthopaedic surgeon, and several of the patient's subsequent physicians were also named in the suit.

Legal implications

The plaintiff's surgery expert was critical of the defendant for not ordering the pneumococcal vaccine in the hospital. He testified that the defendant fell below the standard of care because he only informed the patient of the need for the vaccine and did not make efforts to get him vaccinated. According to this expert, the vaccine is routinely given in the hospital to all post-splenectomy patients before discharge.

The issue of whether the patient should have been given the vaccine before discharge was hotly debated among the defense experts who reviewed this case. The defendant general surgeon testified that he did not routinely order the pneumococcal vaccination in the hospital for fear of eliciting a febrile response that might be mistaken for a postoperative infection. One defense expert testified that he was taught during his residency not to give the pneumococcal vaccine in the hospital, but to advise patients to obtain it later from their primary care physician. Further, though the vaccine is now routinely given in the hospital before discharge, at the time of the patient's splenectomy (2001) this was not prevalent practice. However, the overall consensus of the reviewers was that the defendant fell below the standard of care in not ordering the vaccine.

Another issue for the defense was patient accountability. Though the patient was told at discharge to follow up with the general surgeon, he failed to do so. He did not follow the general surgeon's order to obtain the vaccine from his primary care provider. The patient also failed to follow advice given by two other health care professionals to obtain the vaccine. Unfortunately, neither the general surgeon nor the subsequent treaters documented this advice in the med-

ical record.

Regarding causation, an infectious disease specialist who reviewed this case stated that it is unknown what type of pneumococcal strain infected the patient. It may be that he became infected with a type not covered by the vaccine. It was possible that the patient may have had the same outcome even if he had been given the vaccine. However, the expert stated that the greater likelihood is that had the patient been vaccinated, he would not have contracted OPSS.

Disposition

This case was settled on behalf of the general surgeon. The inability to find a completely supportive expert, the lack of documentation regarding the vaccine, and the debilitating nature of the patient's injuries led to the decision to settle this case. The plaintiffs continued to pursue the case against the hospital and subsequent treaters.

Risk management considerations

All directives from a physician to a patient are expected to be included in the medical record. A discharge order written by the defendant after his final progress note on this patient could have included the recommendation for the pneumococcal vaccine. Physicians who are called for inpatient consults may have no office record on these patients until they present for a postoperative appointment. Consequently, when a patient is not compliant after discharge and does not schedule a postoperative appointment as directed, there is very likely no information regarding that patient in the physician's office.

In this case, the absence of a written reference to the conversation regarding the pneumococcal vaccine allows the plaintiff to state that it never happened. Noncompliant patients create challenges for any physician and practice. It is unfortunate when a noncompliant patient experiences a bad outcome because the scales are not balanced when determining fault. Consequently, the medical record is expected to include an accurate chronology of physician orders, patient education, and compliance.

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indicated the patient's chance of survival was reduced by the delay in diagnosis.

TMLT was unable to retain expert support for the gastroenterologist on standard of care issues. Specifically, defense consultants advised that the standard of care required the results of the November 11 CT scan be relayed to the patient, and the recommendations discussed with the patient. However, defense experts stated that it was unclear whether or not surgery was more extensive or the patient's chances of survival reduced as a result of the nine-month delay. One surgery expert stated that the extent of the surgery probably was not increased as a result of the delay. Although testifying for the plaintiffs, the patient's treating surgeon stated the patient would have required a permanent colostomy even if the cancer had been diagnosed in November. Essentially, the issue of whether or not the patient's surgery was more extensive as a result of the delay in diagnosis came down to a debate between "dueling experts."

Further complicating this case were claims by the patient that she was contacted by "someone" in the gastroenterologist's office, and informed that the results from the November 11 CT scan were normal. According to the patient, she was told that

if the CT scan was normal she should return to her other doctor and undergo pain management. The gastroenterologist advised that this is impossible, since no one in his office is authorized to relay results of a CT to a patient, and certainly would not report an abnormal CT as normal. It is his office protocol for a nurse to contact a patient with an abnormal CT scan and schedule an appointment so the results can be discussed in person. In this case, it appears the patient was not given an appointment and she did not return or ask about the CT scan at future visits because she was allegedly informed everything was normal.

Patient accountability was a factor in this case. The patient did not ask the gastroenterologist about the CT results during her May 29 appointment. She also delayed the June 18 colonoscopy due to travel plans. Given her history of anal cancer, the argument could be made that the patient should have been more diligent in questioning the physician about her test results and obtaining a colonoscopy.

Disposition

This case was settled on behalf of the gastroenterologist. The inability to locate expert support for his care of the patient, and the fact the treating surgeon was criti-

cal on issues of causation and damages led to the decision to settle this case.

Risk management considerations

Every practice needs a well defined and consistently followed process to verify that test results have been received and acted upon. In this claim, the failure by office staff and the defendant to review the CT scan results and order further tests was not explained. Reports must not be filed in a medical record until the ordering physician has reviewed them and determined the next course of action.

Some patients will not be actively involved in their care. Even if advised to contact the practice in a set timeframe, e.g., "call in 2 weeks if you have not been contacted with test results," some will not comply. It is the responsibility of the ordering physician to have a system in place for follow up to ensure continuity of care.

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