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Foreword

“The only real mistake is the one from which we learn nothing.” — John Powell

This volume of closed claim studies has been prepared for just this purpose — to encourage readers to learn from the experiences of others. These studies are based on actual malpractice claims. They illustrate how actions or inactions by physicians led to allegations of medical liability and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The ultimate goal in publishing this book is to help physicians practice safe medicine.

The claims described in this book represent claims with clear risk management issues. The claims featured often involve severe patient outcomes, and are not necessarily representative of all claims.

When writing closed claim studies, we make every effort to eliminate identifying information without compromising the clinical details of the case. Geographic locations and dates have been changed, and the names of patients and physicians have been removed. If you recognize a claim, please be assured that it is presented only to emphasize the important issues in the case.

For those who would like to receive 4 hours of CME and the risk management discount for reading this book, please see page 7 or visit http://lonestara.inreachce.com/. Follow the on-screen instructions to complete the CME forms and download your certificate.
CME information

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The authors listed on page 2 are employees of the claim operations, risk management, and communication departments.

Disclosure
The authors have no commercial affiliations/interests to disclose related to this activity.

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Estimated time to complete activity
It should take approximately 4 hours to read this book and complete the test and evaluation forms.

Release/review date
This activity is released on August 3, 2015 and will expire on August 3, 2018.
Target audience
This 4-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

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

• recognize practical strategies to avoid litigation and enhance defensibility in the event of a lawsuit;
• discuss issues associated with allegations of improper performance;
• identify the types and causes of communication errors;
• explain how good documentation techniques can help prevent malpractice claims;
• list allegations prevalent in lawsuits involving failure to follow up; and
• describe strategies to reduce diagnostic errors.
Improper performance
Uterine rupture during VBAC

Presentation
A woman came to her ob-gyn to begin prenatal care. This was her second pregnancy. The patient’s first child was delivered by cesarean with a low transverse uterine incision. She was now a candidate for a vaginal birth after cesarean (VBAC).

Physician action
The patient’s prenatal care was uncomplicated. She was admitted to the hospital at term. Medication was provided to ripen her cervix, and the next morning oxytocin was administered to induce labor. She made good progress during the day and was approaching the second stage of labor in the late afternoon.

That evening, the ob-gyn left the hospital to eat dinner. At 8:49 p.m., during the ob-gyn’s absence, the patient suffered a uterine rupture with placental expulsion. The nurses stopped the oxytocin and paged the ob-gyn who ordered a stat cesarean delivery. He returned to the hospital and performed an emergency cesarean delivery. A moribund, asphyxiated infant with Apgar scores of 2/0/0 was delivered at 9:14 p.m. Resuscitation efforts were unsuccessful and the newborn was declared dead 30 minutes later.

Allegations
A lawsuit was filed against the ob-gyn, his practice association, and the hospital. The allegations included:
• failure to be immediately available to perform an emergency cesarean delivery during VBAC;
• failure to adequately monitor the patient’s labor pattern and fetal status;
• failure to diagnose a ruptured uterus and fetal distress;
• failure to inform the patient of the risks associated with VBAC; and
• failure to obtain informed consent.

The plaintiffs designated credible experts who provided both standard of care and causation testimony critical of the ob-gyn. The plaintiff’s ob-gyn expert testified that the uterine rupture was the result of hyper-stimulation of the uterus caused by the administration of oxytocin and cervical ripening. He further testified that physicians must be “immediately available” to perform a stat cesarean delivery on VBAC patients. Since the defendant left the hospital, he was not “immediately available.” This delay led to the death of the infant.

The defense of the ob-gyn was complicated by several factors. While defense experts felt the patient met the American College of Obstetricians and Gynecologists (ACOG) criteria for VBAC, and that the induction of labor was correctly conducted, one expert questioned the use of cervical ripening gel and oxytocin.

Though there were no indications on the fetal monitor of an impending rupture or delivery, no defense expert was able to support the physician leaving the hospital. The ob-gyn was 14 minutes away and they questioned whether this constituted being “immediately available” per ACOG guidelines. The ob-gyn delivered the infant within the 30 minute “decision to incision” time frame, but it was questionable
whether this 30 minute standard applies to VBAC deliveries given the ACOG criteria that a physician be “immediately available” for VBAC deliveries.

Regarding causation, defense experts testified that because of the complete separation of the placenta from the uterine wall, the alleged delay did not affect the outcome. They argued that even if the ob-gyn had been with the patient at the time of rupture, the infant would not have been able to survive the total abruption.

Disposition
This case was taken to trial and the jury returned a verdict in favor of the plaintiffs. The jury determined the ob-gyn was responsible for the outcome. An appeal of the verdict was planned; but, a settlement was reached during post-verdict mediation.

Risk management considerations
VBAC is associated with a small but significant risk of uterine rupture. ACOG’s practice guidelines “Vaginal Birth After Previous Cesarean Delivery,” released in 1999 and updated in 2004, state, “Because uterine rupture may be catastrophic, VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care.”

Since the publication of this bulletin, there has been much debate among obstetricians regarding the “immediately available” criteria. One defense expert indicated that the defendant’s decision to leave the hospital was “clearly outside of most stated hospital protocols and policies.” Physicians are encouraged to be aware of and practice within their specialty guidelines and hospital protocols.

ACOG’s “Evaluation of Cesarean Delivery” indicates that in most cases, the cause of uterine rupture in a patient who has undergone VBAC is unknown, but poor outcomes can occur even in appropriate candidates with proper management. In this case, the ob-gyn left the hospital and complications arose during his absence. Whether or not this action contributed to the outcome was irrelevant to the jury.

Secondary to the allegations of failure to monitor, the plaintiffs also claimed the physician failed to obtain informed consent for VBAC. ACOG guidelines state: “After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician. This discussion should be documented in the medical record.” Following this discussion, physicians might consider using a printed informed consent form to document the discussion, the patient’s understanding of the discussion, and the patient’s decision.

Sources
Failure to treat coronary artery disease

Presentation
A 40-year-old man came to a family physician with a chief complaint of an earache. The patient reported that he smoked, and had a family history of heart disease (both parents) and hypertension (sibling and mother). At this visit, the patient’s blood pressure was elevated and labs indicated high cholesterol. An EKG was interpreted as normal.

Physician action
The patient was given bisoprolol/hydrochlorothiazide for his blood pressure and medication for the earache. The family physician also recommended a low-fat diet and regular exercise.

Over the next 5 years, the family physician and his nurse practitioner (NP) treated the patient for his hypertension and high cholesterol. The bisoprolol/hydrochlorothiazide was continued and simvastatin was added. The medical records from these visits indicate that the patient was not completely compliant with the recommendations to exercise and follow a low-fat diet. The patient continued to smoke and have high cholesterol.

Approximately six years after his initial visit, the patient came to the office complaining of “heartburn when runs,” and to obtain prescription refills. The patient was seen by the NP, who noted in the record the complaint of “when running, gets acid burning in chest.” The NP indicated that she always checks the patient’s heart, lungs, and abdomen with a stethoscope and only notes abnormalities. There were no notations for this exam. The patient’s blood pressure was 140/100 mm Hg. The NP diagnosed GERD and recommended a GI study. The office note for this visit was not countersigned by the family physician. The physician does not remember if he and the NP discussed this visit, although it is his practice to do so.

Five days later, the patient reported to a diagnostic center for an upper GI. The results were interpreted as hiatal hernia with no evidence of reflux.

The patient returned to the family physician’s office one month after the upper GI. The NP discussed the upper GI results with the patient, and diagnosed hypertension, hiatal hernia, and occasional reflux when running. The NP prescribed esomeprazole before running and increased the dosage of simvastatin. The patient was advised to return as needed. The written exam findings were minimal, but the NP did say that she checked the patient’s heart, lungs, and abdomen. As with the previous office visit, the office note was not countersigned by the physician. The physician did not recall if he discussed this visit with the NP.

Approximately one month after this office visit, the patient suffered a myocardial infarction and died at the age of 46. In the autopsy report, the pathologist said the patient died as a result of severe coronary atherosclerosis. A 90% narrowing on the descending branch of the left coronary artery, a 30% narrowing of the circumflex branch of the left coronary artery and a 20% narrowing of the right coronary artery were found. There was also evidence of a previous MI.
Allegations
A lawsuit was filed against the family physician and the nurse practitioner. The allegations included:

- failure to treat the patient for a persistent complaint, including signs and symptoms of coronary artery disease;
- failure to order diagnostic tests to determine the cause of the patient’s complaints;
- failure to refer the patient for cardiac evaluation; and
- failure to supervise the nurse practitioner.

Legal implications
The plaintiff’s expert testified that the family physician failed to meet the standard of care because the patient’s “BP and blood lipids were inadequately controlled, aspirin was not prescribed, and the symptom of chest burning was unrecognized as a manifestation of coronary artery disease.” Further, the expert stated the patient should have been sent for a cardiac work-up before being sent for a gastrointestinal evaluation.

The allegations regarding failure to supervise the NP were based on the medical records from visits in which the patient was seen solely by the NP. The records from these visits were not countersigned by the physician, and there was no documentation that the NP and the physician conferred about the patient’s new symptom of “heartburn when runs.”

Defense consultants were not entirely supportive of the care provided by the defendants. It was the opinion of one consultant that exercise-induced chest symptoms in a man with a family history of coronary artery disease, poorly controlled hypertension and hyperlipidemia, and a history of tobacco use is ischemic cardiac disease until proven otherwise. One consultant stated that it is common for a patient to self-diagnose heartburn even when the symptoms are suggestive of coronary ischemia. Practitioners can sort this out by asking questions to support the diagnosis of cardiac versus GI symptoms. Consultants described the care given as significantly weak due to the defendants missing the diagnosis of new onset angina. They were also critical of this physician for not properly supervising the NP.

Patient noncompliance became an issue in this case. A review of pharmacy records indicated the patient did not take his simvastatin regularly — for a period of nine months at a time. The patient also did not follow up as scheduled with the family physician, often only returning for prescription refills. The patient’s wife testified that, after her husband’s last office visit, he reported that the medications did not alleviate the burning sensation. She encouraged her husband to contact the physician, but does not know if he did so.

Disposition
Because the main allegations in this case involved the actions of the NP, the court was asked to dismiss the physician from this suit. This request was denied by the judge who stated that a physician is responsible for the actions of his or her NP. This case was settled on behalf of the family physician and the NP.

Risk management considerations
A complete, comprehensive medical record not only provides a chronological history of patient care, but it may become the foundation for defending the physician and his or her staff if a lawsuit is filed. If an NP routinely examines the patient but only documents
Failure to treat coronary artery disease

the presence of abnormal findings, the record sends the message that the patient was not thoroughly examined. The documentation of each visit needs to accurately reflect everything that occurred.

Complete documentation can also help physicians and mid-level practitioners know which patients they discussed. The notes of the NP are expected to include a notation that the patient’s condition was discussed and that the physician concurs with or alters the plan of care.

When physicians employ mid-level practitioners, they assume responsibility for the actions of that person. It is incumbent on the employer to develop a comprehensive job description and written protocols describing the delegation of duties for that person to follow. Documentation guidelines and when to consult with the physician should be well defined. To document events accurately, a physician can develop a protocol to review and co-sign the notes, indicating that a consultation occurred and that the notes are correct.
Medication error

Presentation
A 37-year-old woman came to her family physician and reported stepping on a nail two days earlier. The patient had severe swelling and pain in the right foot distally near the great toe. She also complained of an earache.

Physician action
The family physician diagnosed cellulitis secondary to the puncture wound and ordered a bone scan. He also prescribed levofloxacin. The radiologist interpreted the bone scan as suggestive of bony involvement and possible infection in the proximal and distal phalanx of the great toe of the right foot.

Upon review of the bone scan report, the family physician instructed the patient to continue the levofloxacin and have a repeat bone scan in four days. The repeat bone scan was interpreted as highly suggestive for osteomyelitis and perhaps associated soft tissue infection. The patient was referred to an orthopedic surgeon.

The orthopedic surgeon recorded the patient’s history of stepping on a nail in her backyard with her left foot three weeks ago. The patient reported that she tried to push off with the right foot and stepped on a nail with that foot as well. Her left foot was symptom free but her right great toe continued to hurt. The orthopedic surgeon’s impression was acute osteomyelitis of the right great toe secondary to foreign body puncture wound. He recommended surgery with incision and drainage to open the cortex of both bones. He planned to place a central line and send her home on IV antibiotics. His report states, “I explained all of this to her today in addition to the problems associated with trying to cure osteomyelitis. It is difficult to maintain a high level of antibiotics in the bone to cure the disease.”

The incision and drainage were performed on July 16. A subclavian catheter was placed on the left for IV antibiotic administration. Tissue cultures, but no bone fragments, were sent to pathology for culture and sensitivity. The physician ordered gentamicin to be administered to the patient via a home health care agency. The initial order for gentamicin administration was 80 mg every 8 hours.

Lab results on July 17 indicated that the patient was below therapeutic peak and trough levels. On July 19, the physician increased the gentamicin dosage to 100 mg every 8 hours.

The patient returned to the office on July 20 complaining of some heaviness in her chest. A chest x-ray revealed no evidence of pneumothorax. Her subclavian catheter was in good position. Her tissue culture revealed *Staphylococcus non-aureus* species and a bacillus. A lab report on this date revealed that the patient had still failed to achieve therapeutic peak and trough levels of gentamicin.

On July 21, the orthopedic surgeon increased the gentamicin dosage to 180 mg every 8 hours. A home health care agency was monitoring the patient and obtaining blood samples to check her therapeutic peaks and troughs. According to the infusion therapy worksheet, the peaks and troughs were checked on July 19 (dosage increased...
to 100 mg), July 21 (dosage increased to 130 mg), July 24 (dosage increased to 150 mg), July 27 (dosage increased to 180 mg), July 30 the patient was not available, and August 2 (same dosage). The collection date was usually the day before the report dates above. The IV therapy was discontinued on August 11. Her toe looked excellent and the osteomyelitis had resolved.

The patient returned on August 30. She reported developing profound dizziness two days after discontinuing her central line and IV gentamicin. She had seen an otolaryngologist for the dizziness. An MRI of the brain was interpreted as normal and her auditory canals appeared to be normal. The orthopedic surgeon reviewed her peaks and troughs and noted that they had always been well within normal limits. The patient reported to him that she has had a profound deafness in her right ear dating back to when she was a teenager. The physician’s impression was labyrinthitis, possibly secondary to gentamicin.

Approximately one month later, the patient called the orthopedic surgeon’s office almost hysterical. Vestibular testing conducted by the ENT indicated she had lost her vestibular function. She reported that she was unable to drive or do anything due to imbalance. She also complained of nausea. The ENT had given her meclizine for dizziness but she was afraid to take anything due to the problems with the gentamicin. The orthopedist recommended hydroxyzine for the nausea and anxiety.

The orthopedic surgeon’s chart contained a consult letter from a second ENT. Her evaluation included audiometric findings of a significant hearing loss in the patient’s left ear (previously reported as right ear), which developed about 20 years ago of sudden onset. The examination showed normal external auditory canals and normal tympanic membranes. The patient was able to ambulate without assistance but was very cautious and unsteady. Testing suggested bilateral vestibular hypofunction. They were hopeful for a good recovery but thought it may take as long as a year.

The ENT recommended aggressive vestibular rehabilitation therapy. The patient and her husband were concerned that a significant mistake was made in her medical management. The ENT advised them that the fact that she had developed bilateral vestibular hypofunction from gentamicin therapy does not in and of itself mean that appropriate precautions were not taken. Vestibular ototoxicity may, in some cases, be essentially an idiosyncratic reaction.

The patient returned to the orthopedic surgeon to inquire if the bone scan could be repeated. The physician advised he would like to wait six months, but he suspected her osteomyelitis was cured. She was to return in six weeks but did not keep the appointment.

**Allegations**
A lawsuit was filed against the orthopedic surgeon and the home health care agency. Allegations against the physician included:
- failure to prescribe an adequate course of treatment;
- prescribing gentamicin when it was not indicated;
- prescribing excessive amounts of gentamicin;
- failure to reasonably inform plaintiff of possible consequences of treatment;
- failure to monitor plaintiff’s medication levels;
- prescribing gentamicin for a longer period of time than was reasonable;
Medication error

• failure to act within the reasonable standard of medical care; and
• failure to order and interpret diagnostic tests.

Legal implications
During the I&D performed on the patient, there were no bone samples submitted to pathology to seek a definitive diagnosis of osteomyelitis and obtain culture and sensitivity data. The lack of this information left the indications for the use of a potentially toxic antibiotic in question. The patient was tested on multiple occasions after the date of loss with a demonstrated level of zero vestibular function, showing a permanent injury in this relatively young plaintiff.

The amounts of gentamicin prescribed by the physician exceeded the Physicians Desk Reference black box warnings that carried a recommended dosing schedule not to exceed 7 mg/kg in patients with what is to be considered a life-threatening condition. The dosage recommended for lesser conditions was recommended not to exceed 5 mg/kg. This patient’s dosing schedule included amounts that were as high as 8 mg/kg. The plaintiff contended that the highest indicated dosage was 5 mg/kg. It was noted by the defendant’s expert that the orthopedist’s final order to increase the gentamicin level was entered after the patient’s lab reports indicated that she had achieved a therapeutic level of the drug.

Helpful to the defense were the results of the patient’s peak and trough measurements. These never reached toxic levels and only reached therapeutic levels after the administration of progressively increased doses of gentamicin. The plaintiff contended that the pattern of the patient’s response to therapy should have raised the physician’s index of suspicion for lab error, given the sub-therapeutic results in the face of increasing dosages.

Disposition
The lack of a pathologic diagnosis of osteomyelitis combined with gentamicin administration at dosages in excess of those recommended for life-threatening conditions were weaknesses in this case. This, combined with the permanent nature of the patient’s injuries, led to the decision to settle this case.

Risk management considerations
Medication errors continue to be a prevalent allegation in lawsuits against physicians. The orthopedic surgeons who reviewed this case felt that more in-depth testing was needed to make a definitive diagnosis of osteomyelitis. The lack of information left the physician’s indications for the use of a potentially toxic antibiotic in question. In addition, the amounts of gentamicin prescribed exceeded the PDR black box warnings. The defendant’s final order to increase the gentamicin level was entered after the patient’s lab reports indicated she had achieved a therapeutic level of the drug.

Obtaining a comprehensive medical history on new patients is essential to planning appropriate care and managing risk. A complete medical history on this patient would have made the physician aware of her hearing problems and perhaps altered the choice of antibiotic.
Unnecessary spinal surgery

Presentation
A 62-year-old woman with a long history of back pain came to the defendant orthopedic surgeon. She complained of chronic back pain, leg pain, and foot pain. The physician took x-rays of her lower back, which showed that some of her pedicle screws still remained in place with the left L4 screw possibly dislodged from the pedicle. He also reviewed the patient’s MRI scan of the lumbar spine. He indicated that the scan showed spondylitic changes and a degenerative condition in the patient’s lumbar spine.

The orthopedic surgeon did not physically examine the patient on this visit, but watched her walk and observed the manner in which she stood and sat. From these observations and the x-rays, he believed that the patient had functioning distal motor nerve roots, and that she was probably suffering from a non-healing fusion with residual stenosis and scar tissue.

Physician action
On the patient’s next visit, the orthopedic surgeon examined her. She was continuing to complain of back and bilateral leg pain with numbness in her right foot. He ordered a standing scoliosis film. According to the radiologist, the film showed scoliosis in the lumbar spine of approximately 21 degrees. After reviewing all the patient’s films, the orthopedic surgeon believed that she had significant degenerative scoliosis, and a failed fusion at the L4 to S1 level of her spine.

The patient was admitted to the hospital and underwent an exploration of her previous lumbar spinal fusion, a take-down of a pseudoarthrosis at the lower lumbar levels, a neuroplasty bilaterally at the L4-S1 levels of her spine, and bilateral foraminoectomy from L3 through the sacrum. The orthopedic surgeon also performed a laminectomy and bilateral foraminoectomy from the L3-4 level to the L5-S1 level and a posterior spinal fusion from the 11th thoracic vertebrae to the sacrum.

Eight months postoperatively, the patient was complaining of right leg pain, which radiated to her foot. The orthopedic surgeon indicated that her exam was within normal limits and diagnosed her condition as sacroiliac joint arthrosis and pain secondary to his previous fusion, with a need to rule out continued discogenic pain and residual stenosis as the cause of the complaints. He ordered lumbar spine x-rays which, according to the radiologist, showed postoperative and degenerative changes such as hypertrophic spurring involving the anterior vertebral body margins at the 11th thoracic through first lumbar vertebrae, but also that her fusion was in place with normal alignment.

The patient obtained a second opinion from another orthopedic surgeon. He diagnosed her condition as failed back syndrome, and referred her to his partner for consult. That exam revealed a markedly depressed patient with an antalgic posture, reversed lumbar lordosis and an instrumented fusion. He also said that x-rays taken showed excellent positioning and early progressive healing, although she was having difficulty with her brace. After reviewing her records, he documented a lack of understanding why the patient underwent such extensive surgery. It was his opinion that
Unnecessary spinal surgery

she would need a wheelchair for community ambulation, with the assistance of a walker and wheelchair in her house. She has successfully fused, however he did not see any potential improvement in the future no matter what was done other than trying to maintain her pain control with medications.

Allegations
A lawsuit was filed against the orthopedic surgeon. The allegations included:
• failure to properly evaluate the patient’s condition by submitting her to appropriate test procedures before subjecting her to additional surgery;
• performing unnecessary procedures, which did not alleviate her condition; and
• performing surgical procedures negligently which aggravated her condition and caused her to experience incessant pain on a daily basis.

Legal principle
Negligence, when used with respect to the conduct of a physician, means failure to use ordinary care—that is, failure to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances.

It was the opinion of defense consultants that the physician failed to document the indications for the surgery, and that the patient was not a good candidate for such an extensive fusion. These consultants felt that the surgery was excessive and the result was predictable.

Disposition
This was a difficult case to defend due to the permanent injury suffered by the patient as well as the lack of documented indications for the surgery. This case was settled during mediation.

Risk management considerations
The defendant physician felt that he was qualified to perform the procedure and performed a proper exam to justify the surgery. Thus did not seek a second opinion. However, consultants were concerned with the lack of documentation justifying the surgery and felt the patient was not a good candidate for such an extensive fusion.

When contemplating surgery of this magnitude in an elderly patient with a long history of chronic back pain, it is prudent for the physician to seek other opinions regarding the surgery and the indications. Complete, comprehensive documentation of the indications for and the alternatives to surgery along with concurring surgical opinions would have assisted in this physician’s defense.
Pathology contamination

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

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

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

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

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

The oncologist questioned the diagnosis of small cell carcinoma, stating in the medical record “tumor board review of her history and scans still is not definitive.” The patient did have a mediastinal mass, but the oncologist indicated this could also be a normal thymus. He requested that the patient undergo a PET scan. In his deposition, the oncologist stated that he planned to inform the patient of the need to re-biopsy the jaw cyst, but was unable to specifically recall discussing this with the patient. There was no mention of a re-biopsy in the medical record.

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

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

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

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

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

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

**Allegations**
The patient filed suit against the pathologist and the pathology group, alleging improper interpretation of the biopsy specimen.

**Legal implications**
The cross-contamination of the pathology slides did occur and this exposure fell to the pathology group regarding their handling of the tissue specimen. The contamination most likely occurred during the processing of the specimen into a paraffin block or during the creation of the slides. It was alleged by the plaintiff’s experts that the pathology group fell below the standard of care in not discovering the cross-contamination when it was first suspected by the pathologist.
Regarding the liability of the pathologist, the plaintiff’s expert did not express any opinions as to whether the pathologist appropriately read the pathology slides, and he even acknowledged that contaminations can occur. The plaintiffs alleged that the pathologist fell below the standard of care by not investigating the possibility of cross-contamination and assigned office personnel to check the pathology reports. The investigation should have been conducted either by the pathologist or by experienced lab technicians or medical transcriptionists.

Defense experts felt that the pathologist appropriately interpreted the slides, such as they were, and that it was appropriate to request office personnel to conduct the search of the records as long as those individuals were qualified to understand the terminology. It was also helpful to the defense that two other pathology laboratories reviewed the patient’s slides and did not mention any suspicion of contamination. However, the defense was weakened because it was the pathologist herself who had reviewed and reported the other small cell carcinoma case. This raised the question: why didn’t the pathologist recall this seemingly rare diagnosis.

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

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

Risk management considerations
Documenting the recommendation for a second biopsy and the performance of that biopsy may have prevented this unnecessary surgery and the subsequent suit. When care involves multiple physicians, some with differing opinions, it is advantageous for one physician to serve as the primary coordinator with all the medical information available. This patient went from an oral surgeon to a facial plastic surgeon who biopsied the cyst. The specimen was interpreted by the defendant pathologist and the plastic surgeon then referred the patient to an oncologist who then recommended a consult with an otolaryngologist. This physician had the slides reviewed by another pathologist who concurred with metastatic small cell carcinoma but also recommended clinical correlation.

The defendant pathologist, upon conferring with the plastic surgeon who did the biopsy, recommended a second biopsy but did not document this exchange in writing. Though pathologists may not routinely establish a direct patient/physician relationship, it is advantageous to document interactions regarding a patient.

In retrospect, reliance on business office personnel to search for patient reports was ineffective. Had the defendant taken the time to focus on this search, the other report with this diagnosis may have been identified and contamination suspected.
Death following plastic surgery

Presentation
A 32-year-old woman came to a plastic surgeon for consideration of cosmetic surgery.

Physician action
Initially, the patient expressed interest in treatment for wrinkles under her eyes and breast enhancement. The surgeon documented that the patient would be a good candidate for a TCA peel and breast augmentation mammoplasty with a McKissock breast lift. The surgeon discussed his plan to perform the procedures under “twilight anesthesia.”

The patient returned to the office approximately 5 weeks later, and expressed interest in liposuction and additional cosmetic surgery to her face. The surgeon agreed to add a standard abdominoplasty with suction-assisted lipectomy to her flanks and hips, and Kadiane injections to the nasolabial folds and frown lines as procedures to be performed at surgery. Three days later, the patient contacted the surgeon to request additional procedures, to include liposuction to the thighs, buttocks, upper arms, and underneath the chin.

The patient came to a Class B ambulatory surgical facility—a facility not authorized to provide general anesthesia services—and “twilight” sedation (diazepam and ketamine) was begun at 1:10 p.m. Surgery commenced 10 minutes later under local anesthesia (lidocaine with epinephrine). No anesthesia provider was present, and the surgeon was assisted only by a scrub nurse. A dose of midazolam was given at 7:05 p.m. The surgery lasted almost 7 hours, concluding at 8:15 p.m. Procedures performed were: liposuction to the back, hips, lateral and medial thighs; abdominoplasty with diastasis placations; McKissock pattern breast lift with saline breast implant insertion; Radiance injection to the nasolabial folds and frown lines between the brows; autofat injections at the corners of the mouth; and a light TCA peel of the lower eyelids.

After surgery, the patient was monitored in recovery for one hour. At 9:15 p.m., it was documented that the patient was awake and alert. She was discharged home and was able to ambulate to her vehicle with minimal assistance.

The next morning, the patient was found non-responsive in her bed. EMS found the patient to be pulseless and apneic. A witness indicated that the patient had been awake at approximately 8 a.m., had taken her postoperative pain medications, and then had gone back to sleep. The witness reported that the patient had then coughed and stopped breathing. CPR was performed until the arrival of EMS. Resuscitation was initiated, and after 6 to 7 minutes, the emergency medical technicians were able to capture a tachycardic pulse. The patient was intubated and transported.

In the hospital, the patient remained completely unresponsive. Life support was discontinued three days later. The autopsy report listed the cause of death as “mixed drug toxicity involving drugs remaining in her system from the surgical procedure with prescription drugs given for pain after the procedure.”
Death following plastic surgery

Allegations
The patient’s family filed a lawsuit against the plastic surgeon, alleging:
• inappropriately “bundled” multiple procedures;
• failed to perform these procedures under general anesthesia versus local anesthesia with sedation;
• inappropriately discharged the patient after surgery with little to no monitoring versus keeping her overnight for recovery and monitoring;
• inappropriately performed extensive surgery without an assistant surgeon or anesthesia provider; and
• failed to order appropriate follow up after surgery.

Legal implications
This case presented challenges to the defense. Multiple consultants could not support the use of local anesthesia with sedation for a surgery this extensive. It was noted that the liposuction procedures alone removed 4.95 liters of tissue, and that published studies recommend overnight observation for any patient undergoing a liposuction that removes 5 liters or more of tissue. The surgery was performed in a Class B facility that did not offer accommodations for an overnight stay. It was felt that the failure to provide anesthesia services along with the surgeon’s fee for these elective procedures might lead a jury to believe that the surgeon had a profit motive and compromised patient safety.

Disposition
This case was settled on behalf of the plastic surgeon.

Risk management considerations
Claims involving complications from elective cosmetic surgery are often difficult to defend to a jury. There is often a public perception that these procedures can be routinely performed with little risk to the patient. In this case, it appears that the surgeon acceded to the patient’s requests in the preoperative period to add procedures that were not part of the original operative plan. This combination of procedures resulted in a much more extensive surgery than originally envisioned by the surgeon. Given that the surgery concluded after 8 p.m. in a facility not offering overnight accommodations, suggests a lack of appreciation and planning for what turned out to be a prolonged and extensive surgery.
Premature extubation

Presentation
A 21-year-old man with a genetic facial deformity of cleidocranial dysplasia was scheduled for surgery. His surgical history included uvulopalatopharyngoplasty, nasal septoplasty, tonsillectomy, and adenoidectomy. During these procedures, the patient required a tracheostomy that was later closed. In addition, the patient had sleep apnea and hypertension.

An oral surgeon was to correct the skeletal-facial malformation and a neurosurgeon was to perform a cranioplasty for reconstruction of the skull. The defendant was to provide anesthesia for what was anticipated to be a lengthy procedure.

Physician action
Although the surgery lasted 14 hours, it was uneventful. The patient was taken to the recovery room and extubated by the anesthesiologist approximately 5 minutes after arrival. Vital signs at that time were: blood pressure 94/50 mm Hg; pulse 98 beats/min; respirations 16 breaths/min; and O₂ saturation rate of 100% on a portable O₂ tank. It was noted the patient was responsive to tactile stimuli.

Immediately after extubation, the anesthesiologist noted stridor and diminished lung sounds bilaterally. The patient was bagged, but his oxygen saturation continued to drop into the 80% range. Direct laryngoscopy revealed an extremely edematous tongue and supraglottic region. Blind intubation resulted in an esophageal entry. There was a delay before the defendant could perform an emergency tracheostomy. The instrument tray was not at the bedside and accessing the tray added to the delay.

After the third attempt to place the endotracheal tube, the patient started breathing again. However, during these attempts, the patient went into cardiac arrest. The patient became severely bradycardic without a registered blood pressure. CPR and epinephrine were administered, and the patient responded to resuscitation. Arterial blood gases drawn within the next hour revealed severe acidosis resulting in ischemia and brain damage.

Subsequent MRIs indicated that the patient suffered a hypoxic episode that resulted in severe brain damage. As a consequence, the patient remains in a semi-vegetative state with a permanent tracheostomy, a PEG, spasticity, joint contractures, and bowel and bladder incontinence.

Allegations
A lawsuit was filed against the anesthesiologist. The allegations included:
- premature extubation of the patient before meeting appropriate criteria;
- failure to properly replace or provide an alternative airway; and
- failure to properly monitor patient during the extended surgery.

Legal implications
Two consultants were supportive of the defendant’s actions, stating the standard of care was met with regard to the extubation. Since the patient had been breathing on an endotracheal tube for more than 30 minutes, had a tidal volume of 700, a minimal
volume of anesthetic vapors, a strong gag reflex, a regular respiration rate of 16, and was reactive to commands, criteria were met for extubation. They characterized the patient’s response of a grossly swollen tongue as an unexpected complication.

Two other consultants were unable to support the defendant’s actions. They noted that the patient’s history of sleep apnea and a prior tracheotomy held a potential for airway management problems. The length and site of the surgery contributed to additional risk for swelling and a compromised airway. It was also noted the patient’s hematocrit of 18.1 could have lessened the oxygen carrying capacity of the blood resulting in hypoperfusion, another indication of a decompensating respiratory system. One consultant indicated arterial blood gases should have been ordered before extubation. Also, direct visualization of the patient’s oral structures should have been made. Evaluation of the airway for patency could have been accomplished by deflating the balloon to see if the patient could breathe around the occluded tube. If so, extubation could be completed.

The oral surgeon said that he repeatedly told the anesthesiologist to keep the patient intubated overnight. However, this was not heard by the other OR staff and it was not written in the postoperative orders. A PACU nurse noted the anesthesiologist called the patient’s name without response. A second attempt was made to arouse the patient with the defendant repeating the patient’s name and applying a slap on his chest. The patient’s arms went up and, at that point, the tube was removed.

Disposition
Due to the unsupportive consultant reviews, this case was settled on behalf of the anesthesiologist.

Risk management considerations
Two consultants noted that the defendant’s failure to record his criteria or rationale before extubation after a long procedure weakened the defense of this case. Documenting one’s rationale in patient care is beneficial should an adverse outcome occur. If the patient’s record reveals clinical complications in the context of a well-reasoned plan of treatment and conscientious care, “the chart notes should stand as the backbone of the doctor’s defense.”

One nursing expert testified that the attempt to perform re-intubation and an emergency tracheostomy was further delayed by the lack of preparation by the PACU staff. Emergency airway supplies, equipment, and a tracheostomy tray placed at the bedside could have helped reduce the delay in re-establishing the patient’s airway.

In this case, the defendant practiced good management of the patient’s anesthesia during a 14-hour surgery. This complicated procedure required the skill of two specialists — an oral surgeon and a neurosurgeon. Consideration for the human factor of fatigue may have been indicated before the anesthesiologist attempted to manage the case alone. When should an anesthesiologist arrange for relief? There is a limit to the demands one can effectively manage without fatigue interfering.

Source
Patient not referred

Presentation
Having given birth to her second child in December, a 36-year-old woman came to her family physician for a check up on January 28. Complications during the pregnancy included high blood pressure and proteinuria. At this visit, her blood pressure was 140/80 mm Hg and weight was 170 pounds. Medications included amlodipine 5 mg and clonidine 0.2 mg. Her neck showed no bruits, lungs were clear, and she had regular heart rate and rhythm. No edema was noted.

The physician’s diagnosis was hypertension. The patient reported that she smoked one pack of cigarettes daily and had a significant family history of hypertension, myocardial infarction, and cardiomegaly. The physician continued her clonidine 0.2 mg at bedtime.

This patient had three more office visits during the year for blood pressure checks, a work-related hand injury and cold symptoms. At each visit, heart rate and blood pressure were essentially normal.

On February 17 of the next year, the then 37-year-old patient returned complaining of chest pain, weak arms, and numbness of one day’s duration. The results of the physical exam was unremarkable with the exception of third rib pain and proximal muscle weakness. She was treated with triamcinolone 60 mg IM and a sample of diclofenac and misoprostol 75 mg twice a day.

After seeing the physician again on February 19, the patient did not feel better and went to the emergency department (ED) with complaints of chest pain, tightness, coughing, and burning. Upon examination, lungs were clear and muscle strength was normal. Chest x-ray and CBC were also read as normal. The impression was pneumonia. That same year, the patient had several more visits with the family physician, including a hospital admission for vertigo and vomiting. Other medical issues included vaginal bleeding, anemia, yeast vaginitis, and a second complaint of hand pain.

The patient again came to the physician’s office on December 18, now 38 years of age. Her complaints included chest pain “again,” palpitations, shortness of breath, cough, insomnia, crying, and decreased concentration. She had additional complaints of “white stuff in her mouth,” a sensitive tongue, and toe fungus. Her current medications included an iron supplement, vitamins, and she was currently using inhalers for the treatment of asthma.

Physician action
Upon examination, her tongue showed slight increased papillae and was slightly swollen. Her neck was normal, lungs clear, and her heart rate and rhythm were normal. An EKG was performed and the computer interpretation indicated a short PR interval, extensive ST-T changes that were borderline abnormal for age and sex. The physician determined the EKG to be “nonspecific” and his impression was glossitis, palpitations, and dysthymia. He ordered a CBC, iron, and thyroid tests. Samples of metoprolol 50 mg and a prescription for bupropion were given. Vital signs for this
visit were not documented, a cardiac work up was not performed, and the physician did not refer the patient to a cardiologist.

On December 22, EMS was called to the patient’s home. She was found suffering from a myocardial infarction. Despite resuscitation attempts, she died. An autopsy revealed the cause of death as atherosclerotic cardiovascular disease with bronchial asthma and pulmonary emphysema as contributing factors. The description of the heart in the autopsy report indicated the LAD had 50% stenosis from calcifications. There was an 80% stenosis of the left circumflex artery with extensive occlusion of the right coronary artery and the valves. The heart showed a necrosis consistent with recent myocardial infarction.

Allegations
A lawsuit was filed against the family physician, alleging that the family physician should have referred the patient to a cardiologist or admitted her for cardiac work-up at the December 18 office visit.

Legal implications
Although cardiac disease is not normally expected in such a young woman, the medical consultants were not supportive of the treatment provided. This patient had a family history of hypertension and myocardial infarction. In fact, this patient was known to suffer from hypertension and smoked cigarettes, placing her at higher risk for coronary disease. Consultants were critical of the defendant for failing to document vital signs and for failing to document more information about the location and duration of the chest pain. The consultants were also concerned with the EKG findings as they felt the results warranted a cardiac consultation and additional cardiac testing.

Consultants interpreted the EKG as abnormal with short PR interval but not typical for Wolff-Parkinson-White Syndrome. They also noted non-specific ST-T wave changes and specifically what appeared to be a 1 mm ST wave depression in lead V3 that was prolonged, and could imply more significant ischemia to the heart muscle. The subtle ST depression could have been caused by hypertension, anemia, medications, emphysema, and possible myocardial ischemia. This indicated the need for additional testing that may have included an exercise stress test, thallium or Persantine stress testing, or cardiac consultation.

Consultants were critical of the defendant for the apparent lack of concern regarding the significant signs of a potentially severe heart condition, including complaints of palpitations and shortness of breath with cardiac symptomology in a young woman. In addition, the physician did not recommend an exercise stress test on the December 18 office visit after the patient’s second complaint of chest pain.

Disposition
This physician was the only defendant in this lawsuit. Because of unsupportive consultative reviews, this case was settled with the consent of the physician.

Risk management considerations
In this case, consideration of the patient’s multiple risk factors including hypertension, family history of myocardial infarction, cardiomegaly, and personal smoking history was
essential in evaluating the patient’s risk for coronary insufficiency. Consultants suggested that these risk factors justified a more aggressive approach to cardiac evaluation. An abnormal EKG, plus the history of palpitations and shortness of breath would suggest a cardiology consultation, exercise stress testing, thallium stress testing, Persatine stress testing, or other testing modalities. Additionally, pulse oximetry may have been indicated to determine proper oxygenation. When patients report cardiac symptoms or risk factors, a cardiology referral may be indicated.

Likewise, the presentation of multiple complaints challenges the most conscientious physician to avoid bundling potentially acute cardiac symptomology with the other patient problems. Use of an objective problem list may help manage and prioritize multiple patient complaints.

Finally, vital signs were not documented. When treating patients, thorough documentation of each patient visit is recommended. This encompasses all elements of the assessment relating to patient condition and complaints, including vital signs.

Family physicians remain among the physicians most likely to be sued, third only to obstetricians-gynecologists and internal medicine physicians. In fact, the most prevalent medical misadventure for family physicians is “error in diagnosis” and the most prevalent patient condition is acute myocardial infarction. Consequently, proactive risk management continues to remain essential for good patient care and a strong defense.
Complications following bariatric surgery

Presentation
A 32-year-old morbidly obese woman came to a bariatric surgeon for consideration of bariatric surgery. The patient was from a small rural community more than 250 miles from the surgeon’s office in a large metropolitan area.

Physician action
The surgeon saw this patient in his office for morbid obesity. She was 5’6” and weighed 275 pounds. She was approximately 140 pounds overweight and had a BMI of 44 kg/m². The patient reported that she had tried to lose weight using various attempts, (prescription diet pills, over-the-counter pills, fad diets, Weight Watchers, Jenny Craig, hypnosis, low-fat diets, physician-directed diets, low-calorie diets, over-the-counter liquid diets and exercise) all without success. She also reported that she smoked one pack of cigarettes per day for the past 15 years. Her medical history included hypertension, hypothyroidism, and a previous cesarean delivery.

The surgeon’s plan was to admit her as an outpatient for EGD to evaluate her GI tract and then re-admit her for laparoscopic silastic ringed vertical gastroplasty.

Preoperatively, an EKG was performed and a cardiologist interpreted it as “normal sinus rhythm, poor R wave progression, otherwise normal EKG.” An internal medicine physician also evaluated the patient, reporting “(t)he patient is a good surgical candidate for this procedure. The patient is cleared for surgery from an internal medicine standpoint with a risk estimate of moderate surgical risk . . . postoperatively, she may require a Catapres patch until she is able to tolerate oral medications. . . the patient will require aggressive postoperative pulmonary toilette and bronchodilator therapy . . . I will be happy to follow the patient with you during postoperative period.”

The surgeon performed an upper GI endoscopy. The impression was: normal second part of duodenum, erythematous gastropathy, normal cardia and normal lower third of esophagus.

The patient returned and was admitted the next day. The surgeon performed a laparoscopic silastic ring vertical banded gastroplasty. Perioperatively, an NG tube was placed and no leaks were noted. She developed a low-grade fever on postoperative day two, but no signs of infections were noted. The patient complained that she felt “absolutely miserable” and wanted her NG tube out. Three days after the surgery, the patient looked better, but a low-grade fever persisted. She was discharged home on omeprazole and clarithromycin and was instructed to follow up on an outpatient basis. Her wounds were healing without evidence of bleeding or infection. The patient traveled to her home in a distant rural community by private automobile.

The next day, the patient’s mother called the surgeon’s office requesting pain medication. The fentanyl patches given at discharge were falling off because of the patient’s sweating. The surgeon spoke with the patient, who reported shortness of breath. She reported that her bowels were moving and she was tolerating fluids. The surgeon suggested warm tea to address her gas.
Complications following bariatric surgery

Later that day, the patient’s mother called again from the emergency department (ED) of a local rural hospital reporting that the ED physician felt the patient had a leak requiring an exploratory laparotomy. The ED physician declined to speak with the surgeon, and the surgeon offered to have the patient returned to a large regional hospital for additional care.

A general surgeon in the rural hospital performed an exploratory laparotomy and found a gastric perforation secondary to infection and associated necrosis. The patient then began a long and difficult treatment course consisting of 14 surgical procedures. Presently, she has an esophageal reconstruction utilizing a segment of her colon.

Allegations
The patient filed suit against the bariatric surgeon, the internal medicine physician, and the hospital where she underwent the bariatric procedure. The internal medicine physician was later dismissed from the lawsuit. Allegations against the surgeon included: negligence in the performance of the surgery; failure to recognize a surgical complication; and negligently discharging the patient. The patient alleged that the hospital was negligent in failing to recognize and report changes in the patient’s postoperative condition before discharge.

Legal implications
Negligence—when used with respect to the conduct of a physician—means failure to use ordinary care or failing to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances.

This case presented challenges for the defense. The operative report was not prepared until three months after the surgery. That operative note, although dictated after it was known that the patient suffered a complication, indicated that the surgery was uncomplicated. While the surgeon had considerable experience in bariatric surgery, this procedure was his first performed laparoscopically. The patient complained of feeling miserable and had a fever postoperatively. The nurses testified that the surgeon was informed of the patient’s deteriorating condition after he wrote discharge orders, yet the patient was discharged and allowed to travel more than 250 miles to her home by private automobile.

After arriving at her home, the patient’s mother contacted the surgeon to report continuing pain and possible signs of infection, and the surgeon recommended only that she drink green tea. These events may have led a jury to believe that the surgeon did not meet the ordinary care standard.

While defense consultants indicated that perforation was a known complication of the procedure, there were concerns—shared with the patient's expert witnesses—that the signs of a potential perforation and resultant infection were ignored, and that it was imprudent to discharge the patient.

Disposition
Despite efforts to resolve this matter before trial with the consent of the surgeon, no agreement could be reached and trial began. A settlement was reached during trial.
Risk management considerations
Bariatric surgery is an elective procedure with significant risks. Patient selection should be carefully evaluated, with consideration given to physical, environmental, and psychological factors. In this case, the patient was a smoker and had other comorbidities putting her at increased risk for complications and poor wound healing. Additionally, this patient lived more than 250 miles from the hospital where the procedure was performed.

Communication is always important. In this case, the surgeon displayed communication lapses in multiple areas. First, he did not timely prepare an operative report. When an operative report was dictated, a surgical assistant dictated it and it was incorrect. Next, he did not respond to calls from the nursing staff reporting changes in the patient’s condition after he had written discharge orders. Additionally, he had telephone conversations with the patient’s family after she arrived home that were described by family members as being without appropriate concern. Poor communication and follow up present a picture of an uncaring surgeon to a jury.

The patient was discharged despite showing signs of a potential infection. As noted earlier, the patient had multiple comorbidities and it was known by the surgeon that, upon discharge, she would be traveling more than 250 miles by private automobile to her home to be cared for by family members without medical training.
Failure to test for pregnancy

Presentation
On July 6, a 35-year-old patient came to her ob-gyn for her annual well woman exam with complaints of urinary incontinence with coughing and straining, heavy irregular bleeding while taking birth control pills, and cramping. During this visit, the physician performed a pelvic exam, and noted the patient’s last menstrual period (LMP) was June 18. In response to her complaints, the physician recommended a hysterectomy and bladder suspension which was then scheduled in August after the patient called the office to confirm that she would like to proceed with the operation.

The patient began seeing the physician 11 years earlier for prenatal and gynecological care. Seven years later the physician removed an IUD because of excessive bleeding, and discussed removal of her uterus if the removal of the IUD did not solve the problem. However, the bleeding ceased and there was no further discussion of a hysterectomy. The patient was using a contraceptive pill for birth control.

Physician action
On August 22, the patient was admitted to the hospital with diagnoses of stress urinary incontinence, menometrorrhagia, and pelvic relaxation. After informed consent was obtained, the physician performed a hysterectomy. After the patient’s uterus was removed, it was described as “very large, about 12 weeks.” The physician suspected a pregnancy at the time the uterus was removed. He later received a phone call from pathology, confirming the pregnancy. The physician told the patient about the pregnancy the following morning.

Allegations
A lawsuit was filed against the ob-gyn, alleging that a hysterectomy was performed without obtaining a preoperative pregnancy test.

Legal implications
Although the defendant physician did not feel a pregnancy test was necessary because the patient reported she could not be pregnant, some of the consultants and the plaintiff’s expert were critical of the physician for performing a hysterectomy without ordering any type of pregnancy test as part of the preoperative lab work-up. As one reviewer commented, for the menstruating woman of childbearing age, “it is the standard of care to obtain a pregnancy test prior to any gynecologic surgery, especially a hysterectomy surgery, at the time preadmission laboratory studies are obtained.”

Peer reviewers were also critical of the physician’s discharge summary and the physician’s suggestion that the patient should have known that she was pregnant when she called the office with her decision to have the hysterectomy. Upon the reviewer’s analysis, the patient had reported and the physician documented that her LMP was June 18. Therefore, on July 6, the patient would not have missed a period, and would not have suspected pregnancy.

In addition, the discharge summary included wording that may have been perceived as inflammatory. The physician noted the patient’s “hysterical reaction” to hearing
about the pregnancy loss as a result of the hysterectomy was inappropriate for the situation. Reviewers felt this language blamed the patient for not realizing that she was pregnant and was accusatory of her behavior when she was made aware of the consequences of failing to diagnose her pre-existing pregnancy.

Although some defense expert opinions supported the physician, citing that he met or exceeded the standard of care, ultimately the plaintiff’s attorneys argued that the loss of the patient’s unborn fetus and the accompanying pain and suffering were directly and proximately caused by the negligent care she received from the physician. They argued that, based on reasonable medical probability, if the physician had ordered a pregnancy test before performing a hysterectomy, the test would have been positive and the physician would have canceled the surgery. Ultimately, the patient would have had the option to make a decision regarding continuation of the pregnancy.

**Disposition**
After three days of trial, negotiations led to a settlement on behalf of the ob-gyn. The patient also settled with the hospital.

**Risk management considerations**
Although the physician did disclose the unexpected outcome to the patient and document the physician-patient interaction, it is suggested that the physicians avoid language in the medical record that may be perceived as negative toward the patient. Although it was argued by defense experts that the physician did not breach the standard of care, a jury verdict may have been influenced by the sympathetic nature of this occurrence.

In this case, it was suggested that a pregnancy test could have been ordered on several occasions: at the doctor’s office; with preoperative laboratory testing; and from standing anesthesia orders. Adding a question to the patient encounter forms regarding pregnancy status may prompt physicians regarding risks that may need to be assessed.

The removal of a pregnant uterus at the time of surgery is an unusual occurrence. Factors such as obesity and the use of birth control pills may make the diagnosis of pregnancy more difficult. Pregnancy testing is advisable when planning gynecological surgery in women of reproductive age.
**Failure to test for pregnancy 2**

**Presentation**
A 42-year-old woman came to her ob-gyn for evaluation of gynecologic problems on November 20. The patient reported a history of infertility for approximately 20 years and complained of pelvic pain, prolonged menstrual flow, and irregular bleeding. During this visit, the physician performed a pelvic exam and ordered an ultrasound.

The interpreting radiologist described the uterus as normal in appearance with no focal masses or bulges. The ultrasound report noted an irregularity, described as an endometrium of 1.3 cm in thickness. The physician suspected that the thickened endometrium indicated the possibility of hyperplasia in the lining of the uterus. He recommended follow-up care.

On December 12, the ob-gyn performed a hysteroscopy. The hysteroscopy revealed a polyp on the lining of the endometrium, which was removed. A D&C was also performed. The patient returned to the ob-gyn two times between January and April. During these visits, the patient stated that she wanted to proceed with a hysterectomy because of pelvic discomfort and heavy irregular bleeding.

**Physician action**
The patient was admitted to the hospital on the morning of May 1 for the hysterectomy. Since surgery was scheduled for the afternoon, the physician had arranged for preoperative lab work to be drawn when the patient arrived that morning. The only blood test requested by the physician was a CBC. No preoperative pregnancy test was ordered.

After an informed consent discussion with the patient, the physician proceeded with the hysterectomy. After incision the patient was found to have an enlarged uterus approximately 15 weeks gestational size, with numerous subserosal and intermural fibroids. The uterus was not incised or cut into in any fashion according to the physician’s operative report. After suspecting that the patient was pregnant, the procedure was terminated and the abdomen was closed. An intraoperative ultrasound performed on the uterine cavity revealed an intrauterine pregnancy of approximately 14-15 weeks.

The next day the patient complained of contractions and vaginal bleeding. An ultrasound was performed and revealed a 15-16 week fetal demise with no fetal heartbeat. The patient spontaneously aborted the fetus the following day. The pathology report indicated that the fetus had a laceration in its abdominal-intestinal area. A chromosomal analysis did not reveal any abnormalities.

**Allegations**
A lawsuit was filed against the ob-gyn. The plaintiff alleged that the physician performed a hysterectomy without obtaining a preoperative pregnancy test resulting in a miscarriage the following day.
Legal implications
Although the patient had a low probability of conception and carrying a fetus to term, consultants were critical of the physician for performing a hysterectomy on a woman of childbearing age without first ordering a preoperative pregnancy test. One consultant commented that there could be many clinical manifestations that would suggest a patient is not pregnant. However, clinical presentation or history from a patient can be misleading, and does not necessarily rule out the possibility that a patient is pregnant.

Disposition
The lawsuit was settled on behalf of the ob-gyn before trial.

Risk management considerations
Many factors make the diagnosis of pregnancy difficult, especially in an older patient with a long history of infertility and irregular menstrual cycles. Physicians are advised to order preoperative pregnancy tests for all women of reproductive age before performing abdominal or gynecological surgery.

Additionally, a question on the patient encounter form regarding pregnancy status may prompt physicians regarding unassessed risks.
Negligence in treating diabetic ketoacidosis

**Presentation**
A 29-year-old man came to his family physician with complaints of dry mouth, heartburn, and weakness. He reported a 34-pound weight loss recently. Physical exam revealed that he was tachycardic with 124 beats/minute.

**Physician action**
The family physician suspected new onset diabetes mellitus. Lab work, including blood sugar levels, was ordered. The patient was asked to return to the office in two days. Immediately after the appointment, the patient went to the physician's lab.

Lab results were delivered to the family physician the next day, revealing a blood sugar level of 544; carbon dioxide levels of 10; white blood count 14,300. The physician reviewed the results and decided to wait to see the patient until his appointment the next day. When the patient came for the appointment, the family physician immediately sent him to the emergency department (ED) because the patient looked very ill.

The ED physician noted that lab work indicated the patient was in diabetic ketoacidosis (DKA). He administered one liter of normal saline and the patient was admitted under the care of an internal medicine physician.

The internal medicine physician began treatment for the patient’s DKA, dehydration, and low potassium. Because his potassium levels were 2.2 to 2.0, the physician ordered potassium phosphate intravenously and orally. Although the patient’s white blood count was 23,300, the physician did not believe the patient had an infection.

During the early morning hours the internal medicine physician was called because the patient’s serum potassium was 1.5. The physician gave the order to increase potassium. Lab results later that morning revealed a white count of 21,400; serum potassium of 1.7; and blood sugar of 266. The patient was short of breath but arterial oxygen saturation was 95%. 

The 3:30 p.m. lab results showed potassium at 1.5. The CO₂ was now 10 and the sodium was 5.0 The patient’s temperature was 103 degrees. In response, the internal medicine physician ordered blood and urine cultures and increased the potassium infusion.

At 4 p.m., the serum potassium was read at 5.0 In response, the internal medicine physician reduced the amount of potassium infusion. Approximately 30 minutes later, the patient went into ventricular fibrillation and had a cardiac arrest. A prolonged resuscitation was successful but resulted in anoxic brain injury.

After the resuscitation, the patient’s white blood count increased to 23,900 and the potassium was 1.6, indicating that the previous 5.0 potassium reading was a lab error. Potassium infusion was increased two-fold to 20 mEq/L per hour. The patient was placed on a ventilator, received hemodialysis, and antibiotic therapy which then stabilized the patient’s DKA and infectious process.
Neuropsychiatric testing and exams performed by a neurologist indicated that the patient now has an IQ of 50. His EEG is compatible with a diffuse, mildly severe cerebral abnormality that is most consistent with metabolic encephalopathy and cerebral hypoxia. Medical records reveal that the patient is mentally handicapped. He is completely dependent on his wife.

Allegations
A lawsuit was filed against the family physician, the family physician’s lab, the internal medicine physician, and the hospital. Allegations included:
• failure to recognize the signs and symptoms of diabetic ketoacidosis;
• failure to administer appropriate amounts of insulin and potassium in a timely manner to reverse the effects of ketoacidosis; and
• failure to appreciate the severity of the patient’s condition upon admission.

Legal implications
The internal medicine physician was confronted with a very ill patient who was developing diabetic ketoacidosis. Defense consultants were critical of the physician’s management of the infusion rates of potassium and the lack of antibiotic therapy early in the patient’s hospital course. The consensus was that the defendant should have ordered twice as much potassium. Further, administering oral potassium to a patient who is nauseated and vomiting would not significantly affect the low potassium level.

The internal medicine physician testified that he felt an infectious process caused the patient’s cardiac arrest. The consultants, however, felt that the lack of a sufficient amount of potassium caused the arrest.

The defense was able to retain an expert supportive of the defendant’s actions. This expert argued that the infusion of potassium is a delicate balancing act. High-dose potassium infused too rapidly may have detrimental effects. Additionally, the patient was very ill when he came to the hospital. It was argued that if the family physician had sent the patient to the hospital the day the lab results were received, the outcome might have been different.

Disposition
Based on the concerns of the consultants and the catastrophic nature of the injuries, this case was settled on behalf of the internal medicine physician. The hospital also elected to settle this case. The plaintiffs are still pursuing the case against the family physician.

Risk management considerations
Retrospective review of any case provides an unfair advantage. As mentioned in the case summary, internal medicine consultants were critical of the defendant’s management of the potassium infusion and his delay in initiating antibiotic therapy. Although the only sign of infection was the elevated white count, consultants felt that its persistence warranted therapy. The physician chose to treat the potassium imbalance conservatively to avoid potential complications. A lab error also led him to believe that the potassium infusion was correcting the patient’s levels. The internal medicine physician may have benefited by consulting a specialist in this complicated case.
Failure to diagnose osteosarcoma

**Presentation**
A 16-year-old girl came to the emergency department (ED) complaining of pain in her right lower leg. She reported that she had hit her leg just below the knee and that her leg became bruised and swollen and continued to hurt. The nurse noted an 8 cm swollen area just below the right knee.

An x-ray of the lower leg was ordered and read by the on-call radiologist. His impression was “poorly defined area of increased density with evidence of cortical erosion and soft tissue ossification in the proximal right tibia which could represent a primary bone neoplasm such as osteogenic sarcoma. Further evaluation is recommended.” The patient was told to follow up with her family physician.

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

**Physician action**
Five days later, the patient was seen by an orthopedic surgeon (the defendant in this case). He reviewed the ED x-rays and ordered new x-rays. His impression was the patient had a subtle fracture of the proximal tibia with some evidence of healing, i.e., a periosteal bone reaction. He put the patient’s leg in a cylinder cast that was to stay on for six weeks. The patient was to return in four weeks. He noted in the chart that the patient had been told that “there could be a tumor there,” and he stated, “I do not see evidence of that.”

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

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

Three weeks later, the patient returned and reported continued pain. When he examined the patient, he noted a palpable mass just below the knee. X-rays were again taken and the physician interpreted them as showing heterotopic ossification of the
Failure to diagnose osteosarcoma

proximal right tibia. The patient was instructed to continue taking indomethacin and return in one month. The patient never returned to this physician.

Three weeks after her final appointment with the orthopedic surgeon, the patient visited another family physician in a neighboring town. She complained of leg swelling and pain. The family physician ordered an MRI that was performed two days later. The radiologist stated that the findings from the MRI were “highly suggestive of osteosarcoma.” He recommended a tertiary care referral, and discussed these results with the family physician and the orthopedic surgeon.

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

Allegations

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

Legal implications

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

There was great debate among the physicians consulted—three general orthopedic surgeons and two orthopedic oncologists—as to when the defendant should have ordered additional testing. The orthopedic oncologists stated that additional testing should have been ordered on the patient’s first visit based on the radiologist’s suspicion of tumor. The two orthopedic surgeons stated that additional testing was not required at the initial visit, but was necessary when the patient continued to complain of pain after the casting. None of the experts were supportive of the defendant’s care after the second visit when findings inconsistent with fracture and heterotopic ossification were present.

One of the main issues for the defense became whether or not an earlier diagnosis would have allowed for a limb salvaging procedure instead of amputation. The patient’s orthopedic oncologist testified that he could have saved the patient’s leg if the defendant had made a more timely diagnosis. This opinion was based on his review of the x-ray taken at the ED. However, the oncologist admitted on cross-examination that he had never recommended a leg salvage procedure based solely upon plain films. He stated that CTs and MRIs are necessary to evaluate the size of the tumor and the involvement of the vessels and nerves. The defense was able to locate an expert who testified that the patient’s leg was not salvageable. His opinion was also based on the ED x-ray. The issue of limb salvage became one of “dueling experts,” and it was impossible to definitively state whether the patient was a candidate for limb salvage surgery when she first saw the defendant.
Disposition
With the consent of the orthopedic surgeon, this case was settled. The lack of a completely supportive defense expert and the subsequent treater’s criticism of the defendant were factors in the decision to settle this case.

Risk management considerations
As the series of medical care visits started for this patient, one cannot ignore the words on the first x-ray report “… could represent a primary bone neoplasm such as osteogenic sarcoma. Further evaluation is recommended.” Several actions did not occur. The ED did not contact the family physician to request an order for more imaging studies. Once seen by her family physician and referred to the defendant, the primary care physician did not call the orthopedic surgeon and share his concerns regarding the x-ray findings. This report was in the orthopedic surgeon’s medical record of the patient. It was not evident the report had been reviewed as there were no physician’s initials, date, or comments regarding the findings and impression.

Lack of communication among the physicians was a weakness and became the foundation for liability when this unfortunate outcome occurred. A follow-up system to ensure that all reports are reviewed and timely addressed may have led to a better result for the patient. And finally, taking steps to rule out potentially serious and life-threatening diagnoses can improve patient outcomes.
Failure to diagnose and transfer: epidural abscess

Presentation
A 53-year-old man came to the emergency department (ED) on a Saturday with a complaint of severe low back pain for five days, reporting he had no sensation or movement in his legs or feet. His oral temperature was elevated at 100.4 degrees. Further history revealed five prior back surgeries performed by an orthopedic surgeon in a large metropolitan area.

Physician action
The ED physician called an orthopedic surgeon (the defendant in this case) for consultation. Initial examination of the lower extremities showed no weakness, intact sensory function, motor strength 5/5 in all muscle groups, and normal rectal sphincter tone. Reflexes were symmetrical and straight leg raising was negative. He also documented in the admission note that the patient did move his legs and feet, and had some peripheral nerve function. Because of the probability of infection, a blood draw was ordered for culture and sensitivity studies. Pain medication and antibiotic therapies were initiated.

The next day the patient reported he could not move his legs. A CT scan of the lumbar spine ruled out any evidence of an acute canal block, but did show severe stenosis at L3-4 and L4-5. Chronic postoperative changes, including degenerative changes and scar tissue, were noted with indication that a spinal fusion had been performed. All metal was absent from the back, but screw tracts in the pedicles were evident.

A myelogram was attempted but aborted, as the radiologist did not obtain any CSF return. Entrance was made at L3-4 with a 22-gauge needle and the radiologist tried up to the level of L1-2 with still no CSF. This would indicate severe scarring and changes within the spinal canal that might be contributing factors to the patient’s pain. Lab studies showed a high white count consistent with an infection. The IVP and chest x-ray were negative. An abdominal x-ray showed a probable paralytic-type ileus. An MRI was ordered, but the orthopedic surgeon was told the procedure was not available at this hospital on the weekend.

Upon re-examination, the patient had good rectal sphincter tone. The physician suspected possible cauda equina syndrome. The possibility of transferring the patient to another facility was discussed at a family conference. The conclusion was made that the treatment would be the same as he was already receiving. The defendant told the family that he made multiple attempts to contact the patient’s original orthopedic surgeon with no response. However, there was no documentation to support this. In fact, the call logs for the original orthopedic surgeon did not show any calls from the defendant.

On Monday, the original orthopedic surgeon was contacted and the patient was transferred by ground ambulance to his care. Medical records indicated that during the patient’s weekend stay, the patient did improve with the return of some sensation and some active movements of the feet and legs. The next day, blood culture results from a specimen taken at the time of admission showed a positive infection for *Staphylococcus aureus*. 
Failure to diagnose and transfer: epidural abscess

When the original treating surgeon examined the patient, there was no anal/perineal sensation. He had flaccid paralysis of the lower extremity. There was no sensation. The surgeon’s impression was the patient had cauda equina syndrome and surgery was scheduled.

A detailed operative report described a central decompression laminectomy from T-8 to L-5 and drainage of an epidural abscess. Gross pus was encountered at L-5 and upward to T-8 upon entering the spine. All areas suspected of purulent material were cleaned. A left subclavian Hickman catheter was placed for prolonged antibiotic therapy. The patient was ultimately discharged to a rehabilitation facility where he received IV antibiotic therapy for six weeks. The patient is currently paralyzed from the waist down with bowel and bladder incontinence.

Allegations
A lawsuit was filed against the orthopedic surgeon. The plaintiffs alleged that the defendant failed to timely diagnose cauda equina syndrome and transfer the patient for emergency treatment. They further alleged that the patient should have been transferred to a facility for an MRI that would have resulted in an earlier diagnosis of the spinal epidural abscess. Also named in the suit was the hospital where the patient came for emergency treatment.

Legal implications
No consultants reviewing this case, either orthopedic surgeon or neurosurgeon, were supportive of the defendant’s treatment.

The plaintiffs deposed the patient’s first treating surgeon who was very critical of the defendant’s management of this patient. He maintained that his orthopedic group always had physicians available on call when the primary treating physician was not available. It was also determined by checking the telephone records at the hospital that the defendant had not been accurate in describing his efforts to reach the previous treating surgeon to expedite a timely transfer and treatment intervention.

Although the defendant wanted to perform an MRI of the lumbar spine and could not do so since this was not an option at the current treating facility, it was discovered that the physician had knowledge that an MRI was available at another hospital in the area. The defendant also indicated there were no technicians on call over the weekend, but this was disputed by personnel from that facility.

The physician made a judgment that the patient’s condition was not emergent enough to transfer him to a major orthopedic and neurosurgery center in that area, although this was a viable option.

Disposition
Given these issues, the decision was made to resolve the suit. This was a case with significant damages as the plaintiff had permanent paraplegia. The potential for a large, adverse jury verdict was a concern. A settlement was made on behalf of the defendant physician. The hospital also settled for an undisclosed amount.
Risk management considerations
Clearly hindsight is always an unfair advantage in reviewing any closed claim. It should be noted that the tests ordered by the defendant were appropriate, given the presenting symptoms of the patient. Risk challenges are heightened for the on-call consultant facing a new patient with a complex medical history. Also, a physician practicing in a smaller locale may confront limitations at the hospital ED that are critical for an accurate and timely diagnosis. Knowledge of available 24-hour services at facilities, both locally and via transport, will assist on-call physicians when facing difficult situations, as illustrated in this case. When faced with differential diagnoses that include potentially serious conditions, definitive steps to obtain needed diagnostic tests and care may need to be expedited.

The attempts to reach the patient’s first surgeon should have been documented in the medical record. Whether delegated to hospital staff or the responsibility of the physician, those calls cannot be verified unless they are noted in the medical record. Accurate and timely documentation of medical decision-making, as well as attempts to obtain a thorough patient history, will increase the likelihood of a better outcome.
**Difficult intubation**

**Presentation**
A 38-year-old man with left-sided facial paralysis secondary to recurrent cholesteatoma was scheduled for a revision tympanomastoidectomy with an exploration of the facial nerve with decompression and removal of any residual disease and possible ossicular chain reconstruction. The patient was 6’3” tall, weighed 306 pounds, and had been diagnosed with chronic otitis media, asthma, and obstructive sleep apnea that required CPAP and oxygen.

**Physician action**
The defendant anesthesiologist evaluated the patient before surgery, and noted that the patient’s preoperative lab report, EKG, and chest x-ray were not available. Pre-anesthesia blood pressure was 146/86 mm Hg upon arrival at the ambulatory surgery center. Physical exam indicated that the airway was clear, lungs had bilateral breath sounds, and heart rate was sinus rhythm. Hypertension, possibility of diabetes mellitus, obesity, sleep apnea, and decreased neck [mobility] were noted. The patient was given an ASA status of 3. The patient had history of successful anesthesia. No specific mention of airway problems was made on the preoperative examination. The pre-anesthesia evaluation indicated that informed consent was obtained, and that risks were accepted by the patient and family. The patient was pre-oxygenated, starting at 7:45 a.m. with oxygen at 3 liters and an initial oxygen saturation of 96%.

At 7:48 a.m., anesthesia was initiated with fentanyl 2 cc, midazolam 2 mg, and another drug that consultants interpreted as pancuronium. Initial consultation revealed difficulty in reading and interpreting what anesthetic agents and amounts were administered. At 7:50 a.m., blood pressure rose from preoperative values to 165/94 mm Hg. By 7:55 a.m., blood pressure had gone down to 144/84 mm Hg. Oxygen saturation had fallen to 94%, exhaled carbon dioxide level was at 46, and pulse remained at 78 beats/minute. At 8 a.m., blood pressure was reported at 130/64 mm Hg and pulse rate was 80 beats/minute. Sodium thiopental 300 mg and another “4” of pancuronium was administered, as well as 1% of inhaled ethrane at 8:02 a.m.

By 8:20 a.m., oxygen saturation had decreased into the 80s. At 8:30 a.m., an additional 2 cc of fentanyl and 100 mg sodium thiopental were administered. During the course of anesthesia, the patient continued to have problems. Attempts at intubation failed, and attempts at mask ventilation were unsuccessful. A decision was made to call in another physician to perform a tracheostomy. Although the anesthesiologist stated that oxygen saturation was at 80% when the tracheostomy was performed, this was not documented in the record. It was documented in the record that the anesthesiologist was unable to intubate secondary to obstruction. However, it was not clear what blades were used, how many attempts at intubation were made, and no exact time line of events was documented. The operation and anesthesia ended at 9:08 a.m., and the patient was transferred to PACU, intubated via the trachea.

The patient was taken back to surgery the next day and the planned procedure was completed successfully, with anesthesia delivered by the same anesthesiologist. Approximately 45 minutes after arriving at the post-anesthesia care unit, the patient was noted to be complaining of pain, numbness, and partial weakness in the right
arm. After evaluation by a hand surgeon, it was speculated that compression of the right arm might have occurred when it was tucked with a sheet and the operating room table tilted. A working diagnosis of compression neuropathy was made, but no therapy other than a sling would be required. Eventually, the patient went through a successful course of physical therapy, concluding with 75% use of his arm. He was expected to make a full recovery. The patient was later diagnosed with carpal tunnel syndrome, believed to be unrelated to the compression injury.

**Allegations**

A lawsuit was filed against the anesthesiologist. The allegations included:
- failure to perform an appropriate preoperative exam and plan for intubation difficulty;
- failure to attempt less invasive intubation before tracheostomy; and
- incorrect positioning during second surgery resulting in compression neuropathy.

**Legal implications**

Consultants in this case were critical of the anesthesiologist’s lack of planning and documentation. They noted that the preoperative examination made no mention of airway problems, and described the airway as clear. They were critical that there was no further comment regarding the patient’s sleep apnea or details about anatomy, mouth opening, flexibility, and extension of the neck. Although the patient was described as obese with decreased neck, and given an ASA status of 3, there was no documentation in the record of planning the anesthesia technique for this complicated patient. The anesthesia plan noted was for general endotracheal anesthesia, but there was no specific documentation of planned airway management or a secondary plan in the event of difficulty.

The American Society of Anesthesiologists has developed an algorithm for the management of the difficult airway, which suggests different pathways to optimal anesthesia technique for the difficult airway. One consultant was critical of the anesthesiologist for not considering the alternatives detailed in the ASA difficult airway algorithm. Although use of the algorithm is not mandatory, it does suggest specific criteria for the management of this case. One consultant had concerns about the lack of review of preoperative lab, EKG, and chest x-ray, which were noted to be unavailable.

Consultants were also critical of the limited documentation of the events leading to the tracheostomy. There was no information in the record as to what triggered the emergency requiring the tracheostomy. The record stated only that obstruction was encountered in the airway and that the anesthesiologist was unable to visualize or intubate the trachea. One consultant felt that alternative modalities for this patient should have included awake intubation, blind oral or nasal intubation, and alternative laryngeal blades. It was unclear whether alternatives to tracheostomy had been considered, how many attempts to intubate had been made, or what type of scope had been used. Consultants suggested that even if this information had not been entered into the anesthesia record, a late entry into the progress notes would be warranted. There was also concern that the use of pancuronium, a muscle relaxant, in this patient may have been initiated prior to the airway being established via facemask. This may have added to the difficulty of intubation.

Regarding the positioning injury, the anesthesiologist admitted some responsibility for patient positioning. It was speculated that there might have been a sheet roll that caused the ensuing compression injury.
Difficult intubation

Disposition
Due to the fact that consultants were not supportive, and the lack of documentation, it was felt that settlement of this case was warranted. This case was settled with the consent of the anesthesiologist.

Risk management considerations
Completing and documenting a thorough preoperative examination is a routine practice for anesthesiologists representing a standard of care. This physician did not document details about the patient’s anatomy, and did not comment on the sleep apnea that could cause intubation difficulties. The physician also admitted that the preoperative examination was conducted in a sitting position, which would not reveal problems that could emerge in the operating room when the patient was reclining. Although this patient had a history of successful anesthesia, his history of obesity and sleep apnea would indicate an increased risk and would warrant a plan for intubation and consideration of an alternate plan of action.

Documentation of potential difficulties with intubation and an alternate plan, along with implementation of appropriate action, may have aided in the defense of this physician.

This physician also failed to document the details of the events leading to the emergency tracheostomy. The consultants mentioned it was difficult to interpret the amount of each drug administered, due to lack of documentation in the record. Accurate documentation in the anesthesiology record reflects the anesthesiologist’s decision-making process. Had there been complete documentation of when and how intubation attempts were made, it may have helped to defend this physician. Although there were notations for the course of anesthesia, the correlation between time frame and events occurring with the patient was not clear. In the event of an emergency, anesthesiology documentation should include details about when and how intubation was attempted, and what equipment was used. These details can provide justification for the anesthesiologist’s decision-making process.

A thorough preoperative examination that includes planning for potential risk factors is an essential part of the anesthesiologist’s documentation. When tests are done for preoperative clearance, the results should be available to all physicians involved in the patient’s care. Proceeding without that information may prove to be unwise, and may allow a plaintiff’s attorney to question a physician’s judgment.

Details about the course of anesthesia are invaluable in the event of complications. Document thoroughly and legibly in both the preoperative and operative areas of the anesthesiology record, and write additional progress notes that chronologically explain the events that occurred during the patient’s treatment. Undocumented actions in patient care are difficult to verify by memory and the incomplete medical record provides a basis for controversy regarding actual events.

Physicians and operating room staff share responsibility for proper patient positioning. Developing effective strategies to help prevent nerve injuries should be a part of quality patient care in the operative setting.
Failure to prescribe medication and diet

**Presentation**
A 29-year-old man was brought to the emergency department (ED) of a regional medical center. The patient’s chief complaint was bilateral leg weakness. He had a history of poorly controlled hypertension, chronic headaches, chronic fatigue, post-traumatic stress disorder, bipolar depression, and irritable bowel syndrome. Lab studies revealed an extremely low potassium level (1.3 mEq/L). The ED physician contacted the on-call internal medicine physician who ordered the patient’s admission and potassium replacement.

**Physician action**
The internal medicine physician saw the patient the next morning. The physician ordered a repeat potassium study, and requested a nephrology consult to help determine the cause of the patient’s hypokalemia. The nephrologist ordered several diagnostic studies and ultimately diagnosed the patient with a rare condition known as thyrotoxicosis. The nephrologist consulted an endocrinologist to assess for hyperthyroidism and to assume the management of the patient’s endocrine disorder. The endocrinologist made the diagnosis of thyrotoxic hypokalemic periodic paralysis (TPP), a rare condition characterized by recurrent episodes of motor weakness associated with hyperthyroidism. The nephrologist and the endocrinologist felt the patient could be treated on an outpatient basis.

The internal medicine physician discharged the patient with the following instructions: follow up with the endocrinologist in one month for a thyroid scan; see the nephrologist within two weeks; and, call the internal medicine physician’s office to schedule an appointment immediately after arriving home. The patient was discharged on a high-potassium, low-sodium diet and was given information on this diet. The nephrologist prescribed the beta-blocker propranolol for treatment of the thyrotoxicosis. It was later discovered that this prescription was filled, but the medication was not taken by the patient.

Three days after his discharge, the patient was brought back to the ED by ambulance. Seven hours before becoming ill, he had eaten a large, carbohydrate-rich meal. His potassium level on admission was 1.3 mEq/L. While in the ED, the patient suffered cardiac arrhythmias. Resuscitative efforts lasted more than one hour, but were unsuccessful. An autopsy was performed and the pathologist concluded the patient died as a result of TPP, precipitated by a high-carbohydrate meal.

**Allegations**
Lawsuits were filed against the internal medicine physician, the nephrologist, and the endocrinologist. The allegations included:

- failure to timely evaluate, diagnose, and treat the patient’s hyperthyroidism and thyrotoxicosis;
- negligence in deferring treatment of hyperthyroidism for two weeks after discharge;
- failure to prescribe the appropriate medication and diet before discharge; and
- failure to provide the counseling and treatment to prevent further drop in potassium level before discharge.
Legal implications
Defense consultants were supportive of the care given by all three physicians. The physicians successfully diagnosed and treated a very rare medical condition, one that many physicians may never see. According to nephrology and endocrinology experts, the patient did not need long-term potassium supplementation once he left the hospital because his potassium level stabilized following replacement therapy. Propranolol, which reduces the frequency and severity of TPP attacks, was prescribed appropriately. All the experts reviewing this case, including the plaintiff’s experts, agreed that if the patient had taken propranolol as prescribed, he would not have suffered a fatal attack of TPP.

The main allegations against the physicians involved the discharge instructions and the failure to instruct the patient to follow a low-carbohydrate diet. The patient’s wife claimed that the propranolol was not taken because there was confusion over the reason for its prescription, and that they had not been given a physician’s number to call with any questions. The nephrologist’s discharge summary clearly indicated that the patient understood why propranolol was being prescribed. The discharge instruction sheet, signed by the patient, listed phone numbers for all three physicians, but none of the physicians were ever contacted. The patient also failed to make the follow-up appointments as instructed at discharge.

During the investigation of this claim, it was also discovered that the plaintiff did not follow the low-sodium diet. The patient’s wife testified that he consumed 12 soft drinks daily after leaving the hospital. The meal the patient consumed before his death consisted of a fast-food hamburger and french fries.

Regarding the failure to counsel the patient about a low-carbohydrate diet, the plaintiff’s internal medicine expert claimed that any physician treating a patient for TPP must advise the patient to reduce carbohydrate intake. Further, the standard of care would require a physician to tell the patient that a high carbohydrate load could increase the risk of an attack of TPP. Conversely, the defense endocrinology expert stated the standard of care does not require a discussion of precipitating factors because most cases of TPP attacks are idiopathic. Additionally, if the patient had taken the propranolol as prescribed, it would have prevented the fatal attack of TPP, even in light of the high consumption of carbohydrates. It was also unlikely that the patient would have followed a low-carbohydrate diet because he failed to follow the low-sodium diet.

Disposition
The cases against the internal medicine physician and the nephrologist were successfully defended and were closed without indemnity payment. The case against the endocrinologist (who was not a policyholder) was settled by his carrier before trial.

Risk management considerations
An on-call physician and two consultants responded in a timely manner to care for a patient admitted from the ED. A critical potassium level was corrected, the proper diagnosis of a rare disorder was made, and the appropriate medication was prescribed. The death of the patient was the direct result of his noncompliance, the failure to take propranolol.

Why indemnity was paid on behalf of the endocrinologist is not known. Perhaps, an unwillingness to proceed to trial and present this emotionally charged case in front of jurors led to the decision to settle his case.
Failure to treat hypertension

Presentation
A young man came to his internal medicine physician over several years for various complaint-focused visits. On the majority of these visits the patient’s blood pressure readings were elevated. Two months after his last exam, the patient died suddenly at home. He was 31 years of age. The cause of death was determined to be a complete occlusion of the left anterior descending artery (LAD).

Autopsy findings were inconsistent with hypertensive coronary artery disease as there was no heart enlargement, dilation of the left ventricle, pitting of the kidney surfaces, or dilation of the aorta. The pathologist did not see any evidence of end-stage organ damage caused by untreated hypertension. The pathologist concluded that the cause of death was from atherosclerotic plaque becoming disrupted and traveling to the LAD, causing occlusion and a fatal arrhythmia. Both the pathologist and consulting cardiologist agreed this heart attack could not have been prevented since the patient did not suffer from hypertension-induced coronary artery disease.

Physician action
The defendant, while providing reasonable episodic care, did not appear to pay attention to the elevated blood pressure. There was no documentation that the physician ever addressed the patient’s blood pressure elevations. The physician says he instructed the patient to watch his diet, but this is not documented in the records. The physician did not order any lab work or evaluations addressing the hypertension.

Allegations
The patient’s family filed a lawsuit against the physician for failure to diagnose and treat hypertension. It was further alleged that the physician failed to order proper evaluations and lab work and failed to provide the patient with precautions and advice on lifestyle changes. They argued that had the physician treated the patient’s hypertension, it would have prevented the sudden heart attack and death.

Legal implications
The patient presented to the physician nine times over an 8-year period for various symptoms. During this time the patient never described any chest pain or dyspnea that would have increased the suspicion of heart disease in such a young patient. However, high blood pressure is a risk factor for heart disease, and the patient’s initial blood pressure reading was 164/110 mm Hg. Although the blood pressure readings fluctuated, consultants felt the patient had stage 1 hypertension.

Though most consultants agreed stage 1 hypertension does not require immediate medication, they were critical of the physician’s inaction (i.e., not taking repeat readings, considering family history of hypertension, documenting in the medical chart discussions of hypertension counseling, conducting lab studies for lipid profiles and other tests). Additionally, though there was not a complete history in the chart, the physician also treated the patient’s father for hypertension.

Most defense consultants agreed that it was a judgment call to treat this young man for borderline hypertension, and the lack of hypertension treatment had no bearing
Failure to treat hypertension

on the sudden MI. However, they all stated that the patient should have been more closely monitored with regular blood pressure checks, diagnostic labs, and counseled on modifying diet and lifestyle. The defendant said he did instruct the patient on lifestyle and dietary changes; unfortunately, the education provided was not documented. Making this case more difficult to defend was the physician’s admission at deposition that he was not clear on the standard of care in treating hypertension.

Disposition
This case went to trial but was settled before the jury returned with a verdict in favor of the plaintiffs. The amount awarded by the jury was for much more than the amount agreed to in settlement. When the jurors were polled, they cited the physician’s lack of diligence in treating this patient as the reason for the verdict.

Risk management considerations
Incomplete documentation often hinders the defense of lawsuits. Each patient encounter should include the chief complaint, examination findings and prior diagnostic tests results (if applicable), assessment, clinical impression or diagnosis, and the plan of care. Not only did this physician not support his clinical impression of the patient’s blood pressure, the only acknowledgement of the blood pressure readings was a circle around the numbers.

Completed histories are the basis for patient information. It is not unusual to have a patient complete a questionnaire before the appointment as this helps expedite the patient visit; however, reviewing the form and completing areas left blank may provide additional insight. By initialing and dating each page, a physician can provide verification that the information was reviewed.

Most physicians and their employees spend a great deal of time educating patients and their families on the diagnosis, the disease process, treatment options, and risks and benefits of treatments. However, this information is often not documented in the patient record. Whether the education is provided orally, with pamphlets or videos, or through pre- and post-treatment instructions, initial and continued education are important elements of the treatment process. Documentation of such activities will provide evidence that the patient was given the information needed to make informed decisions. This case strongly supports the need to document patient education.

Some consultants believed that, given the patient’s family history of hypertension, medications should have been started immediately. Most consultants agreed that education on dietary and lifestyle changes was more important the first year. Unfortunately, the patient’s chart supported the plaintiffs’ view that the physician failed to advise the patient of his cardiovascular and hypertension risk factors, and failed to educate and inform him of lifestyle modifications necessary to ameliorate the effect of these factors.

In this case, although the patient’s death could not have been prevented, the jury found against the physician because they felt he was not paying enough attention to the patient’s condition. Physicians can make themselves more defensible by obtaining a complete history, documenting each patient encounter, and documenting any education provided to the patient. This assists both the patient in making informed choices and the physician, should the patient allege failure to diagnose and treat.
Surgery performed when not indicated

Presentation
While a 41-year-old woman with a history of excessive vaginal bleeding and anemia was being cleared for a hysterectomy, an ultrasound revealed gallstones. During this time, the patient also reported episodes of reflux in her throat while lying down.

Physician action
The gynecologist sent the patient for a surgical evaluation. Because of the patient’s history, the surgeon felt she may have been suffering from GERD and sent her to a gastroenterologist for an endoscopy and manometry testing. The gastroenterologist did not perform an esophageal acidity test (the most sensitive indicator of gastric reflux), but reported back to the surgeon that there were no contraindications for the proposed laparoscopic Nissen fundoplication. The patient was then scheduled for surgery. The gynecologist would perform a hysterectomy after which the surgeon would perform the Nissen fundoplication and laparoscopic cholecystectomy. The surgeries occurred without incident.

On the second postoperative day, the patient began experiencing chest pain and shortness of breath. A chest CT was completed and read as negative. On the sixth day after surgery, a barium swallow revealed a pinhole leak in the esophagus. The surgeon returned the patient to surgery to repair the leak laparoscopically. Five days later another barium swallow revealed a persistent esophageal leak. The patient was placed on total parenteral nutrition and kept NPO, giving the leak a week to close.

One week later, however, the leak was still present. The surgeon took the patient back to surgery, took down the wrap, and fixed the leak with a Toupet procedure. The patient recovered and was ultimately discharged home still suffering from a small pleural effusion.

After two subsequent visits to the surgeon, the patient was discharged to return as necessary. Approximately six weeks later, the patient was seen by a pulmonologist for continuing chest symptoms. The patient was then admitted to the hospital for a left empyema.

After a thoracic surgeon was consulted, the patient underwent a decortication to relieve the residuals of the unresolved pleural effusion. Since this hospitalization, the patient has undergone three procedures by a gastroenterologist to dilate the area of the wrap done by the initial surgeon. The patient continues to have complications with eating and digestion.

Allegations
In the lawsuit filed against the surgeon, the allegations included:
• the Nissen fundoplication was not indicated;
• delay in diagnosis of the esophageal leak;
• a drain tube should have been placed at the area of the Nissen following the first repair procedure and, had this been done, the patient would not have suffered from the subsequent empyema;
Surgery performed when not indicated

- failure to obtain informed consent; and
- negligence for not dictating the operative report from the first surgery until almost six weeks after the procedure.

Legal implications
In reviewing this case, consulting surgeons were consistently critical that conservative treatment options were not suggested to the patient. There was no evidence that the patient had ever tried medical therapy for her symptoms of reflux before surgery. It was felt that a pH study (esophageal acidity test) should have been done before a diagnosis of GERD was made, and surgery should not have been done without first obtaining the pH study. Consultants also said that the surgeon caused a delay in diagnosing the leak by ordering the CT scan. A barium swallow should have been done a day or two after surgery, instead of the CT scan. Consultants were also critical that a drain tube was not placed following the first procedure. The consultants felt not placing a drain tube caused the empyema.

The patient’s current gastroenterologist stated that all the patient’s postoperative problems and subsequent treatment were the result of the surgeries done by the defendant.

Disposition
As the consultants were critical and stated that they believed the surgeon deviated from the standard of care by not requesting a pH study or placing the drainage tube, this case was settled on behalf of the surgeon.

Risk management considerations
Informed consent refers not only to surgical procedures but also medical treatment. This means the doctor must disclose to the patient the most common inherent risks of the treatment that could influence a reasonable person in making an informed decision to accept or refuse that treatment.

While consents are signed at the hospital or surgical center the day of the procedure, it is prudent for the physician and patient to discuss the potential risks and complications. The patient should ideally then sign a consent form after that discussion. The office environment is conducive to the question and answer period necessary to provide informed consent. When consent is obtained in the office, there is then no question that the patient had adequate time to thoroughly review and understand risks, benefits, and alternatives of treatment.

Ideally, dictation should be completed contemporaneously. When notes are dictated late, it is easily argued that the physician could not have remembered details due to the number of patients seen. The defense of this case was compromised because the initial discharge summary was very brief and non-specific after a very difficult hospitalization, and was dictated six months later. The first operative report was dictated close to six weeks late with no indication in the note the patient had a hysterectomy first. The third operative report was dictated three months after the patient’s discharge. When a problem arises, this lack of timely documentation is detrimental to the physician’s defense. Lack of timely documentation may compromise the patient’s care, as other physicians caring for the patient will not have easy access to that information.
Studies have shown that when patients perceive that their physicians show interest, listen attentively, clarify details, and respond to their concerns, they are less likely to file suit. The consultants in this case were critical that, after a particularly difficult hospital course and then after only two office visits (both within two weeks), the patient was discharged from further care. Also, record entries were felt to be too brief and without adequate explanation.

Although patients rarely see the physicians’ notes outside of the litigation process, they are often aware of their physician’s attitudes by the amount and quality of attention given during office visits, the tone of voice used, body language, and other similar signs. Care should be used to show empathy for each patient’s situation and to provide sound advice about how to resolve his or her health problems. The importance of the physician-patient relationship, particularly in terms of shared respect, trust, and open communication, cannot be underestimated.
Over-prescribing psychotropic medications

Presentation and physician action
A 73-year-old man was admitted to a nursing home with diagnoses of congestive heart failure (CHF), atrial fibrillation, bowel and bladder incontinence, and dementia with psychotic features. He was under the care of an attending physician. Two months after his admission, the patient was reportedly delusional and having conflicts with his roommates. After an evaluation by a physical rehabilitation physician, it was determined that the patient was not a good candidate for rehabilitation due to his moderate to severe dementia. Over a two-year period a cardiologist treated the patient for atrial fibrillation, prescribing warfarin, amiodarone, metoprolol, and clonazepam.

The next year, the nurses’ notes indicated that the patient was combative, hitting, kicking, and repeatedly attempting to leave the facility. Within the next three months, the patient became increasingly hostile and disoriented. It was reported that the patient was found in a female patient’s room and stated that she was his wife, and they owned the building. Within this period, the attending physician prescribed the antipsychotic, molindone hydrochloride.

A short time later, during a transfer from a shower chair, the patient fell and fractured his left femur. He was treated with hip surgery at a nearby hospital and released to the nursing home. The patient was put on the hydrocodone and acetaminophen for pain. Within one week, the patient was again found on the floor. X-rays did not reveal any injury. The physician ordered a vest restraint to be worn while the patient was in bed. Four days later the patient fell and dislocated the left hip prosthesis.

A psychiatric consult was ordered. Another antipsychotic, loxapine was added and molindone hydrochloride and clonazepam were continued. The psychiatrist also ordered a vest restraint. However, the patient removed the vest, fell, and once again dislocated his left hip. His hip was successfully reduced at the hospital.

During this time, the attending physician was monitoring the patient’s anticoagulation therapy. After several weeks, the lab results indicated a low INR and the patient’s warfarin was increased from 2 mg to 2.5 mg daily. When the INR level registered 4.0, the patient suffered a GI bleed and was admitted to the hospital with ischemic colitis. This required a colon resection and a blood transfusion.

A few months later, the patient fell again injuring his shoulder, which required an additional hospitalization. After recovering from this incident, the patient transferred to a different nursing home and all psychotropic medications were discontinued. It was reported that his cognitive function improved.

Allegations
In their lawsuit against the attending physician, the plaintiffs alleged that the physician was negligent in failing to respond appropriately to the cause of the patient’s multiple falls, which in their expert’s opinion was due to continued use of the antipsychotics molindone hydrochloride, loxapine, and clonazepam. The second area of
Over-prescribing psychotropic medications

alleged negligence was failure to properly monitor the patient’s anticoagulation therapy resulting in a GI bleed.

Legal implications
Defense consultants were concerned about the number of psychotropic medications the physician had prescribed. These medications were not effective in managing the patient’s disoriented and agitated state. It was also during this time that the patient continued to suffer from multiple falls. It was later learned that after the patient was taken off all of his psychotropic medications, his mental status improved.

Concerns were also expressed about the physician’s management of the anticoagulant therapy. The elevated INR went unaddressed for approximately one week before the GI bleed.

Disposition
After negotiations, this case was settled on behalf of the attending physician.

Risk management consideration
Anticoagulant therapy requires close monitoring and management. The PT/INR results are often communicated by phone or fax. Whether the nursing home staff failed to accurately report the patient’s levels or the physician incorrectly prescribed is not known in this case.

Physicians who treat nursing home patients should maintain detailed notes in a chart independent from that kept at the nursing home, even when the physician is the director of the facility. These records should include any changes in the treatment plan and the reasons for those changes.
Impaired child

Presentation and physician action
A 32-year-old woman came to her ob-gyn’s office on July 15 to begin prenatal care. She was given a due date of February 22. Ultrasound studies were conducted on July 30, October 22, and December 10. The results from these studies were described as normal.

At 4 p.m. on February 12, the patient came to the hospital, and was admitted to Labor and Delivery. At admission, her temperature was 99.8 degrees, but the medical record indicates that she told staff that her temperature at home had been 100.8 degrees. The L&D admission sheet notes the chief complaint as “fever 100.8 and nauseated.” Subsequent medical records indicate that the patient was feverish (up to 102 degrees) during the two weeks before coming to the hospital. The patient also had a low-grade fever for the last two months of the pregnancy that began after she ate unpasteurized Jalisco cheese.

Approximately two hours after admission, the patient was having contractions every 8 minutes lasting 45 seconds. The fetal heart rate (FHR) was in the 160 to 170 beats/minute range. At 7:30 p.m., the contractions occurred every 5 to 7 minutes. The FHR continued to be in the 160-170 beats/minute range, but the patient’s pulse rate had risen to 150 beats/minute. At 7:45 p.m., the FHR was in the 170 to 180 beats/minute range.

The next note appears in the record at 9:40 p.m. The patient was 6 cm dilated and 80% effaced. Her contractions were noted to be irregular and the FHR was 175 to 178 beats/minute. These notes indicate that the ob-gyn ordered oxytocin.

The next entry at 10 p.m. lists only the FHR as 175-179 beats/minute. Pitocin was increased to 48. At 10:15 p.m., the notes indicate that the patient was 90% effaced and dilated 6 to 7 cm. FHR was 170 beats/minute. Oxytocin was increased to 60 and the notes state “continued variables.” The heart rate decreased to 130 beats/minute for 10 seconds with contractions.

The L&D summary notes that a 6-pound, 5-ounce boy was delivered at 10:44 p.m. The Apgar scores were 2 at one minute and 5 at five minutes. According to the newborn’s hospital record, he had aspirated meconium and his condition was “poor.” He was resuscitated with oxygen, bag and mask, and intubation. At 11 p.m., thick meconium was suctioned. At 11:15 p.m., he was placed on a respirator.

Two pediatricians took over his care at 11:20 p.m. They inserted an umbilical arterial catheter and drew an arterial blood gas, which revealed the following: pH of 6.97; PCO2 of 121; and base excess -8. A notation at 12:35 p.m. states “1/2 cc thick green mucus aspirated via NG tube.” The tube was removed and an oral gastric tube was inserted. The respirator was increased to 55. At 2 a.m., one of the pediatricians inserted a chest tube, and 4 cc of thick, green mucous were aspirated from the tube.

At 3:30 a.m., the infant was transferred to a children’s hospital. His condition was listed as stable but serious. An ABG revealed a pH of 7.2 and PCO2 of 41.
The placenta was sent to pathology and the report notes the clinical diagnosis as “possible growth retardation.” The pathologic exam indicated that the cord had only two blood vessels and that the placenta was discolored. This suggests that the meconium was passed long before birth. A section from the membrane showed severe acute chorioamnionitis. A blood culture revealed gram-negative rods, found to be *Listeria monocytogenes*.

The infant was discharged from the children’s hospital 28 days after birth with the final diagnosis of severe meconium aspiration; pulmonary hypertension; system hypertension, resolved; hyperbilirubinemia; *Listeria* septicemia; and negative head sonogram.

Fourteen years after his birth, when this lawsuit was filed, the child was reported to have developmental delays with associated behavioral abnormalities. He has been treated for attention deficit disorder, optic atrophy with resultant visual impairment, and simple partial seizures. Repeated MRIs have shown persistent periventricular leukomalacia.

**Allegations**
A lawsuit was filed against the ob-gyn, alleging failure to timely and properly deliver the infant; failure to timely and properly manage late decelerations; ordering oxytocin in the presence of late decelerations; increasing the dosage of oxytocin after the late decelerations; and failure to timely perform a cesarean delivery. Also named in the lawsuit were the hospital where the infant was born and the two pediatricians who cared for the infant after his birth.

**Legal implications**
The issues in this case were complex. The plaintiffs argued that the newborn was injured as a result of perinatal asphyxia. The defense argued that the injury was the result of *Listeria* sepsis related to the mother’s ingestion of unpasteurized cheese during her pregnancy, coupled with an abnormally developed placenta and umbilical cord.

The weaknesses in this case were primarily related to documentation. In addition, the baby was slightly tachycardic and there were some decelerations during labor. During his deposition, the ob-gyn admitted that this was a “non-reassuring” fetal heart rate.

**Disposition**
Given the sympathy factor in this case, the defense felt the chance of a successful jury verdict was 50% to 60%. The case against the ob-gyn was settled during mediation. The plaintiffs continued to pursue the case against the pediatricians and the hospital.

**Risk management considerations**
Documentation of patient conditions in a timely manner is essential to having a complete and accurate medical record. Current, complete medical records are not only essential to assist in diagnosis and treatment, but are also extremely helpful to the physician’s defense in a malpractice claim. Every effort should be made to ensure that thorough and timely documentation is done.

While the defense was able to retain experts who testified that the child’s impairments did not occur during labor; the ob-gyn’s decision to order oxytocin in the presence of late decelerations weakened the defense.
Failure to prevent aspiration

Presentation
A 54-year-old woman came to the emergency department (ED) with abdominal pain, nausea, and constipation. She was admitted for 23-hour observation, given a suppository and a half bottle of magnesium citrate. Dicyclomine was also administered to alleviate cramping. An abdominal film revealed evidence of a possible ileus or early small bowel obstruction. The patient was kept NPO in preparation for surgery.

Two days later, a small bowel series and a CT scan with contrast was obtained. The patient was given meperidine and promethazine for pain. The CT scan revealed a small bowel obstruction from an incarcerated right femoral hernia. The patient told the general surgeon that she had the hernia for years with no change, and that her physician had advised her to leave it alone.

The general surgeon planned to do a right femoral herniorrhaphy, but advised the patient there was a possibility that the bowel could be strangulated and would require resection. The patient’s abdomen was noted to be distended and firm. She was subsequently taken to the anesthesia holding area.

Physician action
Prior to the induction of anesthesia by the anesthesiologist, and while the general surgeon applied cricoid pressure, the patient vomited approximately two liters of gastric contents. The oropharynx was suctioned. The patient was placed in a Trendelenburg position and intubated. The anesthesiologist performed a bronchoscopy and the patient aspirated more material. The bronchi were suctioned. The surgery proceeded, and at the end of the surgery the anesthesiologist performed another bronchoscopy. Small amounts of material were removed.

The patient was transferred to the ICU where she suffered respiratory failure and was put on ventilator support. She later developed signs of sepsis. A week after the surgery, the patient became hypotensive and bradycardic and was placed on epinephrine and atropine. The patient subsequently arrested and died despite resuscitative efforts.

Allegations
The patient’s family filed a lawsuit alleging the anesthesiologist failed to prevent the aspiration and failed to insert an NG tube before induction of anesthesia. The general surgeon was also named in the suit.

Legal implications
The primary issue in this case involved whether or not an NG tube should have been placed before induction of anesthesia, when the patient came to the holding area with a fully distended abdomen. The plaintiff’s expert testified that had an NG tube been placed before induction of anesthesia, the vomiting, the aspiration, and the subsequent complications leading to the patient’s death would not have occurred.

Defense experts testified that NG tubes are normally inserted after induction, but efforts should be made to reduce the volume in the abdomen. Defense consultants...
who reviewed this case shared similar opinions. A consultant anesthesiologist stated that the placement of an NG tube is “the responsibility of the surgeon.” A consultant general surgeon stated “it would have been appropriate to place a Levine tube to decompress the patient’s stomach prior to surgery and before sedation.” This reviewer felt that the anesthesiologist had a patient who had not been properly prepped before surgery.

The anesthesia nursing notes all indicated that the patient was alert, awake, and oriented times three. However, the anesthesia record prepared by the anesthesiologist contained a late entry, and reflected that the patient was sedated upon arrival with decreased mental status. The patient’s sister (a fact witness and not a party to the suit) testified that the patient was alert when she arrived at the holding area. The anesthesiologist also wrote that this was an emergent situation, but the general surgeon did not indicate the surgery was emergent, only urgent. The plaintiff and defense experts all testified that if the patient had been awake and alert, it would have been appropriate to insert an NG tube in an effort to reduce the volume in the abdomen.

**Disposition**
This case was settled on behalf of the surgeon and the anesthesiology group.

**Risk management considerations**
The pre-anesthesia evaluation determines whether a patient can safely undergo anesthesia and which precautions should be taken. The pre-anesthesia evaluation can also facilitate the relationship between the anesthesiologist, the patient, and the surgeon.

In this case, the anesthesiologist made a late entry in the record indicating that the patient was sedated with decreased mental status upon arrival. This contradicted the anesthesia nursing notes and the patient’s sister, who indicated the patient was alert and oriented times three. Complete and timely pre-anesthesia notes serve as a comprehensive description of a patient’s medical and mental status and the rationale for the anesthesia plan. The pre-anesthesia evaluation also serves as a second opinion about the patient’s preoperative condition. Errors or late entries in the anesthesia record can cause many legal problems, and may give the appearance of negligence when none actually occurred. If late entries must be made, they should be appropriately dated and signed.

Other anesthesia documentation pitfalls
- Advanced charting — a pre-charted entry in the anesthesia record could jeopardize the credibility of the entire record in the event of an adverse outcome. No matter how routine the procedure, no portion of the anesthesia record should be pre-charted.
- Blank spaces on preprinted forms — preprinted forms that contain blanks may be interpreted as showing that the question was not addressed. The use of N/A for non-applicable items where there are blanks is appropriate.
- Timing of events — the accuracy of timed events is critical, especially when an unanticipated outcome occurs. If more than one person documents in the anesthesia record during resuscitation efforts, inconsistencies can arise.
- Documenting unanticipated outcomes — if an unanticipated outcome occurs, review the completed anesthesia record and other pertinent forms. If inconsistencies are identified, a narrative progress note may be used to describe the discrepancies in the timed entries. Addenda should be appropriately timed, dated, and signed.
**Bariatric surgery complications not recognized**

**Case 1 — Presentation**
A 45-year-old woman with a 20-year history of morbid obesity was referred to a general surgeon, the defendant in this case. She weighed 296 pounds and was 5’4” in height. Her symptoms included severe low-back pain and arthralgia in her knees, ankles, and feet. Over a three-month period, the physician and patient discussed gastric bypass surgery. The physician obtained informed consent and performed a Roux-en-Y gastric bypass procedure.

**Physician action**
Postoperatively, the patient developed a low-grade fever, sinus tachycardia, and leukocytosis. She was returned to surgery four days later and the surgeon found leakage from the staple line. The gastric pouch had suffered spontaneous perforation near the staple line and part of the stomach appeared unhealthy with vascular deficiency. Following the second surgery, the patient became septic and developed acute respiratory distress syndrome. She remained in the surgical ICU for several weeks, under the treatment of a team of specialists.

The patient was taken back to surgery a few weeks later for drainage of a left subphrenic abscess and tracheostomy. She continued to show signs of persistent fistula. Again, the staple line leaked, requiring another surgery two months later. During this surgery, two fistulas were repaired and the colostomy was closed. The patient’s condition slowly improved, and she was discharged from the hospital four weeks after the fourth surgery. She was instructed to follow up with the general surgeon.

Ten days after leaving the hospital, the patient returned to the surgeon. The tracheostomy and gastrostomy tubes were removed without difficulty. The patient reported that she was able to eat small meals, but continued to have diarrhea. The surgeon instructed the patient to return for follow-up care in three weeks. She did not show up for the appointment and never returned to the surgeon.

Over the next 13 months, the patient was hospitalized several times for chronic liver disease, sepsis, and persistent gastrointestinal fistulas. She eventually underwent a takedown of the gastric bypass procedure performed by another surgeon. Her postoperative course was complicated by respiratory, renal, hepatic, and gastrointestinal failure. She died shortly after the surgery.

**Allegations**
A lawsuit was filed against the general surgeon. The allegations included:
- failure to test the anastomosis for leaks intraoperatively;
- failure to obtain a timely upper GI series;
- failure to properly monitor the patient; and
- failure to perform a timely surgical revision of the leakage.

**Legal implications**
The plaintiff’s attorney was able to retain an expert in general surgery who was critical of the surgeon, and who related the development of the patient’s severe complications and eventual death to the first gastric bypass surgery. Specifically, the expert
stated that the surgeon fell below the standard of care in failing to test for leakage from the staple line at the time of the surgery. He was also critical of the delay in recognizing the complication and returning the patient to surgery.

Defense consultants offered differing opinions about this case. One surgeon stated that it was his practice to test for staple line leaks before closing when performing gastric bypass procedures. Another consultant surgeon said that testing for leakage intraoperatively would not necessarily have shown a leak and would not have prevented the subsequent complications. Two other surgeon consultants believed the patient suffered from Crohn’s disease, and it was this underlying condition that caused the staple line to leak and contributed to her final outcome.

Disposition
Due to the grave complications from a difficult surgical procedure, high medical expenses, and liability issues this case was settled.

Case 2 — Presentation
A primary care physician referred his patient, a 36-year old woman, to a general surgeon for consultation about vertical banded gastroplasty. The patient was 5’9” in height and weighed 290 pounds. The surgeon discussed the procedure—its risks and benefits—with the patient, and provided her with a three-page handout.

Physician action
Six months later, the surgeon performed the vertical banded gastroplasty on the patient. The procedure was carried out without complication, and the patient did well postoperatively. Four days after the surgery, a barium swallow study was performed, and it showed no evidence of extravasation of contrast. The patient was discharged. The surgeon next saw the patient eight days later for removal of her skin clips. The patient’s weight was 268 pounds and she did not report any problems. She was told to return in one month.

Seven days after this office visit, the patient came to the emergency department (ED) with fever and left-sided pleuritic chest pain. An x-ray showed a left lower lobe infiltrate and the patient was diagnosed with community-acquired pneumonia. She was given erythromycin and discharged.

Three days later, she again came to the ED with complaints of left-sided chest pain, fever, chills, nausea, vomiting, weakness, and headache. The patient was admitted, and her care was turned over to a hospitalist who consulted the surgeon to rule out any complications from the gastroplasty. On her second day in the hospital, the surgeon ordered a CT scan, which revealed a left upper quadrant abdominal abscess. The surgeon performed an exploratory laparotomy and drained the abscess. No areas of perforation were noted.

One day after the laparotomy, the patient continued to have fever and infection. The surgeon started the patient on prophylactic heparin for the prevention of deep venous thrombosis. Throughout the patient’s hospital stay, the surgeon ordered early and frequent ambulation and TED hose as a prophylactic measure. The surgeon ordered a barium swallow study, which showed a small leak from the stomach. An NG tube was placed, and the surgeon opted to use suction and TPN to avoid further surgery.
On her seventh day in the hospital, the patient developed shortness of breath and hypoxia for the first time. The hospitalist consulted a pulmonologist, and ordered a ventilation/perfusion lung scan. The radiologist read the scan and orally reported to the hospitalist that it was negative for pulmonary embolism. However, the radiologist’s written report indicated “low to indeterminate for possible pulmonary embolism.” This report was not read by the hospitalist until ten days later. In retrospect, the hospitalist indicated that if he had known about this finding, he would have started the patient on heparin or placed a Greenfield filter.

The patient’s condition worsened, and she was returned to the OR. The surgeon re-positioned the chest tube and repaired the leak in the stomach. The patient did well postoperatively and continued to improve until two days later when she began to complain of chest pain. The hospitalist and pulmonologist ordered another lung scan and again, the radiologist read the scan as having a low probability for pulmonary embolism. The next day, the hospitalist received a call from the radiologist who was now changing the report to indicate an “intermediate to high probability of pulmonary embolism.” The hospitalist and pulmonologist ordered a change from prophylactic anticoagulation to full heparin anticoagulation.

The next day, the surgeon placed a Greenfield filter in the patient’s inferior vena cava, and performed a total gastroectomy, cholecystectomy and appendectomy. The patient remained in critical condition for the next two days. She began to have seizures, suffered an acute brain stem stroke, and became neurologically unresponsive. The patient’s family signed a do-not-resuscitate order and the patient died.

An autopsy was performed and the pathologist determined the cause of death to be submassive pulmonary emboli with prolonged heart failure and shock leading to acute respiratory distress syndrome. The findings also revealed the presence of chronic gastritis suggesting the possibility of pre-existing heliobacter-induced gastritis and peptic perforation following the gastroplasty.

Allegations
A lawsuit was filed against the surgeon and the allegations included:
- failure to provide prophylactic anticoagulation at the time of the original surgery;
- failure to perform a barium swallow study before the gastroplasty; and
- employing an improper technique to repair the leak in the stomach.

Legal implications
The plaintiff’s case did not focus on the initial surgery, but the postoperative care. The plaintiff’s expert was critical of the surgeon for not performing a barium swallow before the second surgery. This would have revealed the leak and would have allowed it to be repaired earlier. Though the cause of death was pulmonary emboli, it was the opinion of the plaintiff’s expert that the patient’s infection led to the pulmonary emboli. He could not offer any explanation as to how this occurred. The expert stated that it was not reasonable to rely on a pulmonologist who was saying the patient had a low probability of pulmonary emboli.

Defense consultants were supportive of the surgeon’s care in this case. Though a leak did occur, the barium swallow performed four days after the gastroplasty negated the pos-
Bariatric surgery complications not recognized

sibility that a tear occurred during the surgery. The experts believe the leak occurred because of the patient’s pre-existing gastritis.

The cause of death was pulmonary embolism, not infection. Regarding the plaintiff’s claim that the infection led to the pulmonary emboli, defense experts indicated this was a “ridiculous statement,” and that there is a “mountain of literature” to dispute this. The consultant surgeons also stated that it was reasonable for the surgeon to rely on the hospitalist and pulmonologist who were following the patient’s pulmonary status.

Disposition
This case was taken to trial and the jury returned a verdict in favor of the defense.

Risk management consideration
The defense consultants’ claim department has identified patient selection, informed consent, and postoperative follow up as prevalent issues in lawsuits alleging malpractice before, during, or after surgical weight reduction procedures.

The first closed claim indicated the patient did not keep her second postoperative appointment and never returned to the surgeon for care. Did the surgeon’s practice have a system to follow up with a patient who does not keep an appointment and does not call to reschedule? Contacting patients who fail to follow up for needed care can result in better patient outcomes. If litigation ensues, this follow up can also assist in the physician’s defense of the case. It is helpful to have a system for staff to document the missed appointment in the record, to contact the patient to determine why it was missed, to reschedule, and to document all of these actions in the record.

No one disputes the fact that patients should be compliant with their physicians’ directives and accountable for their choices and actions. Each scenario will merit review of its uniqueness and the degree of follow up required. A patient who has postoperative complications, three additional surgeries, and an extended hospital stay warrants timely, uninterrupted follow-up care. Developing a system, implementing and using it consistently, and documenting this in the medical record will reflect a conscientious practice committed to quality patient care.
Communication errors
**Failure to diagnose prostate cancer**

**Presentation**
A 45-year-old man came to the defendant, a family physician, with complaints suggestive of urinary tract infection. Laboratory studies revealed a prostatic specific antigen (PSA) of 11.1 ng/mL (normal range 0-4 ng/mL) and a prostatic acid phosphatase (PAP) of 3.8 U/L (normal < 2.8 U/L).

**Physician action**
The patient was informed of the PSA findings and a referral was made to a urologist. Per the managed care guidelines, as the primary care provider, he prepared a referral to the specialist and gave it to the patient explaining the elevated PSA as the reason for the consult. A copy of the referral was not made for the medical record nor did the chart indicate a copy of the PSA report was sent to the urologist, although the family physician thought he sent it.

The patient was seen by the urologist who diagnosed congestive prostatosis and directed the patient back to his family physician. In the discovery phase of this claim, the urologist stated he was not informed of the elevated PSA and PAP, and did not ask the patient or the referring physician the reason for the consult request. However, the referral was in the record at the urologist’s clinic and indicated “prostate level up.”

The patient finished a course of antibiotics and saw the family physician eight months later for an unrelated complaint. At that time, no prostate exam was done.

Three years later, the patient came to the emergency department (ED) for high blood pressure, and was directed to follow up with his family physician. Upon examination a rectal nodule was detected and the PSA was 21. A referral was made to another urologist. A biopsy revealed a stage 3 tumor with a few cells through the capsule. A subsequent radical prostatectomy was done. The patient has done well postoperatively but was rendered impotent at age 48.

**Allegations**
The patient filed suit against the family physician, the first urologist, and the urologist’s clinic for failure to diagnose prostate cancer in a timely manner resulting in unnecessary physical pain, surgery, and anguish for the patient and his family. It was further alleged that this patient lost his sexual function, his cure rate was diminished, and his life expectancy reduced by the delay in diagnosis and treatment.

**Legal implications**
Failure to diagnose is the most cited allegation in claims against physicians. Consulting physicians who reviewed this case for both the defendant and the plaintiff expressed varying opinions about the responsibilities of the family physician and urologist. Some felt that the family physician had met the standard of care and others were critical of his actions. This was also reflected in the opinions about the urologist’s actions.

One family physician consultant stated that the elevated PSA and PAP in a 45-year-old may be suggestive of malignancy, and is the basis for aggressive follow up with,
at a minimum, serial PSAs and prostate exams. This was apparently recommended by
the defendant, but neither his advice nor the plaintiff’s noncompliance was documented.
Another consultant indicated that the failure of the family physician to act appropriately
when presented with evidence in the urologist’s report that the lab values were not evalu-
ated falls below the standard of care. Most consultants did concur that the family physi-
cian should have followed up upon receiving the report from the urologist with no refer-
ence to an elevated PSA and PAP. The defendant, as the referring physician, was required
to act on the report and re-evaluate the patient’s prostate with clinical and laboratory
examination on a routine basis. Had this been done, it is likely the diagnosis would have
been made earlier with an improved prognosis.

Disposition
Although this case had been scheduled for trial, discussions regarding settlement con-
tinued and a settlement agreement was reached. The other parties in the suit not insured
also reached a settlement.

Risk management considerations
Documentation was clearly an issue in this case. If a physician or staff member’s action
is not documented in the medical record, it may be difficult to convince a jury that it oc-
curred. A copy of the referral to the urologist was not made for the patient’s record at the
primary care practice. The family physician also did not document that the elevated PSA
was the reason for the referral or that he explained this to the patient. Receipt of the urol-
ogy consult with no reference to the PSA was an opportunity for the defendant to commu-
nicate directly with the urologist and then to follow up with the patient.

Physicians who order tests or consults hold the responsibility to review the reports when
received; document the review action with initials and date; and initiate appropriate fol-
low up in a timely manner. Because the primary care physician is usually the first point of
care, preventive/routine health care management is part of his/her practice.

This physician indicated that he reminded the patient about the need for annual exams,
including digital rectal exams and PSA levels, but did not document his advice in the
medical record or the patient’s noncompliance in presenting only for problem visits. If a
patient is noncompliant, documenting this behavior may serve to defend a physician or
provide the basis for comparative negligence on the part of the patient.

Many patients have unrealistic expectations when seeking medical treatment. It is
important for physicians to understand each patient’s health literacy, provide education
suitable to the level of understanding, verify that the patient does understand the treat-
ment plan, and always document patient noncompliance.

Other issues that come up frequently are lack of or inadequate communication between
physicians and the failure of physicians to review their prior progress notes for reminders
of potential follow-up needs. Attention to both of these procedures can reduce the number
of issues that are inadequately investigated or lost to follow up.
Failure to inform — diagnosis of abdominal cancer

Presentation
A 29-year-old man came to the emergency department (ED) with complaints of abdominal pain, weakness, and fever. The symptoms began the day before, but became unbearable.

Physician action
The ED physician suspected appendicitis and requested a surgical consult. The surgeon, a defendant in this case, took the patient to the OR for an exploratory laparotomy. The surgeon discovered a ruptured appendix and a mucous-type substance around the appendix. This mucous proved to be a rare cancer called pseudomyxoma peritonei (PMP).

After the surgery, the surgeon told the patient that his appendix had ruptured, and that he had cleaned the peritoneal cavity. There was a dispute between the patient and the surgeon as to whether the existence of the PMP was communicated to the patient. The surgeon did not specifically document the disclosure of PMP/cancer/malignancy to the patient. The patient claimed the surgeon told him not to worry about the “jelly-like substance around the appendix” because it had been removed.

Postoperatively, the surgeon sent the patient to a gastroenterologist (also a defendant in this case) to determine if there was any pathology involving the colon. At this visit, they discussed the patient’s family history of cancer, and a colonoscopy was scheduled.

A dispute existed between the gastroenterologist and the patient as to whether the diagnosis of PMP was disclosed to the patient by the gastroenterologist. The gastroenterologist later testified that the patient brought the pathology report from the surgery to the office visit. The gastroenterologist’s dictated consultation report quoted language from the pathology report, but the specific disclosure of the PMP diagnosis was not documented. The patient recalled a discussion about the “jelly-like substance” with the gastroenterologist, but claims the gastroenterologist told him it was a non-issue because it had been removed. The patient also said he was never told to consult with the gastroenterologist for PMP.

The gastroenterologist performed the colonoscopy and the results were normal. These results were reviewed with the patient and forwarded to the general surgeon. The patient was told to follow up with the surgeon, and he never returned to the gastroenterologist.

There was no record of a follow-up visit between the patient and the surgeon, but both testified to such a meeting. The surgeon testified that he referred the patient to his primary care physician for follow-up treatment of PMP. The patient testified the surgeon told him “I think we got it all out and if it comes back, we can get it out again.” The patient maintained that neither the surgeon nor the gastroenterologist ever told him he had cancer.
Failure to inform — diagnosis of abdominal cancer

Over the next four years, the patient saw his family physician for a number of unrelated complaints. During these visits, there was no mention of PMP, cancer, or any illness that would require further treatment or follow up.

Approximately five years after the appendectomy, the patient began experiencing abdominal pain again. He went to the ED and was seen by a surgeon. This surgeon performed a colectomy for a pelvic mass seen on films. The patient was again diagnosed with PMP. The patient was seen by a number of oncologists and ultimately went to an out-of-state surgical oncologist. He underwent surgery and chemotherapy, and the PMP has not recurred. However, the patient tested positive for signet ring cells intraoperatively, which means there is latent evidence of remaining PMP. The patient must be monitored with CTs and lab work for the next 10 years.

Allegations
Lawsuits were filed against the surgeon and the gastroenterologist alleging failure to inform the patient of the diagnosis of PMP, and failure to refer the patient to a specialist for treatment.

Legal implications
The lawsuit against the surgeon, who was not a policyholder, was settled before trial. The gastroenterologist chose to defend his care through trial.

At trial, the plaintiffs presented an expert gastroenterologist who testified that the defendant fell below the standard of care in failing to inform the patient about the diagnosis of PMP, and by failing to refer the patient to an oncologist. The patient’s family physician—who denied any knowledge of the PMP prior to the colectomy — placed the responsibility for relaying the cancer diagnosis on both the surgeon and the gastroenterologist. He testified that one or both of these physicians “dropped the ball.” An oncology expert testified that the delay in the treatment of the PMP resulted in more extensive and radical surgical procedures performed on the patient.

The defense gastroenterology expert testified that the defendant had no duty to disclose another physician’s diagnosis to the patient. The defendant was specifically asked to rule out colon pathology on the patient, which he did. He sent the surgeon a letter stating the same. The surgeon clearly did not intend for the gastroenterologist to take the lead and refer the patient to an oncologist because the surgeon told the patient to follow up with his family physician.

Patient responsibility became an issue in this case, with the defense expert testifying that the patient had a responsibility to follow up on his condition. It was suggested that the patient was in denial about the cancer, which is why he never mentioned it to his family physician. However, the patient’s family physician testified that when he notified the patient of the PMP after the colectomy, the patient seemed to be totally unaware of the diagnosis from five years earlier.

Disposition
The jury returned a verdict in favor of the plaintiffs, assigning 35% of the negligence to the gastroenterologist and 65% to the surgeon. The defense team for the gastroenterologist planned to appeal the verdict. However, with the consent of the defendant, a settlement was reached during post-verdict mediation.
Risk management considerations
Comprehensive communication and documentation can serve as the foundation for an effective physician-patient and physician-physician relationship. Relying on memory may have limited relevance during discovery, deposition, and trial. Because it is almost routine for a patient to be seen by several physicians, as reflected in this case, it is extremely important for the patient to know who is directing his or her care and who will determine the next step in the course of treatment.

Responsibility for follow-up and timely continuity of care should not be left to chance. If a patient is not an active participant in his or her medical care, it may be caused by a lack of understanding, a reluctance to ask for clarification, or a fear of the unknown. It is expected that physicians educate their patients and verify patient understanding of the information needed to make informed decisions.
Failure to diagnose cornual pregnancy

**Presentation**
A 33-year-old woman came to the emergency department (ED) complaining of bilateral abdominal pain, back pain, and shortness of breath. She reported that she was nine to 10 weeks pregnant. The patient also had a history of pelvic inflammatory disease (PID) and sickle cell anemia.

The patient’s vital signs were normal, but she had tenderness along her abdomen. Blood work indicated that she had a white blood cell count of 8,000 and mild anemia. The emergency medicine physician ordered an ultrasound to determine if the pregnancy was normal.

**Physician action**
The radiology technician completed the ultrasound and contacted the on-call radiologist at his home at 3 a.m. The technician told the radiologist that the images were of poor quality even though the ultrasound had been done twice. The radiologist had the technician send him a copy of the images via teleradiology. After reviewing the images, he determined that the pregnancy was intrauterine but “abnormal.” He reported this finding by phone to the ED physician. However, the ED physician claimed that the radiologist reported that the ultrasound showed a normal intrauterine pregnancy. “Normal intrauterine pregnancy” was written in the ED records.

The ED physician discharged the patient at 6:40 a.m. after giving her meperidine, promethazine and antibiotics. The final diagnosis was abdominal pain due to intrauterine pregnancy, gastroenteritis, or possible pelvic inflammatory disease. She was told to rest at home and follow up with her obstetrician. The ED physician later stated that the patient was discharged because she refused hospitalization, but this was not indicated in the medical records.

A second radiologist reviewed the ultrasound images when he arrived at 8 a.m. He noted that the ultrasound showed an intrauterine cornual pregnancy, a pregnancy in which implantation occurs in the uterus at its junction with the fallopian tube. He recommended that the patient be brought back in for further studies to evaluate the position of the pregnancy. According to his testimony, he asked the radiology technician to call the patient and have her return. The patient was never called. The technician stated that the radiologist never requested that she call the patient.

The patient continued to suffer from abdominal pain at her home before calling EMS at 9:44 a.m. When she arrived at the hospital, she complained of acute pain and difficulty breathing. Ten minutes later she coded and CPR was started. She was sent to the OR for an emergency laparotomy due to suspected ruptured ectopic pregnancy. CPR was continued throughout the surgery. The surgeon located and removed the cornual pregnancy from the left side of the uterus and noted between 1.5 and 2 liters of blood in the abdominal cavity. Despite CPR and several defibrillations, the patient was pronounced dead at 12:17 p.m. The pathologist found the cause of death to be ruptured ectopic cornual pregnancy complicated by acute shock and exsanguination.
Allegations
A lawsuit was filed against the radiologists and the ED physician. The allegations included:
- failure to properly interpret the ultrasound resulting in a premature discharge from the ED (first radiologist);
- failure to provide the diagnosis to the ED in a timely manner resulting in failure to call patient back to the hospital (second radiologist); and
- failure to perform a pelvic exam, failure to call for an OB consult, and prematurely discharging the patient (ED physician).

Legal implications
Cornual pregnancies are extremely rare and some physicians may never encounter them in their careers. They also have a high mortality rate and, according to radiology experts reviewing this case, are very difficult to diagnose.

While acknowledging that the poor quality of the ultrasound films, the plaintiff’s radiology expert stated the final diagnosis of intrauterine pregnancy was incorrect. The patient did not have an obvious extrauterine ectopic pregnancy, but a pregnancy in an unusual position that was neither extrauterine nor intrauterine. In any case, according to the plaintiff’s expert, the failure to diagnose the cornual pregnancy led to the patient’s inappropriate discharge from the hospital and her death.

Defense’s radiology consultants had mixed opinions about the first radiologist’s interpretation, but all agreed that the images were consistent with a cornual pregnancy. One reviewer commented that the radiologist should have asked for a repeat exam or should have come to the hospital to review the ultrasound. Another consultant stated that the radiologist did not rule out ectopic pregnancy just by advising the ED physician that this was an abnormal pregnancy.

The second radiologist’s interpretation of “an intrauterine pregnancy of questionable location” was considered appropriate, but consultants were concerned that he dictated the need to call the patient back rather than contacting the ED physician. In his deposition, the radiologist said that if he had been certain the patient had an ectopic pregnancy, he would have contacted the patient immediately. Since this diagnosis was a “gray area” and since he was informed that the patient had been discharged from the ED, he asked the technician to contact the patient.

Regarding the actions of the ED physician, plaintiff’s experts stated there was not enough information about the patient’s condition to discharge her. Even after receiving word that the pregnancy was not ectopic, he should have performed a pelvic exam and obtained an ob-gyn consult. A pelvic exam would have yielded additional information to make the diagnosis. An ob-gyn consult should have been ordered because he had a pregnant patient in severe pain without an ectopic pregnancy. Defense experts argued that a pelvic exam was not necessary since an ultrasound had been ordered. An obstetric consult was also not necessary because the patient was already under the care of an obstetrician and it was determined, based on the ultrasound, that her condition was not life threatening.

Of great concern in this case was the communication between physicians and the apparent lack of documentation about what was discussed. The first radiologist should have documented his interpretation by faxing a report to the hospital immediately. Though the ED physician did document that the radiologist reported a “normal intrauterine pregnan-
Failure to diagnose cornual pregnancy

cy,” he did not document that he wanted to hospitalize the patient but she refused. For the second radiologist, a call to the ED physician advising him of the need for follow-up studies would have been more appropriate than dictating the need for call back in the report.

Disposition
This was a complex case involving multiple physicians. Finger pointing became a concern, as each party to the suit gave differing versions of the events. These facts, along with the lack of documentation and the communication issues, led to the decision to settle the case on behalf of all three physicians. The ED physician contributed 50% and each radiologist contributed 25% to the settlement.

Risk management considerations
In hindsight, actions that might have made a difference in the outcome of this claim have been mentioned above. Are oral reports acceptable in teleradiology? Was the impression clearly understood when the physicians spoke? It seems unlikely that the ED physician would ignore the word “abnormal.” That is not what he heard. A report emailed or faxed would alert him to “intrauterine but abnormal.” Are images of poor quality satisfactory for interpretation away from the facility? What protocols are in place to determine when the on-call radiologist comes in?

Clearly, communication and timely action may influence outcomes when studies are abnormal and follow up is required. The practice of radiology lends itself to well-defined systems that guide when the ordering physician is told of abnormal findings and any recommendations for further studies. Document this contact. Practicing prudent risk management and implementing well-designed systems to observe the standards of care will promote quality health care and reduce the exposure a radiologist encounters on a daily basis.
Failure to diagnose lung cancer

Presentation
A 55-year-old woman came to her family physician with complaints of chest congestion, wheezing, and shortness of breath. Diagnoses included asthmatic bronchitis, rhinitis, otitis media, and hypertension.

Physician action
A chest x-ray was completed and read two days later by a radiologist, the defendant in this case, who worked three days a week at the hospital. The film was compared with a study done five months earlier that demonstrated an area of atelectatic change or infiltrate. This was no longer present and the current study revealed no active lung disease. The radiology report was faxed to the family physician.

Six weeks later, the patient returned to the family physician. She reported continuing symptoms, and was assessed as having asthma, rhinitis, hypertension, and obesity. Three and a half months later, the patient again reported breathing problems and “not getting enough air.” The assessment at this visit included asthma, rhinitis, hypertension, dyspepsia, and right upper extremity numbness. The patient was given prescriptions and instructed to return the next week.

That evening the patient came to the emergency department (ED) of a local hospital complaining of shortness of breath and difficulty breathing. The ED physician ordered a chest x-ray and discharged the patient with instructions to follow up with her doctor. Three days later, the defendant radiologist interpreted the study and noted an area of slightly hazy density in the left lung with nearby fibrotic changes. Differential diagnoses included a developing small nodule or mass and a CT scan was recommended. This radiology report was sent to the ED, but there was no indication that the ED forwarded the report to the family physician. A note in the patient’s ED medical record dated the day after the ED visit indicated awareness of the evaluation. The entry stated the pulmonary function, oxygen saturation, and chest x-ray were “OK.” The entry also included comments about patient anxiety, a prescription for alprazolam, and that the patient was advised to see her physician in two days.

The patient was seen by the family physician six days later. She reported better breathing and decreased anxiety. Physician assessment indicated that the patient’s asthma had improved, and again listed hypertension, rhinitis, RUE numbness, dyspepsia, and anxiety.

Eight weeks later, the patient came to the ED complaining of breathing problems and chest pain. A different ED physician saw her. He ordered a chest x-ray, which he interpreted as showing increased pulmonary markings. The ED physician prescribed medication, told the patient to continue using an inhaler, and instructed her to follow up with her family physician.

Again, the defendant radiologist over-read the chest x-ray, and compared it with the patient’s first x-ray, but not the x-ray completed during the previous ED visit. The radiologist reported no acute lung disease and no significant change from the earlier study. No mention was made of the suspicious density in the left lung with nearby
fibrotic changes that prompted the recommendation for a CT scan. There was no indication in the medical record that this report was forwarded to the ED or the family physician.

Two days later, the patient was seen by her family physician with complaints of midsternal tightness that increased with exertion, wheezing, dyspnea and a “thick” tongue. Over the next seven months, this patient was seen seven times with continuing complaints of difficulty breathing. The record for these visits reflected the same assessment of asthma, rhinitis, and hypertension.

Another four months passed. During an appointment, the family physician noted for the first time the existence of a left upper lobe nodule. The patient was sent to a specialist who performed a lung biopsy. The patient was diagnosed with inoperable lung cancer. She was subsequently evaluated by an oncologist and underwent chemotherapy. The patient died one year later.

**Allegations**

Lawsuits were filed against the family physician, the radiologist, the two ED physicians, and the hospital. The allegations against the defendant radiologist included:

- failure to diagnose lung disease or cancer;
- negligence in the failure to inform the patient or her physician of the recommendation for a CT scan; and
- failure to compare all chest x-rays available.

**Legal implications**

Determining exposure when multiple defendants are involved is always difficult. Three consultants reviewed this case. Two were generally supportive of the interpretations made by the radiologist. One was critical and felt the developing mass could be seen on the early film.

The case was also reviewed by the Claim Review Committee with a conclusion that was reasonably supportive of the interpretations, but critical of the radiologist’s failure to communicate the recommendation for a CT scan to the ordering physician. The plaintiff’s attorney also retained a well-credentialed expert who was highly critical of the communication issue.

**Disposition**

This suit was settled on behalf of the defendant radiologist. The hospital and family physician also settled their suits. The outcome of the suits against the ED physicians is unknown at this time.

**Risk management considerations**

An emergency medicine physician who reviewed this claim criticized the hospital for lacking a system to ensure follow up for abnormal x-ray findings and notification of physician and patient. It is also imperative for radiologists to communicate with the referring physician and to document that this occurred.

In this case, if the recommended CT scan had been done in a timely manner, the outcome might have been a positive one. It appears that there were three opportunities to act on the recommended CT. The defendant radiologist had the opportunity to communicate
Failure to diagnose lung cancer

with the ED physician, ED staff, or the family physician to ensure the scan would be ordered. ED staff had the opportunity to confirm the over-read was done, and to act on the radiologist’s recommendation. The abnormal x-ray was part of the family physician’s medical record, and one may surmise, not reviewed for more than a year.

All health care professionals need to have systems in place to ensure that abnormal findings requiring further studies, referrals, etc., are reviewed and acted on expeditiously. The practice of radiology is no exception. Even though there is often no direct encounter between the radiologist and the patient, a physician-patient relationship does exist. Prudent risk management and quality care can guide the radiologist to notify not only the referring physician when a study is abnormal, but also to carefully document this action.
Impertinent remarks

Presentation and physician action
A 42-year-old patient was referred by her gynecologist to a mammography center for a screening mammogram. The patient did not complain of any problems with her breasts. She provided the screening center with her medical history, including a family history of breast cancer. Her mother, two aunts, and grandmother all had breast cancer. At the time of this mammogram, the patient’s two previous mammogram films were available. The radiologist, the defendant in this case, interpreted the mammogram as negative for evidence of malignancy.

Approximately seven months later, the patient returned to her gynecologist complaining of a knot in her left breast. She detected this lump a week before the visit. The gynecologist attempted to aspirate the lump, but no fluid was obtained. He referred the patient back to the mammography center for a diagnostic mammogram and sonogram.

The defendant radiologist reviewed the diagnostic mammogram and sonogram. He believed the mass, visible on the mammogram, was suspicious for malignancy. He measured it at approximately 1.5 cm in diameter and recommended a surgical consultation. During this visit to the mammogram center, the patient reported that a staff member “in a white coat” informed her that the radiologist would have found the lump in her breast on the earlier mammogram if he had looked for it. This statement was made as the staff member reviewed her films. The patient was unaware of the staff person’s name.

The patient next came to a general surgeon, who performed a needle biopsy. The biopsy showed malignant cells consistent with mammary duct cell carcinoma. The surgeon told the patient that he did not want to offer an opinion as to why the radiologist did not detect the lump on the earlier mammogram. The patient was quite curious and concerned that the condition had gone undetected.

The patient was admitted to the hospital where the surgeon performed a left excisional breast biopsy, a left breast lumpectomy, and axillary lymph node dissection. Clear margins were established around the tumor during surgery. The pathologist staged the patient’s cancer at stage II A. Over the next two years, the patient completed chemotherapy, radiation therapy, and was started on hormonal therapy. She has remained free of cancer.

Allegations
In her suit against the radiologist, the patient alleged that he negligently interpreted the screening mammogram films. As a result of this alleged seven-month delay, the plaintiffs claimed the cancer progressed to a more advanced stage, required more extensive treatment than would otherwise have been necessary, and that the patient’s prognosis worsened.

Legal implications
The plaintiffs obtained experts supportive of their allegations, mainly that the mass was visible on the patient’s earlier mammogram and was missed by the radiologist.
Defense experts felt that the radiologist did not perform below the standard of care in his interpretation of the mammogram. The expert reviewers, including one for the plaintiff, also stated that the patient would have received the same treatment—surgery, chemotherapy, radiation, hormone therapy—if the cancer had been detected in the earlier mammogram. The experts also hotly debated whether or not the cancer progressed to a more advanced stage during the seven-month period between mammograms.

Disposition
This case was settled on behalf of the radiologist.

Risk management considerations
The sequence of events from this case are played out in physicians’ offices, hospitals, surgery centers, and clinics every day. As this case illustrates, health care professionals can and do incite patients to file lawsuits. A simple remark such as “your child’s seizures are the result of birth trauma,” may be all it takes for a patient to seek legal counsel, thus opening the liability floodgates.

The following risk management recommendations may help minimize the risk of triggering lawsuits against other physicians due to “impertinent remarks.”

• Stick to the facts without blame. If the patient asks you directly whether a previous physician was negligent, you might say “I can tell you what I’ve found and what I recommend. But I did not see for myself what happened, and it’s not my role to determine fault.”
• If the patient is coming to you for a second opinion and you disagree with the first physician’s opinion, be honest with the patient and state your opinion factually. Do not state the other physician is wrong. Simply acknowledge that your recommended course of treatment is different.
• When an error has occurred, you must be open about the situation. Do not lie or cover up for a colleague. Be factual and honest, but do not disparage the previous physician. If the patient asks you why the error occurred, you might say “There are a number of factors that could have caused this to happen. But, I was not there and I cannot answer that for you.”
• Avoid coming to a conclusion without having all the facts. Sometimes the history provided by a patient or family member contains erroneous information. Collect all relevant information before assuming that a patient or family account of the care delivered is accurate.
• Express empathy for the patient’s situation. Showing sincere interest and commitment to solving the problem is important.
• Be aware that seemingly innocent remarks, tone of voice, facial expressions, and body language may lead the patient to believe there was something wrong with their previous treatment. Comments such as “I would hardly expect that kind of complication from such a simple procedure,” or “This surgery will be much more complicated now because someone else has been here before,” may signal a problem to the patient.
• Make sure your employees understand this applies equally to them. A casual comment made by a staff member preparing a patient for examination may be all it takes to provoke a lawsuit. Instruct staff to tell patients to refer questions about previous treatment to you.
• Beware if a patient presents with less than optimal results from a procedure, expresses anger at the previous physician, and solicits your opinion about the treatment.
Encourage the patient to speak directly to the physician about the problem. State that since you were not present at the initial treatment, you do not know how or why the result occurred.

• Just as you would not want to openly criticize a colleague in front of the patient, do not do so in the medical record. When describing the situation, it is appropriate to quote the patient. You might document as follows: “Patient states that Dr. Jones felt a biopsy was unnecessary.”

• If you suspect there may be a problem with the physician, go through the appropriate channels to address it. Appropriate channels include a hospital peer review committee, the state medical board, a specialty society disciplinary committee, etc.

• The medical record is not the place to air grievances or discuss differing opinions with other physicians, nurses, therapists, etc. This, too, should be handled through the appropriate channels.

• Extreme caution is warranted if you are contacted by a plaintiff’s attorney asking about a patient’s previous physician. A number of times the defense consultants’ claim department has learned that a plaintiff’s attorney has told the doctor “if you’ll help me, I won’t sue you.” Often, those “helping” doctors are later sued by that same attorney.

• As always, whether you have talked to the patient or communicated with the previous physician yourself, document your conversations and recommendations in the medical record.
Failure to inform subsequent physician

Presentation and physician action
On January 10, a 24-year-old woman at 40 weeks gestation came to the hospital for delivery. Prenatal testing showed that she was negative for Hepatitis B, HIV, and RPR. She was immune to rubella and her pregnancy was complicated with a positive Group B Strep status (GBS). The mother reported a negative history for herpes simplex virus infection.

Since the attending obstetrician was unavailable, the on-call physician ordered ampicillin intravenously, artificially ruptured the membranes, and vaginally delivered a 2970-gram male. At the time of delivery, the infant was noted to have Apgar scores of 9/9 and also noted to have a generalized rash. A blood culture and CBC were performed on the infant due to the mother’s GBS status, and the results of both tests were found to be unremarkable. After one day in the level 1 newborn nursery, he was discharged home with the mother.

On the second day of life, the infant was seen by his pediatrician with an erythema toxicum-like rash and discharge from one eye described as conjunctivitis. He was treated with erythromycin ointment for the eye discharge. A blood culture was performed and the results were negative.

The mother was seen later that day by her treating obstetrician for postpartum fever. Upon examination, the physician noted a herpetiform lesion on the labia majora and clitoris. A culture was performed and lidocaine ointment was recommended for pain. The physician recorded in the chart “warnings: hand washing, etc.”

The infant was admitted to the hospital on January 13 for a temperature of 102 degrees. Diagnostic tests consisting of CBC, blood culture, and lumbar puncture were performed. He was placed on IV antibiotics, ampicillin and cefotaxime. Results of the CBC were Hct 47.2%; WBC 11.5; neutrophils 60%; bands 23%; lymphocytes 4%; and platelets 292K. A repeat CBC on January 14 provided similar results. The spinal fluid was negative for meningitis, and bacterial cultures were also negative. The infant was discharged from the hospital on January 15 with instructions to take Tylenol. On this day, the results of the mother’s lesion culture were reported in the lab as positive for Herpes Simplex Virus Type 1. The results were logged in the mother’s chart at the primary obstetrician’s office on January 17, and it was noted that the mother called the office asking for the results of the test.

Late in the day on January 17, the infant was brought to the emergency department (ED) with a chief complaint of “jerky movements of one arm and one side of the face lasting 1-2 minutes.” Head CT was negative. Serum glucose was normal at 48 mg/dl. A CBC revealed Hct 45.2%; WBC 11.4; neutrophils 23%; bands 6%; lymphocytes 44%; and platelets 74K. He was admitted to the pediatric intensive care unit for observation. Liver function tests on January 18 showed SGOT 11,771 and SGPT 1871. The infant’s condition continued to deteriorate with increased seizures, metabolic acidosis, and eventually disseminated intravascular coagulation. An EEG was performed on January 19 showing no brain activity. Life support was withdrawn and the infant died.
Allegations
The family filed a lawsuit alleging the mother’s primary obstetrician failed to provide appropriate recommendations regarding the effects of the herpes lesion found on January 12, and failed to timely obtain and report the results of the herpes culture to the infant’s pediatrician.

Legal implications
Discrepancies between the parents’ recollection of the care and what the doctors documented and later recalled began with the infant’s birth. During deposition, the parents stated that the delivering obstetrician discovered a lesion on the mother’s labia. The hospital records of both the delivering physician and the nurses contain no mention of a visible lesion at the time of delivery. The physician further reiterated this information during his deposition, stating that no lesion was present at delivery.

The primary obstetrician, who discovered the possible herpetic lesion on January 12, testified at his deposition that he informed the mother of the possibility of herpes and the consequences of transmitting the virus to her child, including death of the infant. He also told her to inform the infant’s pediatrician of the diagnosis, and told her to wash her hands before handling the baby to prevent transfer. The plaintiff’s attorney contended that the mother was never told of the possibility she had herpes. The discussion was open to interpretation since the only documentation in the record consisted of “warnings: hand washing, etc.”

The physician reviewers in this case varied in opinion whether the primary obstetrician met the standard of care. At question was whose duty it was to inform the pediatrician of the mother’s herpes status and the possibility of transfer to the infant. Two reviewers felt it was the parents’ duty to inform the pediatrician of the possible peripartum exposure to herpes simplex virus. One reviewer felt that the treating physicians would have ordered acyclovir during the initial hospital admission on January 13, had they known of the possible exposure. After considering that the mortality rate of infants with disseminated HSV Type I is around 69%, another reviewer stated there was a reasonable medical probability that treating with acyclovir would have not changed the overall outcome.

The majority of the reviewers felt the primary obstetrician failed to meet the standard of care by not informing the pediatrician of the possible herpetic lesion on January 12.

Disposition
Due to lack of expert support and the possibility of a sympathetic jury verdict, this case was settled on behalf of the primary obstetrician. The practice of the primary obstetrician, and the hospital also settled.

Risk management considerations
The failure of the primary obstetrician to communicate the possibility of a herpetic infection in the mother to the infant’s pediatrician was important in this case. Although the parents of the patient have some responsibility to inform subsequent providers of new diagnoses and conditions affecting future care, juries may feel that the physician is in the best position to relay this type of information.
Physicians should document, along with the test results, their attempts to inform the patient and subsequent caregivers, including any failed attempts. Without detailed, contemporaneous documentation of actual events, a plaintiff’s attorney will allege they did not occur.

Although the defendant physician in this case documented “warnings: hand washings, etc.,” the actual details of the conversation were in contention. Documenting specific details of conversations will increase the defensibility of a physician. This case may have had a different outcome if the primary obstetrician clearly documented that he told the mother of the consequences of spreading herpes to the infant, including the possibility of the infant’s death, and that he told the mother to inform the pediatrician of the possible herpes infection. When potential consequences can be serious, discussions should certainly be documented. The very brief and non-specific nature of the documented warnings in this case was detrimental to the successful defense of the claim.
**Meningitis: failure to insist on lumbar puncture**

**Presentation**
A 14-year-old girl came to her family physician complaining of nausea, vomiting, body aches, and fever. The patient had been receiving treatment from this physician for five years. Her medical history included upper respiratory tract infections, ear infections, skin rash, and episodic fevers.

**Physician action**
The patient was first examined by a third-year medical student who was on rotation in the physician’s office. The family physician then examined the patient and determined that her complaints were consistent with a flu-like syndrome and/or gastritis. The chart reflects absent signs of meningismus (pain on flexion of chin to chest) and negative Brudzinski and Kernig’s signs. The patient had redness and swelling of the pharynx, mild tachycardia, and a temperature of 101.4 degrees. A CBC revealed a white blood count of 15,800. The patient was sent home with prescriptions for zanamivir, cefprozil and promethazine. The patient’s mother was instructed “go to the ER if headache pain worsened. Discussed with patient and mother the need for follow up if pain, headache or other symptoms worsen.”

In his later testimony, the physician recalled that he recommended a lumbar puncture to rule out meningitis, but the mother declined to have the test performed. This exchange was not noted in the chart. The medical student, who was present during the exam, later remembered the discussion about taking the patient to the emergency department (ED) for a lumbar puncture. He recalled there was a money or insurance problem, and that the mother was reluctant unless it was necessary. The physician had the mother agree to take the child to the ED if her symptoms worsened or did not improve the following day.

Two days later, the patient experienced a clonic-type seizure at home and became unresponsive. She was taken to the ED, and was unresponsive upon arrival with agonal respirations. Her left pupil was fixed and dilated, and her temperature was 105 degrees. She coded in the ED, was intubated, put on ventilator support, and admitted to the ICU. A head CT revealed diffuse cerebral edema. She never regained consciousness.

Consultations were obtained from infectious diseases, neurology, pulmonology, and nephrology. The initial diagnosis was meningococcal meningitis and septicemia. All blood cultures showed no growth and viral cultures were negative. Serum antigen tests for *Neisseria meningitidis*, *Escherichia coli*, *Haemophilus influenzae*, *Streptococci pneumoniae* and *group B streptococci* were negative. An EEG revealed no brain activity. The patient was declared brain dead and, after parental consent, was removed from the ventilator.

A limited autopsy of the central nervous system revealed brain stem herniation, necrosis of the pituitary gland and yellow exudate in the left frontal region, meninges, and cerebrum. Special stains for bacteria and viruses were negative. It was unclear which type of meningitis the patient had, and the pathologist noted the cause of death to be “acute pyogenic meningitis.”
Allegations
A lawsuit was filed against the family physician. The allegations in this case included:
• failure to perform a neurological exam;
• failure to insist on a lumbar puncture, which would likely have caught the patient’s bacterial meningitis;
• improper administration of antibiotics prior to performing a lumbar puncture;
• failure to diagnose and treat meningitis.

Legal implications
The plaintiffs were able to locate expert testimony to support their allegations. The expert claimed that it was below the standard of care for the physician not to insist on a lumbar puncture. If the physician suspected meningitis, then he failed to adequately counsel the patient's mother that the test was necessary to rule out meningitis. If a lumbar puncture had been performed on the day of the office visit, according to the plaintiff’s expert, it would have been diagnostic of bacterial meningitis and led to appropriate, immediate hospitalization and definitive intravenous antibiotic therapy. “At this stage of the disease process, the illness is usually curable and this is the reason that LP and/or hospitalization is necessary when meningitis is suspected.”

The expert also indicated that the physician fell below the standard of care when he prescribed an antibiotic and an antiviral without identifying the etiology of the illness. The antibiotic, which made the patient feel better, masked the meningitis and contributed to the family’s inability to determine that the patient was acutely ill until it was too late. (The patient’s condition improved the day after the office visit, according to the mother.)

The expert also faulted the physician for not performing a complete neurological exam and for failure to document the results of his examination of the patient’s neck.

Overall, defense experts were supportive. The physician’s examination and diagnosis were reasonable and within the standard of care. Because it is difficult to differentiate viral syndromes from meningitis, it is the physician’s clinical impression at the time of the exam that determines whether a lumbar puncture or further diagnostic work up is necessary. The patient had non-specific symptoms suggestive of viral illness. She did not have a rash or a stiff neck; she was not photophobic; there was no neurologic deficit or signs of meningeal irritation. Based on these facts, it was reasonable not to have ordered a lumbar puncture.

Disposition
Fact issues and damages warranted settlement negotiations. With the consent of the family physician, this case was settled before trial.

Risk management considerations
The complete, comprehensive medical record is a chronological document of a patient’s health status and care. In this claim, a consultant reviewer indicated that the medical student took the history and performed the physical examination. The reviewer further indicated that there was no documentation of another history and physical performed by the defendant, or it is unclear “who did what in the record” since the encounter form for the visit included three different writers. The physician signature line was signed by the student and the defendant in the style of a co-signature, medical student name/attending
Meningitis: failure to insist on lumbar puncture

physician. Medical records need to reflect the identity of each person and clearly reveal what is done by those who are allowed to document information in the chart. If the physician repeated the physical exam, it is unclear in the encounter notes.

The failure to document the recommendation for a lumbar puncture and the refusal became a significant weakness in this claim. A complete medical record should include all the physician’s advice. When a patient refuses a test or any medical advice, include that response in the notes, and the reasons for the request, if known. In situations where a refusal has potentially serious consequences, it is appropriate to have the patient sign an informed refusal form. When there is an adverse outcome, plaintiffs frequently claim that they were not given enough information about a proposed test to make an informed decision and would not have refused.

Because lawsuits are often filed long after the event, and the events surrounding the allegation of malpractice can recede from memory, timely, accurate, and complete documentation on a consistent basis are often the physician’s best defense.
Failure to discuss interruption of anticoagulation

Presentation
A 72-year-old man came to a general surgeon with a one-week history of pain in the right groin with a reducible mass. Physical examination confirmed a reducible right inguinal hernia. The patient’s medical history included a CVA four years earlier. During the evaluation for CVA, an arteriogram revealed “1) the right vertebral artery was occluded; 2) the left vertebral artery was relatively normal; 3) the left internal carotid artery had a 40 to 50% stenosis in the neck portion, but an 80% stenosis in the cavernous portion; 4) the right internal carotid artery had a very long, irregular stenosis in the neck . . . he also had a 95% distal internal carotid artery stenosis, again in the cavernous portion.” Due to the severity of the disease, the patient was placed on long-term anticoagulation therapy with warfarin. The patient continued to smoke one pack of cigarettes daily.

Physician action
The physician recommended surgical repair of the hernia. The patient was in considerable pain, and the surgeon felt he was at risk for incarceration, bowel obstruction, and strangulation. Further, if such a complication developed, the patient would require emergent surgery, which would occur while the patient was anticoagulated. The risks and benefits of the elective surgery were explained, and the patient consented to the procedure. The surgeon also told the patient that he could not operate while the patient was taking warfarin. The surgeon instructed the patient to discontinue warfarin five to seven days before the hernia surgery. The patient complied and stopped taking warfarin for seven days.

The patient underwent a repair of his right inguinal hernia with mesh. The surgery went well, but in the recovery room the patient was slow to awaken, was unable to speak, and had right-sided weakness. Neurology consultation concluded that the patient had suffered either an intraoperative or postoperative thrombotic ischemic infarct of his brain. The patient was anticoagulated with heparin, but developed a severe right-sided stroke with flaccid hemiparesis and global aphasia.

The patient was transferred to a skilled nursing facility and later to a nursing home where he died from sepsis five months later.

Allegations
A lawsuit was filed against the surgeon, alleging that he fell below the standard of care by failing to discuss the surgery and the interruption of anticoagulation with the patient’s neurologist, and by failing to initiate alternative anticoagulation therapy. It was further alleged that the interruption in anticoagulation was a significant contributing cause of the patient’s stroke.

Legal implications
The plaintiffs were able to locate experts supportive of their allegations regarding standard of care and causation. They claimed that alternative coagulation therapy could have been arranged that would have reduced the chances of intraoperative
Failure to discuss interruption of anticoagulation

stroke. One expert stated that the “safest” alternative would have been to perform the surgery while the patient was in a “heparin window.” For this, the patient is hospitalized for intravenous Heparin infusion several days between discontinuing warfarin and the scheduled surgery. The expert also maintained the stroke occurred because the patient was not anticoagulated.

Defense experts were supportive of the surgeon’s action regarding the interruption of anticoagulation. This expert stated the “heparin window” was not the standard of care for patients on long-term anticoagulation. It is only recommended in extreme cases, specifically in patients who have suffered a recent acute venous thromboembolism in the three months before surgery. Additionally, the expert stated there was no medical literature to support the fact that the warfarin was preventing the patient from having a stroke and discontinuing it was the cause of the stroke.

Defense experts pointed out that even if alternative anticoagulation had been arranged, the patient would still have been at high risk for developing a stroke. One expert stated the patient was a “stroke waiting to happen” due to the severity of his disease and the fact that he continued to smoke.

One area of weakness in this case was that the surgeon did not contact the patient’s neurologist before surgery. The surgeon testified he did not contact the neurologist about discontinuing warfarin because he felt the surgery was necessary, and he would not operate as long as the patient was anticoagulated. Therefore, he did not feel the need to discuss options with the neurologist. While the experts did not assert that this was negligence, they did state it would have been better if he had contacted the neurologist.

Disposition
This case was settled with the consent of the surgeon.

Risk management considerations
With a patient history indicating increased risk of intra- or postoperative complications, it is prudent for a physician to exercise extra caution, and to solicit the input of a patient’s treating doctors for preoperative clearance and management decisions. Further discussion regarding choice of anesthesia may allow the physicians involved to make a decision with the lowest risk for the patient. The team concept of care requires additional planning and time, but a commitment to this coordination of care may have a positive effect on patient outcomes.

In this case, the patient was at risk either with or without the surgery or with or without the anticoagulation. Better documentation of discussions with the patient might have improved the physician’s defense position.
Differential diagnosis not reported

Presentation
A 68-year-old man came to his family physician with complaints of a “several month” history of worsening memory, confusion, difficulty sleeping, and intermittent problems with his left hand and arm becoming weak and numb.

Physician action
The family physician suspected TIAs, but wanted to rule out brain cancer. He ordered a CT scan of the head and arranged for a carotid ultrasound. The family physician completed the order form for the CT, requesting the CT to rule out brain cancer, but noted possible TIAs. He also included the patient’s symptoms on the form, and asked that the patient’s medical records be forwarded to the testing facility.

The family physician’s nurse called the hospital to set up the CT scan. She later testified that she read the request from the family physician as “R/O brain cancer.” The billing clerk at the hospital changed that to read “R/O METS.” This information was then sent to the hospital’s radiology technician who changed it from “R/O METS” to “METS” because “R/O METS” did not fit the Medicare codes.

When the radiologist received the request, the clinical diagnosis was “METS.” None of the family physician’s suspicions or medical records noting “TIAs, organic brain syndrome, or mental status changes,” were forwarded to the radiologist. The CT scan was performed with and without enhancement. In the initial portion of the radiologist’s report, he noted that what he saw was “consistent with metastatic disease.” Later in his report, he made reference to “this metastasis” rather than “this possible metastasis.”

The day after the CT scan, the patient reported to the emergency department (ED) at another hospital. His symptoms included dizziness, weakness, memory loss, and slurred speech. The ED physician suspected a TIA and administered warfarin. The patient was then admitted to the hospital, under the care of an internal medicine physician. This physician continued the warfarin, ordered a carotid ultrasound, and contacted the radiologist regarding the previous CT scan. The radiologist read the report to the internal medicine physician. At that time, the internal medicine physician decided to discontinue the patient’s anticoagulation treatment because it was contraindicated for patients with cancer. The carotid ultrasound was also cancelled.

The internal medicine physician ordered tests to look for the tumor, but they failed to find any evidence of cancer. After two days in the hospital, the patient was discharged with a diagnosis of “metastatic brain disease, primary tumor site undetermined,” and was referred to an oncologist. Two weeks after he left the hospital, the patient suffered a major CVA. A CT scan and MRI of the head identified multiple areas of infarction with no evidence of metastatic tumor. A carotid flow study revealed total occlusion of the left internal carotid artery. The CVA caused severe paralysis to the left side of the body. The patient currently uses a wheelchair and is unable to speak.
Differential diagnosis not reported

Allegations
A lawsuit was filed against the radiologist, alleging the following:
• failure to report an appropriate, accurate differential diagnosis;
• failure to suggest additional, follow-up radiological studies;
• issuing a misleading, inaccurate CT report of metastasis; and
• failure to clinically correlate the information in the CT report which led to a failure to diagnose the patient’s condition.

The family physician, the hospital where the CT scan occurred, and the internal medicine physician were also named in the lawsuit.

Legal implications
The defendant radiologist was adamant that his interpretation of the CT scan was correct and was consistent with the history provided on the radiology request. The statement “METS” led the radiologist to believe that a diagnosis of cerebral metastases had been established, and that he was to report whether brain metastases were present on the CT scan.

Two board certified radiologists reviewed this case and both felt the CT scan was far more suggestive of stroke than brain metastasis. Both radiologists said they would have listed possible ischemia on the differential. The plaintiff’s expert, also a board certified radiologist, felt the defendant’s read of the CT scan was accurate, but the defendant’s final impressions were incorrect because he did not list ischemic disease as a possible differential diagnosis. The defense consultants were able to find an expert supportive of the radiologist’s diagnosis, but this expert did not come across as a very strong witness at deposition.

The case against the radiologist was further weakened by the testimony from the codefendant physicians and their experts. They all testified that it was within the standard of care to rely on the radiologist’s review of the CT in deciding to discontinue the patient’s anticoagulation treatment.

This case was further complicated by two factors. There was a dispute between the family physician’s nurse and the hospital billing clerk over what information was relayed over the telephone about the request for the CT. Regardless of this dispute, the radiology technician changed the diagnosis from “R/O METS” to “METS” and this affected the defendant’s review of the CT. Further, when the family physician received the CT report from the radiologist, the admitting diagnosis at the top of the report said “METS.” Had this been noted, it may have alerted the family physician to the error.

Disposition
The case against the radiologist was settled during trial. The hospital and family physician also settled. The case against the internal medicine physician was closed without indemnity payment.

Risk management considerations
The communications in this case broke down at many levels. The physician might have improved the communication from his office by having a procedure requiring that the CT order form be faxed to the testing facility, along with the pertinent records. That way, the
testing facility staff would have received his full message. Proper staff training can also help keep problems like this from occurring.

It is common for ordering physicians to read only the diagnosis section of lab and radiology reports, missing important information elsewhere in the document. In this case, the physician missed the fact that the admitting diagnosis was erroneously recorded as “METS.” While that may seem understandable, in that he did not expect the information to be transmitted and altered so inaccurately, a jury may not be willing to overlook that error. An attorney will argue that each person in the chain had an opportunity to correct this problem, and none did.

The carotid ultrasound was never performed. Systems that record, in a very visible place, which tests have been ordered and performed, might assist physicians in reviewing their charts for this information. Physicians who fail to review the charts to confirm that ordered tests have been completed not only put their patients at risk, but subject themselves to potential litigation as well. If patients choose not to proceed with the physician’s recommendations, that should be accurately documented.

Changing a diagnosis because it does not meet a coding requirement is fraught with risk. If that is required, there must be some place on the same document to record the full and unaltered information. If more information is needed, or something just does not seem to be complete or “ring true,” then follow up with the ordering physician is advised.

The radiologist’s interpretation in this case was likely swayed by the implication of a pre-existing diagnosis of malignancy, without the clinical history of possible TIAs, cognitive changes, and intermittent numbness of the left arm. Some of the consultants did not feel that the films were consistent with metastasis. It is important for physicians to realize that their unbiased opinions are needed because they may be the ones to correct an inaccurate prior diagnosis. Including differential diagnoses and recommending further studies to rule out or confirm each one will help guide the ordering physician in the efforts to arrive at the correct diagnosis.
Failure to obtain informed consent

Presentation
A 58-year-old woman came to her internal medicine physician with complaints of weight gain, fluid retention, and a mass in her neck that caused her to feel “strangled” at night. The internist noted a 3.0 x 5.0-cm mass at the right thyroid. The patient was referred to an otorhinolaryngologist, the defendant in this case.

Physician action
On May 20, the otorhinolaryngologist examined the larynx and diagnosed goiter with two nodules that were increasing in size despite thyroid suppression treatment. She recommended a total thyroidectomy that was scheduled for May 26.

The patient was seen for a preoperative visit on May 25. During this visit, a consent form was reviewed and signed by the patient. A medical assistant witnessed the patient’s signature. The form carefully described the thyroidectomy along with the documented risks of bleeding, infection, vocal cord paralysis, hypocalcemia, and scarring.

The patient was admitted to the hospital for a total thyroidectomy. The procedure was performed without any noted complication. The otorhinolaryngologist documented that the laryngeal nerves were tracked and identified during dissection. The patient recovered with minimal drainage, and was discharged on May 27.

At a follow-up appointment on June 3, the patient complained of hoarseness in her voice. A stroboscopic examination demonstrated a vocal cord paresthesia, but the incision was well healed and the nerves were intact. She was next seen on June 31, and continued to complain of hoarseness and some restriction in her airway.

On July 13, a neurologist performed an electromyography (EMG) study. The results of the study showed a denervation of the left thyroarytenoid muscle and some damage to the neural input, but the integrity of the nerve was still present.

The patient sought treatment from an otolaryngologist. On December 11, he performed a flexible fiber optic laryngoscopy and thyroplasty, moving the paralyzed vocal cord to the midline position. This did improve her vocal quality. During a follow-up visit on February 9, the patient reported that her voice was dramatically better. She continued to complain of shortness of breath. The otolaryngologist concluded this symptom was unrelated to the cord paralysis, and he recommended a pulmonary evaluation.

The patient was evaluated by a pulmonologist on February 17. Her pulmonary function tests were normal, and a chest x-ray revealed normal pulmonary vasculature. In a report back to the patient’s internist, the pulmonologist stated that he examined the patient on March 24. He found her to have no stridor, and her lung exam was unremarkable with good air entry.

The patient next saw the otolaryngologist on June 29. She expressed complaints of tightening in her throat, but noted improvement in her voice volume and projection.
The otolaryngologist suspected laryngeal dystonia and cervical dystonia. He prescribed a trial of propranolol for vocal tremor.

The otolaryngologist saw the patient the following January and again in April. She reported that at times her voice sounded normal, but at other times her voice was “raspy and breathy.” The otolaryngologist noted left true vocal cord paralysis with slow but progressive improvement in the volume and projection of her voice.

**Allegations**

A lawsuit was filed against the otorhinolaryngologist and her practice group. The plaintiff initially alleged that the defendant failed to provide a reasonable choice of treatment that would lessen the risk of injury and failed to ensure the patient understood the risks, complications, and treatment choices available to her.

The plaintiffs later added allegations against the otorhinolaryngologist: due to the defendant’s inexperience, she should have asked a more senior physician to review the indications for surgery and to assist in the surgery; and she should have used an electrode on the endotracheal tube to monitor the recurring laryngeal nerve function during surgery.

**Legal implications**

The plaintiff’s otolaryngology expert — who examined and began treating the patient — attributed her complaints of shortness of breath, vocal fatigue, throat tightness, and hoarseness to recurrent laryngeal nerve injury. This expert stated that “studies have shown” that inexperienced surgeons have a higher incidence of injury to the laryngeal nerve; and therefore, the patient should have been informed of the defendant’s level of experience.

This expert also stated that failure to warn the patient that permanent voice changes can occur as a result of this surgical procedure is a violation of the standard of care. If the defendant had informed the patient of all the possible treatments for her condition (including medication, partial or total thyroidectomy) and the patient chose total thyroidectomy, the defendant would have met the standard of care. This expert based this conclusion on the plaintiff’s assertion that she was not given informed consent warnings.

The defendant testified that she discussed several treatment options with the patient, but the patient was intent upon total thyroidectomy. The patient testified that if she had known about the risks and complications from the procedure, she would have wanted to explore other options. The patient confirmed her signature on the consent form provided by the defendant, but claimed that she did not read it.

Defense experts were supportive of the defendant’s qualifications to perform the procedure and of the technical aspects of the procedure as outlined in the operative report. In the report, the defendant described the appropriate identification and tracing of both recurrent laryngeal nerves during thyroid dissection. Despite these “gold standard” efforts, injury to the recurrent laryngeal nerves can still occur. The patient suffered a known risk and complication of the procedure — one that is outlined in the signed consent forms.

A pulmonology expert argued that the patient’s complaints were idiopathic, and none of the pulmonary tests substantiate her pulmonary complaints. She testified that even complete paralysis of the vocal cord should not result in shortness of breath.
Failure to obtain informed consent

Disposition
This case was taken to trial and the jury returned a verdict in favor of the defendant and her practice.

Risk management considerations
In this case, the defendant followed the appropriate informed consent procedures. The informed consent discussion was completed the day before the surgery. On the form, the thyroidectomy was described along with the documented risks of bleeding, infection, vocal cord paralysis, hypocalcemia, and scarring. The consent form was reviewed, signed by the patient, and a medical assistant witnessed the signature. Though following these steps did not completely alleviate the informed consent allegations, they made the case against the defensible.
Medical record errors
Delay in diagnosing lung cancer

Presentation
A 62-year-old man came to his family physician’s office complaining of paresthesias and weakness. The patient had been under the care of the physician for three years and had a history of diabetes and hypertension. The medical records indicated he did not smoke or drink. The family physician referred the patient to a local emergency department (ED).

Physician action
The ED physician suspected a stroke, and the patient was admitted under the care of a neurologist, the defendant in this case. The patient had suffered a cerebral infarction that resulted in left-sided hemiplegia. The neurologist evaluated the patient and found there were no x-ray reports on the chart. He initiated medical therapy for the stroke and ordered a chest x-ray if one had not already been done.

When he returned the next morning, the neurologist examined the patient and reviewed his chart. The chart now included a chest x-ray report describing an ill-defined infiltrate of the right lobe and recommended a follow-up study. The neurologist further reviewed the chart and found a second chest x-ray report, this one describing a clear field. The neurologist was satisfied with the lung assessment, and concluded that the second chest x-ray report was the one he had ordered. He was not surprised by the appearance of a second chest film report even though he had not specifically ordered a follow-up chest film. The neurologist assumed the ward clerk or nurse was unaware of the original film and obtained a second in response to his written order to obtain a chest x-ray if one had not been done. The neurologist made reference to the second chest film in his discharge summary.

After six days in the hospital, the patient was discharged to a rehabilitation facility. The patient recovered use of his left leg, but continued to have paralysis in the left arm. He required speech, physical, and occupational therapy as well as psychological support.

Approximately 18 months after the stroke, the patient developed a cough and difficulty breathing. A chest x-ray revealed a moderate-sized right pleural effusion. He underwent a thoracentesis with withdrawal of more than one liter of bloody fluid. A second procedure a month later led to a pathological evaluation for suspicion of malignancy. The patient was found to have a soft tissue mass of 2.2 cm, confirmed to be a metastatic adenocarcinoma consistent with the lung as the primary site. The patient underwent chemotherapy, but died one year later.

Allegations
In their lawsuit against the neurologist and the hospital, the patient’s family alleged delay in the diagnosis of lung cancer. Learning that the lawsuit involved lung cancer, the neurologist reviewed a copy of the patient’s hospital record, and learned for the first time that the follow-up chest x-ray that showed a clear lung field referred to a different patient.
Delay in diagnosing lung cancer

Legal implications
It was clear that the neurologist relied on the “clear lung field” report of a different patient and did not resolve the suspicion raised by the first x-ray. The plaintiff’s oncology expert claimed that the cancer was either stage I or early stage II at the time of the hospital x-ray with a probable five-year survival rate of 30%. When the correct diagnosis was made, the patient’s five-year survival rate was less than 1%.

The plaintiff’s neurology expert testified that the defendant breached the standard of care by failing to recognize the name on the x-ray report was not his patient’s. However, he also testified that when a physician picks up a hospital chart, it is reasonable to anticipate that the documents in the chart belong to that patient. He agreed that the vast majority of reports found in medical charts are properly filed.

At his deposition, the defense neurology expert testified that while not favorable, the wrong report can make it into a physician’s hands unnoticed without the physician being negligent. All defense consultants who reviewed the medical records in this case failed to catch the misfiled x-ray report, as did the other physicians who treated the patient in the hospital.

This case was further complicated by a conflict with the codefendant hospital over responsibility for the error. The hospital staff testified that it was the physician’s duty to verify that each report in the chart was for that patient.

Disposition
Finger pointing between defendants increased the risk of an adverse finding against both defendants. The case was settled by the insurance carriers of both the physician and the hospital.

Risk management considerations
It was easily argued by the plaintiff that responsibility was shared in the events of this case. In fact, the hospital employees testified that the reason documents contain the names of patients is so readers can verify that they are, in fact, reading the information on that particular patient. Physicians, on the other hand, may feel that they have a right to rely on the hospital staff to appropriately file documents in the correct charts. They are very busy caring for patients, and must be able to rely on support staff. This type of conflict only benefits the plaintiff in terms of the final outcome in a lawsuit.

When reviewing charts, it is common for physicians to focus on the diagnosis section of lab and test reports. In this particular record, had the physician read the entire report, he might have noticed that some elements of the description did not fit this patient, not to mention that the name at the top was of a different patient. In fact, the plaintiffs pointed that out in testimony, and it was an obstacle to a successful defense.

Physicians may be well advised to take the extra step of scanning reports in full when reviewing charts. This is especially true when looking for data that can have significant consequences to the patient’s health. Failure to do so can be very difficult to explain, as in this case. Likewise, the hospital has hopefully examined its procedures and staff responsibilities to prevent this from occurring again.
End-of-life care

Presentation
A 76-year-old woman was admitted to the hospital for complaints of lower back pain “going down her left leg to her thigh.” The pain apparently started after a fall at a senior citizen clinic approximately six months earlier. The admitting family physician recorded that the family said that the patient was in so much pain that she could not void, stand, sit, or move her legs.

Pursuant to the Self-Determination Act effective December 1, 1991, the patient’s daughter signed a “Receipt of Information” form along with other admitting paperwork upon the patient’s admission to the hospital, indicating that she did receive information about advance directives. Nursing admission notes also indicated that the patient reported having a living will. No copy of the living will was found in the medical record and no further discussion or clarification regarding the patient’s specific end-of-life wishes was documented in the medical record.

Physician action
Evaluation by an orthopedic surgeon indicated a problem with the left hip. The patient had lost a considerable amount of internal and external rotation, aggravating her symptoms. She was scheduled for a total left hip replacement.

On initial examination for preoperative clearance, the attending physician thought she appeared to be in “good shape.” Medical history was positive for hypertension and a low potassium level. Current medications included potassium twice daily; nifedipine 60 mg daily; fluoxetine 20 mg mornings; and hydrocodone 7.5 for pain. A review of systems revealed a sensitive stomach and muscular pains in her lumbar back, left hip, and left thigh area. He reported that her heart, lungs and electrocardiogram showed no acute changes. A chest x-ray, a complete blood count, a urinalysis, and SMA were all within normal limits. She was cleared for surgery.

The patient then began to complain of abdominal discomfort. She was given a laxative and enemas for complaints of constipation. Her constipation was relieved but she began to have some diarrhea and vomiting and intravenous fluids were administered. Her abdominal pain was not alleviated.

Three days after admission, the total left hip replacement was cancelled by the orthopedic surgeon, and the attending physician ordered a consult with a gastroenterologist. This physician suspected diverticulitis and ordered antibiotics and a CT scan of the abdomen. The CT scan was completed at approximately 5:30 p.m. A note from the gastroenterologist at 7 p.m. indicated “GI films negative. CT with collection in lower abdomen most likely abscess with increased white blood count, thickened bowel wall, but density most consistent with bleeding. Her hemoglobin is elevated however, which makes a bleed unlikely.”

The defendant physician, a colon-rectal specialist, was called for consultation. At 9 p.m., the colon-rectal specialist examined the patient and recorded the increased complaints of abdominal pain for the last “day or two.” He interpreted the CT scan of the abdomen as showing “thickening of left colon with some arch of attenuation
suggestive of possible abscess.” He further noted that the attending physician’s previous attempts to manage conservatively including NPO and antibiotics had failed, and that the patient had increased fever and abdominal pain. Abdominal tenderness of the lower left quadrant without masses was noted. His impression was acute diverticulitis with a possible abscess. He recommended surgical exploration the next morning. He clearly documented the patient’s desire to proceed with the operation, stating “Have discussed this with patient and she is agreeable to this. Will plan to proceed with OR tomorrow.”

Furthermore, at 9:25 p.m., the patient signed a written “Disclosure and Consent for Medical and Surgical Procedures” for a “subtotal colectomy with ileo-rectal anastomosis.” During this informed consent discussion, the patient stated her objections to a colostomy under any circumstances. That day, an “Agreement for Blood Transfusion” was signed by the daughter. Again, no documentation was found relating to the patient’s living will.

At approximately 11 p.m., the patient was found on the floor by nursing staff. Nursing notes indicated that she had apparently tried to use the bathroom and fainted. The note also reflected notification of the primary physician, who then ordered an immediate EKG, blood gasses, and a peripheral line.

At 11:30 p.m., the defendant, as well as the other physicians involved in this patient’s care, were informed of her condition. An on-call hospital physician was also notified of the patient’s fall and ordered labs including a CBC with differential and a SMA7.

At 12:53 a.m., the results of the CBC were reported. The patient’s hemoglobin had dropped from 16.3 to 11.2. Her hematocrit went from 48.9 to 33.12. The impression was that the patient suffered acute bleeding with hemorrhagic shock. Contrary to previous impressions, the patient was thought to be bleeding internally and required immediate medical intervention.

At 1:40 a.m., the physicians and family were present at the patient’s bedside. Her heart rate and blood pressure were stable. Repeat CTs were obtained to determine the nature and location of the bleed. At 3:30 a.m., a “Disclosure and Consent for Medical and Surgical Procedures” form was signed by the daughter for an “exploratory laparotomy with possible resection of abdominal aortic aneurysm.”

At 8:15 a.m., a nurse’s note indicated that the physicians, including the defendant, were paged STAT and that surgery was pending. A nurse’s note recorded at 8:45 a.m. documented the receipt of a living will and that the living will was in the medical record. At 9:35 a.m., a nurse’s note indicated that the defendant was at the bedside of the patient with the patient’s family. It further stated that the family expressed their desire to allow the patient to die naturally. The defendant also documented the patient’s do-not-resuscitate (DNR) status and the family’s wishes.

The last entry made by the defendant was the pronouncement of death at 5:10 p.m. At 6 p.m., the chaplain was called in to counsel the family.

Allegations
The claim filed against the colon-rectal specialist and others included an allegation of failure to undertake an exploratory laparotomy for intra-abdominal bleeding.
End-of-life care

Legal implications
Physician reviewers for the plaintiff were critical, stating that this physician deviated from the standard of care. The physician failed to perform the exploratory laparotomy to identify the etiology of the patient’s drop in hemoglobin and hematocrit and subsequently treat the source of intra-abdominal bleeding, thereby leading to the death of the patient. Defense experts argued that, even if the patient had survived the surgery, she would have required IV feedings and would most likely have died of necrosis of the bowel.

The defendant colon-rectal surgeon spent considerable time discussing the patient’s condition with the family. The documentation reflects a caring, involved physician who was available to the patient and family throughout the decision-making process. In addition, it was also clear that the defendant was aware of the importance of honoring the patient’s wishes regarding her end-of-life care preferences. He also clearly attempted to involve the family appropriately when needed.

Unfortunately, the defendant neglected to document all detailed discussions with the patient and her corresponding oral remarks regarding preferences for care and for her quality of life. In his deposition, the physician was able to describe in detail the unwitnessed informed consent conversation he had with the patient regarding the initially proposed surgical procedure and the patient’s objections to the colostomy under any circumstance. The physician and patient made a decision to then proceed with a subtotal colectomy.

Although an appropriate consent was signed, the physician did not proceed with the surgery due to his belief that the patient would not want it. In his deposition, he further explained his thinking process; if the patient did not want a colostomy, she certainly would not want a feeding tube or to be put on a ventilator, both distinct possibilities if he were to proceed with the proposed surgery. He also elaborated on this discussion with the family. At least partially due to this conversation, the family made the decision to execute a DNR. The absent living will was referenced again in his note in the medical record. Undocumented conversations on which decisions are made are far less defensible than complete entries documenting the physician, patient, and family decision-making process.

Disposition
The case was settled on behalf of the physician.

Risk management considerations
Despite nurses’ notes indicating that a living will existed and was in the medical record, ultimately no living will was filed. For the providers to know what each living will dictates, the document must be collected and put in the medical record for all providers to access. In this case, the physician understood that the patient wanted no colostomy and no heroic measures. In their deposition, the family stated that their impression was that . . . “all measures necessary to save her life” . . . would be taken if she had . . . “any chance for survival.” However, the existence of a DNR order signed by the patient’s family contradicts this statement.

Additionally, the family testified that they felt the nurses were rude and gave them “dirty looks.” Furthermore, they overheard a nurse saying “the daughters are just going to let their mother bleed to death.” Impertinent remarks such as these can be very damaging in the event of litigation.
Failure to follow up
Delay in treating retinopathy of prematurity

**Presentation**
A 27-week-gestation newborn was admitted to the NICU under the care of the defendant neonatologists and neonatology nurse practitioners. His Apgar scores were 5 at one minute and 7 at five minutes. He weighed 740 grams. The infant’s underlying conditions included: respiratory distress syndrome due to hyaline membrane disease; hypotension, apnea of prematurity; necrotizing enterocolitis; hyperbilirubemia; cholestasis; anemia; bilateral Grade 3 intraventricular hemorrhage; inguinal hernia; and possible sepsis.

**Physician action**
On day of life 49, the neonatology team requested an ophthalmology evaluation by the defendant ophthalmologist. The ophthalmologist diagnosed retinopathy of prematurity, assessed as Zone 1, Stage 1+ bilaterally at his initial exam. He charted the child’s risk assessment as low and planned to follow up in two weeks.

On the following two hospital days, one of the nurse practitioners charted plans of care, noting the need for follow-up ophthalmology consultation to be performed 2 weeks from the ophthalmologist’s first exam. The ophthalmologist never returned for a follow-up consultation. The neonatology team stated that they placed calls to the ophthalmology service for this hospital, requesting a follow-up eye evaluation, but none of those efforts were charted. The ophthalmologist did not recall or was never made aware of a request from the neonatology service for a follow-up examination.

The infant was discharged on his 119th day of life. Discharge instructions included follow up with ophthalmology in two weeks, and an appointment was made for the infant in 13 days. The infant was seen in the ophthalmologist’s office 25 days after hospital discharge. He had bilateral retinal detachment, greater on the left side. He was referred to a pediatric ophthalmologist. Despite several attempts at re-attaching the retinas, the infant was left with no light perception in the left eye and light perception only vision in the right eye.

**Allegations**
Lawsuits were filed against the hospital, two neonatologists, four neonatology nurse practitioners, and the consulting ophthalmologist. The hospital was dropped from the lawsuit. The allegations against the remaining defendants included:
- failure to properly follow up on the preliminary diagnosis of retinopathy of prematurity;
- failure to follow up two weeks after the initial evaluation; and
- failure to call the ophthalmologist back for his follow-up evaluation.

**Legal implications**
The ophthalmologist’s failure to follow up after his initial evaluation could not be explained and put him at significant risk. The failure of the neonatology team to document their efforts to obtain the follow-up ophthalmology evaluation compromised their defense. The nurse practitioner’s chart notes for the two days following the initial eye exam (charting the need for follow-up exam) was alleged as the standard of
Delay in treating retinopathy of prematurity

care for neonatology charting in this situation, one not met in the subsequent days of the baby’s hospitalization.

Disposition
The lawsuit was settled by the neonatologists, the nurse practitioners, and the ophthalmologist during the discovery phase of the lawsuit.

Risk management considerations
In treating patients with multiple medical problems during lengthy hospitalizations, daily charting of medical issues requiring follow-up evaluation and treatment will help keep those needs in the forefront. Attending physicians have a duty to monitor their consultants’ acts and/or omissions to assure comprehensive medical care and ensure that medical problems do not “fall through the cracks” in the hospital.
Failure to diagnose breast cancer

Presentation and physician action
A 32-year-old woman came to her family physician reporting a lump in her breast. She had no family history of breast cancer. The physician felt a nodule in the left breast. Its presence was charted and its location drawn in the medical record. The physician also charted a recommendation for an ultrasound of the breast.

Three months later, the patient came to the office to be treated for a gum infection, but was unable to see the physician that day. The patient saw the physician’s assistant (PA), who prescribed antibiotics and referred the patient to a dentist. The order for the ultrasound had not been matched to the medical record, and the PA did not follow up on the breast complaint at that visit.

One month later, the patient returned to the physician complaining of the left breast mass again. The physician attempted aspiration but was unsuccessful. He charted an order for a mammogram and a referral to a surgeon in his building.

Over the next nine months, the PA saw the patient on five different occasions for treatment of a urinary tract infection, allergic rhinitis, sinusitis, reactive airway disease, and neck pain after an automobile accident. No breast exam or follow up on the breast complaint was charted at any of these visits. The patient subsequently went to another family physician for an auto accident injury. That physician referred the patient to a surgeon who diagnosed breast cancer. The breast cancer had spread to her spine, neck, lungs and lymph nodes.

Allegations
A lawsuit was filed against the supervising family physician, the PA, and the entity in which they were employed. The allegations included:

- failure/delay in diagnosis of breast cancer;
- negligence on behalf of the entity for acts and omissions of employees;
- failure to make a surgical referral to have the breast mass biopsied;
- failure to have an ultrasound of the breast performed;
- failure to provide the patient with adequate follow-up instructions to comply with referral information in the chart note;
- failure to inform the patient or give her referral information for ultrasound tests and surgical consultation subsequent to her office visits; and
- failure to adequately follow up on referral information when the patient was seen by the PA after the breast mass was noted.

Legal implications
The plaintiff’s attorney was able to retain experts in primary care and oncology who were critical of the family physician and the PA. The experts related the patient’s Stage IV bone/lung metastases to the 14-month delay in diagnosis. Specifically, the expert stated that if the patient had been diagnosed and treated initially, her cancer would have been localized and treatment would have yielded a 60% to 80% cure rate. Instead she is expected to survive no more than two to three years and has a less than 5% chance for a cure.
Failure to diagnose breast cancer

Defense consultants concurred that the physician initially followed the standard of care by ordering the breast ultrasound. The patient was noncompliant, failing to obtain the ultrasound, mammogram, or the surgical consult. However, the medical records lacked documentation of the follow-up communications with the patient to verify that the ultrasound, mammogram, and surgical consultation had been completed. Additionally, the medical record did not reflect the patient’s noncompliant behavior.

Disposition
The lack of follow up on multiple occasions during this patient’s office visits to verify that the breast studies were complete was a weakness on the part of the family physician and the PA. It was easily argued that the patient’s cancer progressed due to the 14-month delay in diagnosis and treatment, which resulted in a decreased life expectancy. This case was settled on behalf of the physician.

Risk management considerations
The lack of coordination and communication between the physician and the PA was the most obvious weakness in this case. When multiple providers in a practice see a patient, continuity of care becomes a greater and more crucial challenge. It was evident that the physician and PA were not conferring or reviewing the patient’s record. The treatment prescribed during each visit was based on the presenting symptoms, and minimal attention was directed to her previous health history. It is recommended that at the time of patient visits, the previous progress notes and health history be reviewed for follow-up issues.

The lack of follow up on the ultrasound and referral to the surgeon was damaging to the PA and her supervising physician. It was later discovered that several conversations had taken place between the physician, the PA, and the patient to address the patient’s noncompliance; but none of this was documented in the medical record. In a malpractice case, a lack of documentation requires all involved to rely on recollection, which is not viewed as reliable and as objective as a chart note. The patient will generally dispute that these discussions occurred. Additionally, some patients experience denial and can therefore convincingly argue that they “did not know.”

Finally, written patient care protocols can assist in defining appropriate actions for staff to follow to prevent important issues from being overlooked. When a written protocol does not exist or the advanced health practitioner is not aware of it, and their treatment is questioned, it can lead to difficulties in defense. In this case, the PA indicated that she was not aware of the process in place to review pending studies. The physician and the advanced practice nurse should review protocols periodically and make the necessary revisions to ensure the information is current and the process is being followed consistently.
Delay in diagnosing lung cancer 2

Presentation
A 59-year-old man came to the emergency department (ED) with complaints of respiratory problems. His medical history included chronic obstructive pulmonary disease, sleep apnea, chronic bronchitis, emphysema, obesity, and he reported that he had smoked cigarettes for more than 40 years. A chest x-ray revealed a “possible 1 cm pulmonary nodule superimposed over the anterior end of the left 5th rib,” which was not present on a chest x-ray taken seven months earlier. The radiologist recommended a left rib series, which was not done because the patient left the ED against medical advice. This report was faxed to the patient’s internal medicine physician, the defendant in this case.

Physician action
The defendant’s partner had his nurse call the patient to inform him of the abnormal chest x-ray and to have him return to the clinic in the near future. This call was not documented in the record, and the practice did not schedule an appointment for the patient. Two months later, the patient came to the ED, and was hospitalized after a serious episode of respiratory distress. A chest x-ray indicated “a nodular density over the left anterior 5th rib measuring 2.7 cm.” This x-ray report notes the defendant as the ordering physician and was in the patient’s office chart. There was no indication this report was reviewed, and the defendant testified that he did not see the report.

The patient came to the clinic the next month, and was treated for bronchitis by the defendant. Two months later, the patient was re-admitted to the hospital by the defendant’s partner. Differential diagnosis was pneumonia or empyema. A chest x-ray noted “a mass-like infiltrate” measuring 5 cm in diameter, and a repeat film two days later noted “the previously described nodule or mass was totally obscured by pleural effusion.” A CT scan of the chest was ordered.

The radiologist noted no discreet mass, and he suspected that the mass-like density adjacent to the heart border on earlier films represented some focal lung consolidation or loculated fluid. An empyema of the left chest was drained three days later. X-rays were done twice to confirm chest tube placement. At discharge, the radiologists noted, “moderate opacification remained in the left lung base” but was slightly improved since the previous study.

One month after his hospitalization, the patient was seen by the defendant for respiratory distress. The physician ordered a chest x-ray to rule out pneumonia. That report described an apparent mass-like infiltrate, again seen in the frontal view. According to the radiologist, the lack of change of that focal infiltrate raised the possibility of neoplasm. He recommended a CT scan. Seven days later, the CT scan revealed a “4.5 x 3 cm mixed density mass seen inferior laterally in the inferior lingular segment of the left upper lobe abutting the pleural surface.” The radiologist noted that malignant neoplasm along with some associated loculated effusion remained a definite consideration.
The patient was referred to a pulmonologist. A biopsy of the lung tissue indicated squamous cell carcinoma. This diagnosis was made approximately seven months after the patient’s first visit to the ED. At last report, he had received multiple courses of chemotherapy.

Allegations
The patient filed a lawsuit against the internal medicine physician, alleging failure to diagnose lung cancer in a timely manner.

Legal implications
Those representing the defendant felt that causation would be extremely difficult to prove due to the patient’s noncompliance and the presence of comparative negligence (i.e., the patient contributed to his condition by smoking). Physicians who reviewed this case had different opinions about whether an earlier diagnosis of seven months would have made a difference in treatment and prognosis. However, the lack of timely follow up and aggressive action in response to the abnormal chest x-ray report seven months before diagnosis was an obstacle to the defense of this case.

The defendant explained that he was too busy to review every report sent to his office, and that he had no system delegating that responsibility to a staff member with guidelines to bring abnormal studies to his attention. Failure to timely follow up on test results, and aggressive action to confirm or rule out a diagnosis of cancer was acknowledged as a significant weakness in the care given by the defendant physician.

Disposition
Due to concerns regarding liability and potential significant damages, this case was settled on behalf of the internal medicine physician.

Risk management considerations
This case study describes a scenario often seen in claims alleging failure to diagnose lung cancer. National claim data reveal that failure to diagnose lung cancer is a significant professional liability concern. Physicians can consider the following guidelines to help reduce liability in the area of diagnosing lung cancer.

- Document completely all patient complaints, events, and observations as well as the timeline and recommendations for subsequent diagnostic studies and follow-up treatment. Record information in a timely and accurate manner.
- Maintain a high index of suspicion when evaluating patients who report significant smoking history. Educate patients on the risks of smoking, encourage smoking cessation, and document these discussions.
- Evaluate, refer and/or admit a patient presenting with any symptoms or x-ray findings indicative of possible lung cancer until this diagnosis has been ruled out.
- If respiratory symptoms top the list of patient complaints, ask about possible exposure to other toxic substances known to increase the risk of respiratory problems or lung cancer.
- The use of screening chest x-rays and spiral CT scans is not supported in the medical literature and are not always medically indicated. However, the Physician Insurers Association of America Lung Cancer Claims Study recommends that physicians consider screening tests for patients who are at high-risk.
• Timely review and appropriate follow up on all patient reports (lab, imaging, other diagnostic tests, or reports from consultants) is a prudent practice protocol. The ordering/referring physician has this responsibility and allowing reports to be filed in the patient’s record without review is difficult to defend. Physicians are encouraged to write their initials, the date of review, and orders for follow up on the reports to verify their actions. Review non-urgent test findings with patients at their next scheduled appointment, and document this discussion in the medical record.
• To reduce risk, physicians may need to make an extra effort to document a patient’s noncompliance or failure to follow up.
• Losing track of a patient who requires continuity of care, particularly in response to any abnormal report, places a physician at risk. Rather than advising the patient to “return to the clinic in the near future,” give the patient a scheduled appointment. That patient is then on the schedule and if the appointment is not kept, he/she can be contacted and this action documented in the medical record.
Delay in diagnosing congenital kidney disorder

Presentation and physician action
A 3-year-old girl and her mother came to a pediatric group during extended hours services. The patient's history was remarkable for urinary tract infection two years earlier requiring an ED visit. Her symptoms of fever and pyuria were consistent with urinary tract infection. Sulfamethoxazole/trimethoprim and ampicillin were prescribed.

Nearly three weeks later, the child came for a follow-up visit and was seen by a second physician in the group. The next day, a parent brought the child to be treated by a third physician. At this time a second UTI was diagnosed. Cefaclor was prescribed, and the physician requested that the parents follow up within 10 days. An entry was made in the chart the next day questioning if the patient should have a renal ultrasound. The conclusion was made that a work up would be in order if the patient returned to the office with a third UTI, or if the parents voiced concern. The parents did not bring the child in for the follow-up visit.

Six months later, the patient was treated by one of the previously seen physicians for a third UTI. Again, a 10-day follow up was requested. Nearly 3 weeks later, the child was brought in and seen by a fourth physician in the group. She was treated with antibiotics for pharyngitis and sinusitis. There was no mention of the history of recurrent urinary tract infections or reference to the need for a renal work up.

Nearly two months later the patient was brought in with a fourth UTI. She was seen by a fifth physician in the group and treated with antibiotics. The physician contacted the parents four days later requesting a follow-up visit because the UTI culture did not grow out an organism.

During the next office visit, two weeks later, the repeat urinalysis was basically clear with a pending culture. It was noted that there was a need for a renal work up and a monthly urinalysis. Later a note was sent to remind the parents to bring the patient in for the requested urinalysis, but they did not comply. The child was brought in more than three weeks later with earaches, drainage, and an elevated temperature of 101 degrees. The physician who treated and diagnosed the fourth UTI saw the patient. No reference was made to the patient's problematic history or the need for a work up.

Two weeks passed and the patient came again with complaints of earaches. She was treated by a sixth physician in the group. At this visit an abnormal UA was documented and the renal ultrasound and cystogram were scheduled.

From the first visit and over the next 13 months, the patient was seen a total of nine times by six physicians in this group. She exhibited positive symptoms for UTI five times. The parents usually brought her to the extended hours clinic in the evenings or Saturday mornings due to their work schedules.

The patient was taken to a local pediatric urologist and an ultrasound was obtained. The ultrasound showed normal sized kidneys bilaterally with a suggestion of a du-
plex collecting system on the right, a congenital condition. A cystogram showed bilateral Grade III-IV vesicoureteral reflux. She was started on maintenance chemoprophylaxis. Later a renal nuclear scan revealed markedly impaired tracer uptake in both kidneys. The right kidney contributed 69% and the left kidney 31% of overall uptake, thus indicating significantly impaired renal function.

The next month the patient underwent bilateral ureteral reimplantation for the purpose of facilitating an anti-reflux response. Over the next eight months her treatment was followed by the urologist. The last cystogram revealed Grade II reflux persisting on the right with no reflux on the left. Because of the high probability of infection, the patient was maintained on sulfamethoxazole/trimethoprim 5 ml daily.

The family then moved out of state and sought transfer of care to a pediatric nephrologist. Further testing revealed bilateral renal scarring involving the entire left kidney and the lower pole of the right kidney. It was projected that medical surveillance would be required for the rest of the patient’s life, with a risk for chronic renal failure potentially requiring dialysis and/or kidney transplantation.

Allegations
A lawsuit was filed against the pediatricians who treated the child, and allegations included failure to diagnose and treat a congenital ureteral anomaly in a timely manner.

Legal implications
No experts reviewing this claim were fully supportive of the defendants’ treatment of the patient. Defense consultants found that the treating pediatricians fell below the standard of care in the following areas:

- failure to refer the child for a urologic work up after her second urinary tract infection, if not her third;
- delay in identifying the patient’s congenital anomaly until 31% of the function of her left kidney and 69% of her right kidney remained; and
- delay in detecting the congenital problem causing multiple infections resulting in preventable kidney damage.

Disposition
It was determined that three pediatricians held the primary liability exposure. The case was settled before trial with their consent.

Risk management considerations
The most obvious weakness in this case was the lack of coordination and communication among the physicians. When a patient is seen by multiple providers in a practice, continuity becomes a crucial challenge. The records indicate that the physicians were not conferring or reviewing the entire record. It is also apparent that treatment was prescribed based on the symptoms exhibited at each visit with minimal attention given to the patient’s history. Had one physician managed and coordinated the medical care, perhaps the order for a urologic work up would have occurred earlier. Reviewing prior records when multiple physicians are involved is essential to prevent important follow-up care from falling through the cracks.
Delay in diagnosing congenital kidney disorder

In several instances it was noted that the patient’s parents failed to keep follow-up appointments. Noncompliance with follow up and in presenting only for problem visits is not an area to overlook. The process of documenting no-shows with the attempt to reschedule is recommended here. The extra time required to follow up and document the results is critical to prevent potential negative consequences for the patient. Should the patient or legal representative refuse to make an appointment or commit to a date, the response is then noted in the chart. The evidence is then present to defend the physician or provide documentation of comparative negligence.

The medical record contained inferences that the parents were hesitant when a urologic work up was recommended. This is where the informed refusal process may be relevant. Thorough documentation of the informed refusal discussion, and when appropriate, a signed informed refusal, protects the physician from allegations that the patient was not given options or educated adequately.

In this case, however, because the physicians failed to follow the guidelines described above, their actions could not be supported by defense experts.
Postoperative complications not recognized

**Presentation**
A 69-year-old man came to his family physician complaining of right-sided abdominal pain. The family physician suspected cholelithiasis (gallstones) and referred the patient to a general surgeon.

**Physician action**
The general surgeon confirmed the diagnosis, and scheduled the patient for a laparoscopic procedure. The surgery was completed on a Friday morning. In his operative report the surgeon stated that the gallbladder was very contracted with densely packed gallstones with a narrow duct. He elected not to proceed with cholangiogram at that time even though liver functions were abnormal.

The patient was kept in the hospital overnight for observation and discharged Saturday at noon. The surgeon testified that he spoke with the family physician while the patient was in the hospital and told him to contact a gastroenterologist to set up a postsurgical endoscopic retrograde cholangiopancreatography (ERCP). This conversation was not documented. The patient was discharged with instructions to see the surgeon on Wednesday and to follow up with the family physician in two to three days to repeat liver function tests.

At 8:51 p.m. on Sunday, the surgeon was paged and told to call the patient’s wife. During the phone conversation, the surgeon asked her to put the patient on the phone, but she refused to do so. She told him the patient was having hiccups and experiencing pain that was regionalized at the suture site. The surgeon told her to have her husband hold a pillow against his chest when he coughed to reduce the pain. He could also take hydrocodone for the pain. The surgeon told her if she was in any way concerned, to take the patient to the emergency department (ED). He told her to come to his office Monday instead of Wednesday and to see the family physician Monday morning to have lab work done and arrange to see a gastroenterologist. He testified that she did not seem to understand what he was saying and he had to repeat himself numerous times.

The patient and his wife went to the family physician's office on Tuesday. The physician noted the patient was complaining of “postop problems with vomiting.” He recorded a benign abdominal exam and ordered antiemetic medication and follow-up lab work. The lab results were called to the family physician's office that afternoon and a copy was faxed to the surgeon’s office at 2 p.m. The results revealed the patient had a WBC of 25,000 and elevated liver enzymes.

The surgeon testified that he saw the lab results when he arrived at his office at noon on Wednesday. He expected the patient and his wife to be in his office that afternoon for their appointment, and that he would discuss plans to have an ERCP scheduled. Shortly after the surgeon arrived at his office, the family physician called to tell him that the patient had stopped breathing and was at a local hospital. The surgeon went to the hospital and when he arrived the patient had already been pronounced dead. The patient had vomited and aspirated and could not be resuscitated.
Allegations
In their lawsuit against the general surgeon, the plaintiffs alleged that he did not appreciate the patient’s postoperative condition and failed to respond in a timely manner. The plaintiffs argued that it was appropriate to wait to do an ERCP after the surgery, but that it should have been done no later than 48 hours after the surgery.

Legal implications
The surgeon admitted that it was a difficult surgery, and that he could not complete an intraoperative cholangiogram. He then discharged the patient and planned to follow his condition with liver function tests. The patient contacted the surgeon on numerous occasions after the surgery with complaints suggestive of a blocked common bile duct and possible retained stones. Experts suggested that the surgeon should have sent the patient to the ED on Sunday or Monday or insisted that his lab work be performed on Monday accompanied by a visit to the surgeon’s office. The patient should not have been evaluated by the family physician. If the surgeon had evaluated the patient sooner, an ERCP would have been scheduled, revealing the blockage in the common bile duct. This may have prevented the complications that led to the patient’s death.

Disposition
This case was settled on behalf of the surgeon before trial.

Risk management considerations
With difficult surgical cases, such as a cholecystectomy where an intraoperative cholangiogram cannot be performed, surgeons should follow their patients closely. If a discharged patient calls with complaints consistent with a blocked common bile duct, the surgeon should react to those symptoms in an appropriate and timely manner. It is ill-advised for a surgeon to suggest that a family physician evaluate a postoperative patient. Surgeons should personally evaluate their postoperative patients. If they are unable to do so, they should send the patient to the ED for work up.
Failure to diagnose renal failure

Presentation and physician action
A 75-year-old woman was admitted to a nursing home. Her medical history included pressure ulcers, diabetes, peripheral vascular disease, hypertension, left hemiparesis from a CVA, dementia, osteoporosis, neurogenic bladder, and renal dysfunction. During the first 11 days in the facility, decubiti involving her buttocks, coccyx, and feet were noted. She was transferred to a hospital for treatment of her bedsores, and was released back to the nursing home a week later. At this point, the defendant assumed the patient’s care while also serving as the facility’s medical director.

Upon her return she was noted to have decubiti on her right knee, sacrum, and right buttock. Blisters were noted on her right foot on the 2nd and 4th toe and a blood blister on her left foot. Nearly a year later, an NG tube was placed for fluid and medication followed by the placement of a G-tube the next month.

During this period, laboratory values indicated developing renal failure, which worsened over the next two months. Nursing home records indicated lab values of panic level for renal failure were called in to the medical director. No new orders were documented. Two weeks later the patient was transferred to the hospital, upon the family’s request, with admitting diagnoses of stage IV decubiti, dehydration, anemia, acute and chronic renal failure, gastrointestinal bleeding and diabetes. She died one month later.

Allegations
A lawsuit was filed against the attending physician. The plaintiffs alleged that he was negligent in his treatment of the patient’s decubiti, allowing them to worsen. They also allege that he was negligent in failing to properly diagnose and treat the patient’s renal failure, which combined with the decubiti, led to her death.

Legal implications
Unfortunately, the physician had little recollection of the patient or his treatment of her. The nursing home chart did not contain physician progress notes or wound care orders for more than a year while the patient was under his care. The defendant adamantly stated that the notes he wrote were lost by the nursing home. However, all other portions of the chart were complete.

The most damaging evidence in the medical record was the critical lab value with no response. The defendant denied that he was called by the nursing home. Yet when he visited the patient three days later, with the lab report in the chart, no new orders were written to treat the renal failure.

Disposition
No experts were able to support the defendant in this case. The plaintiffs were able to retain expert testimony critical of the care. During mediation and after several hours of discussion, the case settled.

Risk management considerations
Lack of documentation was a major weakness in this case. It is recommended that a physician maintain a chart independent from that kept at the nursing home, even when the physician is the director of the facility. Although it may be impossible or unnecessary to duplicate 100% of the chart, certainly documenting an initial history and physical,
diagnoses, and medication regimen is recommended. Since nursing home care involves the physician taking telephone calls while away from the facility, a process should be in place for keeping a record of what was reported, what was discussed, and the oral orders given. This would offer evidence of care should there be a discrepancy between the nursing home and the physician. This documentation would also assist in the defense of the case. It is dangerous for physicians to rely solely on memory. Information recited from memory is not likely to be considered credible by a jury, especially when it is not consistent with medical records or outcomes.

When a change in the patient’s condition is reported to the physician, some evidence of response is indicated. Since most elderly, bed-bound patients are at high risk for skin breakdown, it is advised that measures addressing pressure sore risk be ordered. There were no notes in the record that indicated orders for adequate turning or repositioning, or for a pressure-relieving mattress.

With non-healing wounds, a nutritional consult may be necessary. The physician should also be aware of the dietician’s recommendations and evaluate them for compatibility with the patient’s other conditions, such as diabetes or renal failure.

There may also be a critical time in the patient’s course that the current facility cannot offer the level of care required to treat the condition. The physician may need to intervene and transfer the patient to a long-term acute care facility, an outpatient, or critical wound care facility. If this is not feasible, a referral for a wound care consult may be necessary.

Inadequate documentation was an obstacle in the defense of the physician. Although the practice of keeping records is time consuming, it is the best way to track the reports received via the telephone and the oral orders given. It also serves as a reminder when phone calls from the facility are received.
Diagnostic errors
Retained surgical retractor

Presentation and physician action
A 29-year-old man with a long-standing history of abdominal complaints was referred to general surgeon A for evaluation of a duodenal ulcer. After examination, general surgeon A diagnosed a chronic peptic ulcer and recommended vagotomy and subtotal gastric resection.

The surgery was performed. A sponge count was completed at the end of the surgery, but an instrument count was not conducted and no instrument count was printed on the OR record. In the following weeks, the patient seemed to do well. He last saw general surgeon A eight weeks after the surgery.

Approximately 18 months later, the patient came to his family physician with complaints of severe lower stomach pain for three or four months. This physician noted that the patient had undergone a partial gastrectomy 18 months prior. Over the next year, the physician provided conservative treatment. When this failed to alleviate the patient's abdominal symptoms, he was referred to a radiologist for an air contrast barium enema. Radiologist A reported that the films demonstrated “a very large unusual radiopaque structure in the anterior abdomen. It appears very thin and flat and extends virtually the length of the abdomen. It is located anteriorly and may be superficial in the anterior abdominal wall, although its exact location and etiology is not known. It may be related to the patient’s midline incision, aside from this the patient's abdomen appears unremarkable on the scout film.”

Two weeks later, the patient saw a gastroenterologist on referral from his family physician. The gastroenterologist did not have the patient’s records or radiographic studies available. He believed that the patient suffered from chronic abdominal pain syndrome, but he planned to locate the patient’s records and evaluate them. The records were relayed to the gastroenterologist, including the barium enema study that noted the radiopaque material in the abdomen. The gastroenterologist concluded this material was an unusual form of surgical mesh related to the patient’s surgical procedure. He believed the patient was suffering from prostatitis and felt there was not a GI source for the symptoms.

Three days after his final visit to the gastroenterologist, the patient came to the emergency department (ED) of hospital A. He complained of lower scrotum and abdominal pain, and was seen by ED physician A. An abdominal x-ray was ordered and was read by radiologist B. He concluded “there is an anteriorly located ‘mesh’ in the subcutaneous tissue most likely related to an abdominal anterior wall hernia correction. There are several surgical clips in the left upper quadrant and surgical staple line to the right of the mesh at the L2 level. There are dense probably residual contrast collections either in the appendix or Secale region in the lower right quadrant. The bony structures are unremarkable. There are minimal degenerative changes.” Radiologist B believed there were surgical changes in the abdomen with no evidence of acute abdominal process. ED physician A diagnosed acute prostatitis, and advised the patient to continue taking the medication prescribed by the gastroenterologist.

Over the next year, the patient continued under the care of the family physician. The medical records indicate the patient continued complaining of abdominal pain.
Retained surgical retractor

Three years and 10 months after the surgery, the patient came to the ED at hospital B. ED physician B’s impression was that the patient suffered from acute abdominal pain, left ureterolithiasis, and hematuria with a high grade left renal ureter obstruction. ED physician B noted in his chart that there was an intra-abdominal metallic foreign body. A urologist examined the patient and reviewed the IVP with radiologist C. They both noted a small distal left ureteral stone and observed a metallic density on the film, which they believed to be mesh related to the patient’s prior surgery. The urologist discharged the patient, as he was pain free.

The patient returned to the ED five days later and was seen by the same urologist. He felt the patient was suffering from a left ureteral stone and admitted the patient. The next morning, the patient was pain free. The urologist encouraged him to increase the pain medication to strain his urine and attempt to pass the stone. The patient was discharged and told to return to the urologist in one week. The patient did not return. However, after receiving a notice of claim regarding this patient, the urologist made two additional entries into the patient’s chart indicating the patient failed to keep appointments.

Two years after the visit to hospital B, (now five years and nine months after the surgery) the patient came to the ED at Hospital C. An x-ray was reported as unremarkable, but the patient reported that he was known to have a wire mesh in his abdomen. The impression by ED physician C was acute abdominal pain. The patient was seen again in the ED of hospital C nine days later. The x-ray report noted metallic clips in the upper portion of the abdomen due to the prior surgery with two wide plates superimposed over the right paravertebral region, possibly representing a back brace. The x-ray results were again reported as negative.

Following these two visits to hospital C, the patient came to general surgeon B who ordered a CT scan and reviewed the previous abdominal x-rays. General surgeon B diagnosed a retained metallic foreign body, probably a surgical ribbon retractor, as the cause of the patient’s pain. The patient was taken to surgery, and the surgeon found and removed a 3-inch-wide x 13-inch-long surgical ribbon retractor.

The patient’s medical records indicate that he had not undergone any other abdominal procedures other than the vagotomy and subtotal gastric resection. It appears that the retractor was left at the time of this surgery. The patient testified that since the removal of the retractor he has experienced no other abdominal complaints.

Allegations
A lawsuit was filed against general surgeon A and the hospital where the surgery took place, alleging negligence in leaving a ribbon retractor in his abdomen during the surgery. The patient also filed suit against all the physicians who treated him after the surgery, alleging negligence in failure to diagnose the retained retractor. Named in the suit were the family physician, the gastroenterologist, the urologist, the three ED physicians, and the three radiologists. This incident was featured in a news story on medical mishaps and aired on a network investigative news program.

Legal implications
The plaintiffs in this case effectively developed their case to pursue two claims: the act of leaving the retractor and the subsequent failure to diagnose it. The surgeon who removed the retained retractor provided a report critical of all those involved in the first surgery.
Defense radiology experts were critical of radiologist B for describing the metal as “mesh,” and that this description led to a delay in diagnosis and removal of the foreign object. This report should have triggered further work up by the referring physician. The consultants also concluded that radiologist A’s report fully described the retractor, and that the referring physician should have followed up on the report.

Other defense consultants were not entirely supportive of the actions of the urologist and the gastroenterologist. The main weakness in the case against the gastroenterologist was the failure to follow up on the cause of the patient’s abdominal pain and the radiology report submitted by radiologist A. Regarding the actions of the urologist, he was under the impression that the prior physicians and the patient were aware of the foreign object based on the previous radiology studies. However, other urology experts were critical of his apparent inability to recognize the retained object as a surgical retractor. The urologist’s alteration of the medical record also undermined his defense.

As is often the case when claims involve multiple defendants, finger pointing became an issue. The plaintiff’s attorney was able to develop conflicting testimony and criticisms between the various subsequent physicians. This, coupled with the damaging testimony from the plaintiff’s own experts, significantly hindered the defense of this case.

Disposition
Given the “shock value” of this case and the difficulty in obtaining supportive defense testimony, this case was settled with the consent of the physicians. Settlement was made on behalf of general surgeon A, the gastroenterologist, the urologist, and radiologist B. The case against radiologist A was dropped. The hospital where the surgery took place also settled this case. The outcome of suits against the other defendants is unknown.

Risk management considerations
Given the benefit of hindsight, it is easy to identify several areas where the care of this patient broke down. When the patient was first taken to surgery, a sponge count was completed but an instrument count was not. Hospitals have protocols to prevent the retention of foreign objects in surgical patients. Physicians and their surgical staff should follow these protocols.

Compounding the initial error was the lack of follow up by the subsequent physicians. Radiologist A accurately described the foreign object, but his report did not trigger follow up. Radiologist B’s use of the term “mesh” in a later report sent the physicians in a different direction and affected their interpretation of the patient’s symptoms.

When a patient has continuing symptoms of unknown origin, further testing may be warranted. Would further testing (i.e., an abdominal CT) have helped the physicians diagnose the cause of the patient’s recurring abdominal pain? Likewise, would contacting general surgeon A to carefully correlate the patient’s surgical history have alerted these physicians to the true reason for the patient’s symptoms?

Altering the medical record seriously jeopardizes a physician’s credibility. Upon reviewing the medical record when served with a notice of claim, physicians may be tempted to add information that they believe will assist in their defense. While the information may be accurate, the addition of such information after the event is detrimental to the defense.
Failure to diagnose dissecting aortic aneurysm

Presentation
A 46-year-old man complaining of right flank pain was taken by EMS to the emergency department (ED) for treatment. The pain had begun sometime before admission, and extended from his right rib area down to his right buttock. There was no history of this pain, but he had been under treatment for hypertension. His urine had been dark for several days.

Physician action
The emergency medicine physician evaluated him in the ED. The physical exam revealed him to be in intense pain. His vital signs were essentially normal, but his abdomen was soft and nontender. Laboratory tests indicated blood chemistries to be normal and urinalysis to be positive for hematuria.

The patient was given medication for pain several times. The ED physician listed in his differential diagnosis the possibility of kidney stones, pancreatitis, urinary tract infection, and dissecting aneurysm. The patient had an IVP without evidence of contrast in the right renal collecting system or ureter. A CT scan of the abdomen and pelvis was performed without contrast. The right kidney showed decreased enhancement when compared to the left kidney. There was no evidence of stones, but that could be explained by some distal ureteral obstruction. Other etiologies suggested were renal arterial embolus versus renal vein thrombosis. The radiologist’s suggestion was that a renal ultrasound should be performed to evaluate the renal vasculature if a follow-up KUB failed to demonstrate a distal ureteral obstruction.

The patient was observed and appeared to be pain free. The emergency physician consulted with a urologist who suggested no further studies. The patient was released with a final diagnosis of right renal colic and was to follow up with the urologist in four days.

The patient appeared in the ED of another hospital less than 24 hours later. He was complaining of continued back pain with numbness and coolness in the right leg. He was evaluated and found to have evidence of severe pain, acute onset renal failure, dehydration, some gastrointestinal bleeding, and vascular insufficiency of the right leg. The patient was stabilized, and after being seen in consultation, was transferred to the ICU.

The patient had an MRI of the chest and abdomen, a CT of the chest, transesophageal echocardiogram, and aortogram. He was taken to surgery for repair of a dissecting aortic aneurysm. This involved the descending aorta from the chest to the bifurcation, with involvement of the celiac artery, right renal artery, superior mesenteric artery and right iliac artery.

The patient had a very stormy postoperative course, and was hospitalized for two months. He had a second surgery that included a colectomy and ileostomy. He subsequently developed gangrene and had amputation of the second through the fifth fingers of the right hand and all toes. He developed progressive renal failure, had a permacath implanted, and began receiving dialysis three times weekly. He had ex-
treme weakness in the legs, and was undergoing physical therapy to improve this problem. At the time of discharge, the patient was still on tube feedings, but his ability to handle oral feeding was improving. The patient also had an ileostomy and was on dialysis. He was scheduled for rehabilitation and ileostomy care. The patient underwent dialysis for a few months and subsequently recovered his kidney function.

Allegations
In their lawsuit, the plaintiffs alleged that the emergency physician failed to investigate, properly diagnose, and treat a vascular source of the patient’s symptoms, and misdiagnosed renal colic. They also alleged that he failed to obtain appropriate consultations with specialists in a timely manner. They state that he failed to respond to the patient’s symptoms and radiologic information and make recommendations at a time when a dissecting aneurysm reasonably could have been detected and properly treated. They further alleged that the physician should have admitted the patient for observation, diagnostic evaluation, and treatment.

The hospital was also sued. The plaintiffs alleged that the nurses failed to adequately assess the patient’s pain and pain history and failed to properly communicate the initial nursing assessment and evidence of the patient’s complaints of chest pain and presenting medical history to the emergency physician.

Legal implications
The biggest hurdle in the defense of this physician was that he indicated dissecting aneurysm in his differential diagnosis and did not pursue diagnostic studies to rule it out. While he ordered a CT of the abdomen and pelvis, it was done without contrast. He did note in the chart that this did not show an aneurysm. However, to rule out dissection it would be necessary to perform a CT with contrast. Secondly, the radiologist recommended further tests. Had they been performed, renal problems would have been ruled out, and the physician likely would have suspected dissection. Lastly, there is the nurse’s note indicating that the patient vomited just prior to discharge. However, there was no documentation that the defendant altered the plan for discharge.

Plaintiffs alleged that because of the delay, the dissection became larger. This created insufficient blood flow causing problems with the bowel. The patient subsequently suffered gangrene in the extremities resulting in amputation of toes and fingers. He had a long and complicated hospital course with subsequent rehabilitation.

Both emergency medicine consultants who reviewed this case were critical that the correct diagnosis was considered, but appropriate testing was not done to verify the dissecting aneurysm. The consultation obtained from an expert on dissecting aortic aneurysm made it possible to defend this case more on causation than on liability. He testified that the loss of the digits on the hands and feet were the result of an adverse reaction to heparin. This testimony helped lessen the damages, so that the case could be resolved for a more reasonable amount.

Disposition
After several weeks of negotiation and mediation, the case was settled on behalf of the emergency physician. The hospital settled their exposure for the same amount.
Risk management considerations
Documentation of all patient encounters should include a description the patient’s chief complaint, the physician’s assessment of the chief complaint, the treatment, and whether the patient’s complaint was resolved.

Charting a differential diagnosis implies that the listed diagnoses will be systematically ruled out by comparing clinical findings. The ED physician in this case listed dissecting aneurysm in the differential diagnosis, but did not order the appropriate diagnostic studies to rule it out. According to the emergency medicine consultants reviewing this case, a CT scan with contrast would have been required to rule out dissection.
Failure to diagnose aortic dissection

Presentation
A 25-year-old woman came to a regional medical center emergency department (ED) three times in one week with complaints of shortness of breath, chest pain, and diaphoresis. She had a history of anxiety, but no history of chest pain.

Physician action
During her first visit to the ED, the treating physician ordered a chest x-ray and an EKG, which were interpreted as normal with the exception of some mild cardiomegaly. The patient was diagnosed with non-cardiac chest pain and/or esophagitis and discharged home.

The next day, the patient returned to the same ED with complaints of chest pain. She was evaluated by another ED physician and gave a history of a sudden onset of severe, mid-sternal chest pain the previous night, which had been episodic since its onset and was progressing. The patient had chest wall tenderness on palpation of the sternum and was rather anxious, crying throughout the examination. Her vital signs were normal with the exception of her blood pressure, which was 134/104 mm Hg.

It was felt that her symptoms were not cardiac in origin, but were probably related to her anxiety and a gastrointestinal origin. She was treated with lorazepam and a mixture of an antacid, lidocaine, and hyoscyamine, atropine, scopolamine, and phenobarbital which provided a partial relief of her symptoms. She was also given an injection of ketorolac, which completely relieved her symptoms. The patient’s primary care physician was also contacted and confirmed the patient’s previous medical history of anxiety and similar symptoms. The patient was discharged to follow up with her primary care physician.

When seen by her primary care physician the next day, the patient continued to complain of mid-sternal chest pain radiating to her back. Her pain was noted as high as 10 on the scale of 1 to 10. She was diagnosed with costochondritis and reflux esophagitis.

Three days later, the patient returned to the same ED with mild hypertension, tachycardia, and significant chest and arm pain. Another ED physician ordered a CBC and SMAC 7, as well as a chest x-ray and EKG. He also reviewed her records from the previous visits to the ED. The EKG on this occasion was unchanged from the earlier EKG and was basically normal. The chest x-ray was also unremarkable. The ED physician ordered a “GI cocktail” and lorazepam, and her symptoms resolved somewhat. She was given meperidine and prochlorperazine before being discharged with the diagnosis of non-cardiac chest pain, gastroesophageal reflux disorder, and anxiety.

Later that afternoon, the patient fainted and was taken by ambulance to the regional medical center. She had no pulse when the emergency medical technicians arrived at her home. She died shortly after arrival to the regional medical center. An autopsy concluded that she died as a result of cardiac tamponade due to a ruptured aortic dissection from the ligamentum arteriosum to the ascending aorta.
Allegations
The patient's family filed a lawsuit against the primary care physician and two of the emergency physicians (those who saw the patient on the second and third ED visits). The allegations included:

- failure to diagnose aortic dissection;
- failure to obtain sonographic evaluation and thoracic CT scan; and
- failure to obtain consultation by a cardiac thoracic surgeon.

Legal implications
Aortic dissection may be revealed on an aortic angiography; chest MRI or CT scan of the chest; an echocardiography; a chest x-ray which may show mediastinal widening; a Doppler ultrasonography; EKG which may show signs of cardiac tamponade; or a CBC which indicates blood loss. In this case, the patient had a normal EKG, her pulses were checked in all four extremities and were considered normal. Her chest x-ray was basically normal (the chest x-ray did show some cardiomegaly, but no abnormalities of the great vessels). This was a very difficult and rare diagnosis to make, especially in a 25-year-old woman with a negative family and personal history of vascular abnormalities.

While defense consultants felt the third ED physician was not negligent for failing to diagnose the aortic dissection, some expressed concern that he may have been outside the standard of care for failing to call in a cardiology consult and consider further diagnostic testing due to the severity and continuous nature of the patient's complaints. Although the other ED physicians also missed her diagnosis, the third ED physician was in the unique position of having seen her on her third visit to the ED in less than a week with complaints of severe chest pain.

Disposition
The case was settled on behalf of the third ED physician. The first ED physician was not sued. The case against the second ED physician was dropped. The primary care physician also reached a settlement with the plaintiffs.

Risk management considerations
According to the medical experts reviewing this case, the exact cause of aortic dissection is unknown, but risks and causes include atherosclerosis, hypertension, blunt trauma to the chest, infection, and congenital weakness of the aorta. Symptoms of aortic dissection, which may begin suddenly, include chest pain, which is sudden and severe and may be described as sharp, stabbing, tearing, or ripping. The pain may be located below the sternum, under the shoulder blades, or in the back. The pain may radiate to the shoulder, neck, arm, jaw, abdomen, or hips and the location of the pain may change. Symptoms also include changes in ability to think clearly and concentrate, decreased movement, decreased sensation, anxiety, pallor, rapid heart rate, profuse sweating, dry skin or mouth, nausea or vomiting, dizziness or fainting, and shortness of breath.

Clearly this patient did not fall into the demographic of persons whom aortic dissection affects most commonly. However, the true etiology of the patient's chest pain was never determined, leading to her repeated discharges from the ED. Further diagnostic testing and a cardiology consult were warranted due to the severity and continuous nature of the patient's symptoms.
Delay in diagnosing colon cancer

Presentation
A 44-year-old man came to his family physician with a three-day history of rectal bleeding.

Physician action
Anoscopy revealed a torn internal hemorrhoid and a double contrast barium enema showed diverticulosis. The patient returned to the family physician eight months later and reported continued rectal bleeding. At this visit, the patient alleged the physician told him that the rectal bleeding was due to his diverticulosis and was not life threatening. For this reason (according to the patient), the patient never reported continued rectal bleeding to the physician, despite numerous office visits and opportunities to do so.

Four years later, the patient came to the physician’s office with rectal bleeding and severe abdominal complaints. The family physician referred the patient to a gastroenterologist.

Colonoscopy and later surgery revealed Stage IV colon cancer with metastasis to the liver. The patient underwent colon resection and chemotherapy but his prognosis was very poor.

Allegations
A suit was filed against the family physician alleging failure to fully evaluate symptoms suggestive of colon cancer and delay in diagnosing colon cancer.

Legal implications
In reviewing this case, defense consultants stated that a double contrast barium enema was inadequate to investigate the patient’s rectal bleeding when he first mentioned it to the family physician. The standard of care required that either a colonoscopy or sigmoidoscopy be performed. The physician was also unable to testify that he had inquired about continued rectal bleeding when he saw the patient eight months later. The consultants felt the standard of care required the physician to inquire about the previous rectal bleeding instead of relying on the patient to report a continued problem.

Disposition
The standard of care issues created considerable weakness for the defense of this case. With the consent of the family physician, this case was settled.

Risk management considerations
Failure or delay in diagnosing colorectal cancer is one of the leading causes of litigation against physicians. Physicians can consider the following guidelines to help reduce liability in the area of colorectal cancer screening and diagnosis:

- Stay current with clinical practice standards.
- Screen your patients for colon cancer following a reasonable, authoritative guideline.
Delay in diagnosing colon cancer

- Have an informed consent discussion and include the risks, benefits, alternatives, and limitations of screening and the procedures involved. Document informed consent, and if appropriate, informed refusal.
- Assess and document your patients’ family histories for hereditary risk factors, with special care toward ascertaining hereditary nonpolyposis colon cancer and familial adenomatous polyposis.
- If the preparation for flexible sigmoidoscopy or colonoscopy is inadequate, repeat the procedure.
- Document cecal intubation and careful withdrawal techniques in the colonoscopy report.
- Recommend appropriate follow up, and consider implementing a patient reminder system.
- Document informed consent, refusal, procedures, and follow-up recommendations.
- Ensure adequate support systems, particularly patient reminder systems.
Failure to diagnose endocarditis

**Presentation**
On October 9, a 13-year-old girl, accompanied by her mother, came to the pediatrician with complaints of fever, nausea, and dizziness for two days. She had a five-month history of decreased activity, decreased appetite, weight loss, occasional fevers, and occasional fast heart rate. She was previously seen by a gynecologist in Mexico for excessive menstrual bleeding. She also said that she had a urinary tract infection about three months earlier.

**Physician action**
Vital signs revealed that she was afebrile, and blood pressure was recorded as 100/44 mm Hg. The pediatrician ordered a CBC, which indicated anemia, and metabolic profile (CMP), which was within normal limits. The pediatrician diagnosed the patient with anemia, upper respiratory infection, and urinary tract infection. No antibiotic was prescribed for the urinary tract infection. Iron therapy was prescribed for the anemia, and she was scheduled for pelvic and renal ultrasounds at a later date. The pediatrician also felt the patient was depressed and referred her to a psychiatrist. The pelvic and renal ultrasounds were performed on October 14, and the results were normal.

The patient continued to feel unwell, and returned to the pediatrician on October 16. The medical record indicated that the physical exam was normal, temperature was 97.3 degrees, and there was a one pound weight loss. A repeat CBC and UA were performed. The urinalysis showed the following: 1+ bilirubin; positive ketones; 3+ blood; 1+ protein; and 2+ urobilinogen. It was not noted in the chart whether the patient was menstruating at the time of the UA. The pediatrician diagnosed anemia and depression, and the patient was put on a nutritional supplement drink. No antibiotics were prescribed.

The patient returned for the blood test results on October 24, and was again diagnosed with anemia. Temperature was 98 degrees, blood pressure was noted to be 90/40 mm Hg, and a heart murmur was noted for the first time. The pediatrician ordered a CBC and a stool check for occult blood and parasites. CBC results from October 24 were: red blood count 3.38; hemoglobin 8.4; hematocrit 25.5; MCV 75.3; and MCH 24.9. MCHC was normal. Platelet count was normal, and her differential showed 72.4 neutrophils, 19 lymphs, 7.5 monocytes and 0.9 eosinophil. Treatment or recommendations for the heart murmur were not documented in the medical record. According to the pediatrician, he advised the patient’s mother that the child should see a hematologist and a cardiologist, but the mother was noncompliant for financial reasons. This discussion was not documented.

Reportedly, the child was seen some time in late October or early November by physicians in Mexico, and found to be anemic. While in Mexico, she was evaluated by a hematologist/oncologist and a blood transfusion was given. She also reportedly received multiple courses of antibiotics at unknown times in Mexico for unknown causes, possibly urinary tract infection. Although unclear, it appears that the antibiotic therapy begun in Mexico may have been started in July or August and continued sporadically through the end of October.
On November 24, the patient was taken to the emergency department (ED) of a local hospital with weakness, palpitations, and anemia. The ED physician noted the heart murmur and ordered an echocardiogram. It was determined that the patient had endocarditis, and she was admitted to the hospital. She was transferred to a larger medical center the next day.

The patient was transferred the same day to a children’s hospital for further evaluation and consideration of surgical repair of the valve. The patient was continued on antibiotics. On November 26, aortic valve replacement was performed for her diagnosis of aortic insufficiency secondary to endocarditis (large aortic valve vegetation). She was transferred from critical care to the floor five days after surgery.

On her second day on the floor she had a seizure followed by cardiac arrest with ventricular fibrillation, requiring cardioversion. She was successfully resuscitated and taken to the ICU, where she did well for the next 36 hours, although heart function remained poor. A CT of her head revealed a right occipital lobe cerebral infarct. The patient showed some increased activity and purposeful movement. The patient was extubated, but was reintubated within an hour due to tachypnea and hypoxia.

On December 3, she began to deteriorate and required placement of an intra-aortic balloon pump and Swan Ganz catheter. A transplant center was contacted on December 6, and agreed to accept her for transplant evaluation. Although the patient was transferred to the transplant center, her condition continued to decline, and she developed multi-organ failure. Life support was withdrawn and the patient died two days later.

Allegations
A lawsuit was filed against the pediatrician, alleging failure to appropriately recognize, diagnose, and manage the patient’s bacterial endocarditis.

Legal implications
Consultant reviewers were not fully supportive of the physician’s care in this case. One consultant felt the documentation for all the visits was inadequate, and questioned why the physician did not document a treatment plan and diagnosis of the heart murmur found on October 24. The consultant felt that the wide pulse pressure recorded on two visits signaled a possible aortic insufficiency, and was critical that no cardiac evaluation was ever documented at any of the visits.

Consultants questioned why abnormal urinalysis results were never followed up on, and whether the October 24th CBC indicated more than just iron deficiency. Although the pediatrician indicated that he had discussed the child’s condition and the need for cardiology and hematology consults with the mother, consultants were critical of the physician’s failure to recognize the urgency of the situation and insist upon a cardiology consult. If indeed the mother was noncompliant because of financial issues, documentation of this discussion would have assisted in the physician’s defense.

One consultant suggested that although endocarditis is not an obvious diagnosis in a child, quick follow-up with a cardiologist for the heart murmur could have revealed it. The lack of any mention of treatment, follow up, or recommendations for the patient’s heart murmur in the medical record made it difficult to judge whether the doctor sufficiently understood and explained that the child had a potentially life-threatening condition.
Consultants agreed that this was a difficult patient to evaluate and treat because of the ongoing and somewhat confusing medical treatment in Mexico. The patient was seen periodically from June until early November, and given various unknown antibiotics and eventually a blood transfusion. Because this care was self-reported to the pediatrician, and records were unavailable, there was an added complexity and a level of uncertainty to the pediatrician’s evaluation and care of this patient.

**Disposition**
In light of the critical consultant opinions, substantial medical costs, and the death of a 13-year-old child, the case was settled before trial.

**Risk management considerations**
Discussion with the family about the serious nature of the child’s medical condition, and the insistence that the child see a cardiologist might have prevented the patient’s condition from going untreated and deteriorating. Although the pediatrician claimed that he discussed the need for cardiology and hematology consults with the mother, there was no documentation in the medical record to support this. If the mother was unwilling to take the child to a cardiologist because of the cost, documenting informed refusal of treatment, and perhaps even obtaining a signed refusal, might have helped to defend this physician. When a patient’s condition is urgent, making an appointment with a specialist on an emergent basis for the patient before they leave your office can help to increase patient compliance.

An incomplete medical record that lacks information from other health care professionals and a patient with a bad outcome became the foundation for a difficult defense. Ask patients or their legal representative (in this case, a parent) to sign an authorization and request the records from all physicians, facilities, etc. If possible, it is important to obtain relevant medical records from other countries to facilitate a thorough patient assessment.

The lack of documentation of any treatment, referral, or follow up for a new condition can leave the medical records open to interpretation. Any recommendations for care and any refusal on the part of the patient should be documented in detail in the record. In this case, the pediatrician’s failure to respond to the urgency of the situation and lack of follow up or treatment recommendations fell below the standard of care.
Misdiagnosis of Staph infection

**Presentation**
A 45-year-old man with a history of type II diabetes came to the defendant internal medicine physician with complaints of pain in the right great toe. Physical exam revealed the toe to be red and swollen and the symptoms were attributed to either cellulitis or gouty arthritis.

**Physician action**
Indomethacin and prednisone were prescribed and refilled nine days later without the patient being seen in follow up. Four days after the medications were refilled, the patient returned with a temperature of 103 degrees and an infected and semi-necrotic right foot. He was sent to the emergency department (ED) and admitted to the hospital. The day after admission the patient was taken to surgery. Incision and drainage with excision of necrotic tissue and bone was done followed by partial amputation of the first and second toes.

Four days postoperatively, due to continued demarcation of his foot and nonviable tissue, the patient underwent revisional surgery that included transmetatarsal amputation. Three days later the patient was discharged with a diagnosis of amputation secondary to a diabetic infection identified as *Staphylococcus aureus*. Antibiotics were continued as well as medications to control his diabetes. He was scheduled for hyperbaric oxygen therapy.

**Allegations**
The patient filed suit against the internal medicine physician with allegations that he was negligent by incorrectly diagnosing gout rather than a serious Staph infection; in prescribing corticosteroids when they were contraindicated; and in his failure to closely monitor the patient’s condition.

**Legal implications**
Failure to diagnose is the most cited allegation in claims against primary care physicians. All the consultants reviewing this claim stated that, due to the patient’s diabetes, an infection should have been the first suspected problem. They all agreed that prednisone should not have been prescribed unless gout was definitively diagnosed and an infectious process ruled out. The consultants also felt that the defendant acted below the standard of care when he made no attempt to obtain joint fluid for a cell count, crystal exam, or culture and sensitivity.

Review of the defendant’s medical record identified several weaknesses in documentation. These included an illegible office record, undocumented phone calls, and antibiotic samples reportedly given to the patient but not entered in the record. The patient disputed the physician’s statement that he was given antibiotics. It was also discovered that the defendant added entries to the record after the suit had been filed.

**Disposition**
This claim was settled during mediation with the consent of the physician.
Risk management considerations
Poor documentation may present a challenge that cannot be overcome in the defense of a physician. Illegible writing continues to be a common weakness in medical records and may make it impossible to accurately determine all aspects of a patient’s condition and care. The documentation can be subject to broad interpretation as to what was written, and may lay the foundation to question the quality of patient care. All entries in a medical record need to be legible.

All phone calls and prescription refills should be documented in the medical record. All patient encounters whether in person, by phone or email, likewise, should be included in the record. It is dangerous to rely on memory that invariably differs between the plaintiff and defendant.

The failure to document pharmaceutical medication samples creates an incomplete record. It is recommended that medication samples be documented with the same elements as a new prescription or refill. Include the name, dosage, route of administration, frequency, duration, number prescribed, and patient education regarding side effects and potential adverse interactions.

Making additions to a record after a notice of claim may place a physician in a compromised position. Complete and accurate entries at the time of the encounter may decrease the potential for record alterations. An addendum or late entry in a 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 late entry, the added information, and signature of the author. Avoid after-the-fact entries as they may be viewed as record alterations and may ultimately compromise the defense.

Misdiagnosis of Staph infection
Failure to diagnose pulmonary embolism

Presentation and physician action
A 70-year-old woman with a history of Parkinson’s disease, dementia and congestive heart disease was admitted to a nursing home. Her activities of daily living showed significant impairments, justifying the need for nursing home care. Early documentation in the medical record indicated that the woman would not ask for assistance, and would sit in the wheelchair for hours not wanting to bother staff. A compression fracture of T-10 was diagnosed within two months of her nursing home stay. Although functional assessments showed periods of disorientation and forgetfulness, the attending physician’s nurse practitioner (NP) documented the patient had good rehabilitation potential.

Within the second year of her stay, the patient became cyanotic and lost consciousness while being assisted to the bathroom. The physician’s NP gave orders to transfer the patient to the local emergency department (ED). Initial vital signs of BP 75/32 mm Hg; pulse 78; respirations 24; and temperature 96 degrees were documented. The ED physician diagnosed the patient with dehydration, hypokalemia, and hypotension. She was given IV fluids and Dopamine to elevate her BP. Vital signs taken at time of ED discharge revealed a BP of 110/65 mm Hg; temperature 97.5 degrees; pulse 100 beats/minute; and respirations 20 breaths/minute.

Two days later, the patient was noted to have labored respirations and a faint, irregular pulse. Her BP revealed hypotension of 72/38 mm Hg. The NP was notified and instructed that the patient be transported to the local ED. After the administration of IV fluids, the ED physician notified the defendant that vital signs had stabilized. The patient then returned to the nursing home.

The next morning, the patient had increased respirations, dyspnea, and a weak pulse. Family members were present and asked to speak with the patient’s attending physician. Three attempts were made by the nursing staff to contact the physician, each within 30 minutes. Messages were left to call the nursing home. Nearly 30 minutes after the third attempt, the NP responded and gave oral orders for a stat chest x-ray, EKG, and change in the antibiotic. Later in the day, the NP visited the patient and gave orders for additional lab work of CBC, CPK, CKMB and Troponin I. ASA was started daily. Lab results were reported to the NP that evening. No new orders were received.

At 3 a.m. the patient began complaining of pain and discomfort throughout her body. She was now on oxygen and in the Trendelenburg position. Vital signs remained fairly stable the next three hours until the physician was notified at 6 a.m. of the patient’s faint pulse and blood pressure too weak to register. Both hands revealed cyanotic fingernail beds. He was also notified that the patient was a full code status. The physician informed the nurse that he had discussed the patient’s case with the ED physicians. Since they could not find anything wrong with the patient, he gave orders not to transfer the patient to the ED, but to keep her comfortable.

Shortly after the phone call, the patient became diaphoretic with labored breathing and a faint pulse. The patient was transferred to the ED. CPR was initiated, but the
patient did not respond and she was pronounced dead. An autopsy showed cause of death as massive bilateral pulmonary emboli, originating from the pelvic veins.

**Allegations**
A lawsuit was filed against the NP. The plaintiffs alleged that the NP was negligent in failing to react to signs and symptoms of a pulmonary embolism when lab studies confirmed such a finding. Further, it was alleged that the NP failed to notify the physician of changes in the patient’s condition resulting in a delay in diagnosing and treating her PE which led to the patient’s death.

**Disposition**
Each expert witness reviewing this case concluded that the NP failed to react to signs of a pulmonary embolism when the lab studies and EKG likely confirmed such a finding. Secondly, the experts agreed that the NP was negligent in his failure to alert the physician of the changes and the patient’s downward spiral throughout the last four days of her life.

**Risk management considerations**
The physician’s lack of availability to the patient and the family was a factor listed in the family’s allegations. In this case, there was no documentation in the medical record indicating a physician’s visit during the last year of the patient’s life. The expert witness for the defense listed this as one of the weaknesses of the case.

The lack of communication and coordination between the physician and the NP was an issue in this case. When an advanced health practitioner chooses to work in a collaborative practice, there is a requirement to practice under the protocols established by the physician. The physician also incurs the responsibility to supervise, and can be vicariously liable for the actions of the advanced health practitioner. Inadequate supervision or over-delegation of duties may be perceived as negligence with the NP practicing beyond his or her scope of practice. Failure to supervise is a frequent allegation in these cases.
Failure to diagnose pneumonia

Presentation
A 69-year-old woman was evaluated in the emergency department (ED) for non-radiating, mid-sternal chest pain. She indicated that the pain began that evening and grew worse during the night. She did not have a productive cough, shortness of breath, nausea, or vomiting. There was no evidence of rales, bronchi, or wheezing.

Physician action
The emergency medicine physician evaluated the patient, and performed an EKG to rule out potential cardiac problems. He found sinus tachycardia. The patient was also evaluated for chest pain, and the physician noted some sternal tenderness. His impression was acute chest wall pain, and he diagnosed costochondritis.

The physician gave the patient hydrocodone and ibuprofen to take at that time. Before discharge, he prescribed hydrocodone and naproxen, and instructed the patient to follow up with her primary care physician.

The patient saw her internal medicine physician two days after the ED visit and again approximately 10 days later. Following an examination during the office visits, the patient was continued on the previously prescribed medications. Consequently, the patient developed abdominal and chest pains the day after her second visit with the internal medicine physician. She complained of pain radiating from the breast area to the left arm and lower quadrant. She was taken to the ED and subsequently diagnosed with pneumonia and dehydration. Despite aggressive treatment measures, her condition did not improve. She developed necrotizing pneumonia and died.

Allegations
Lawsuits were filed against the ED physician and internal medicine physician. It was alleged that the ED physician failed to obtain a chest x-ray that would have led to a diagnosis of pneumonia, and the internal medicine physician failed obtain a chest x-ray and order a CBC to aid in diagnosing pneumonia.

Legal implications
The ED physician’s failure to perform a chest x-ray to rule out pneumonia put him at risk. The lack of documentation regarding the ED visit also hindered his defense. The internal medicine physician was at risk for failing to obtain a chest x-ray and order CBC, especially during the second office visit when the differential diagnosis included pneumonia.

Disposition
The lawsuit was settled on behalf of the ED physician and the internal medicine physician during the discovery phase of the lawsuit.

Risk management considerations
It is important to perform a thorough and complete work up. Likewise, the medical record should reflect a complete and documented history and physical examination. The patient should also be re-evaluated again before discharge to determine if any other symptoms have developed.
Failure to diagnose viral myocarditis

**Presentation**
An 18-month-old boy with respiratory distress, a two-day history of fever, congestion, and wheezing was brought to his pediatrician's office for evaluation.

**Physician action**
The pediatrician had been treating the child since he was born. He had been previously treated for reactive airway disease, cough, bronchitis, and asthma. He had been seen seven days before this visit for cough, congestion, and a fever.

Physical examination indicated a normal heart rate and harsh breath sounds with rhonchi, wheezing, and subcostal retractions. A blood count and chest x-ray were performed, and the x-ray showed infiltrates in the right lung. The pediatrician felt this was associated with viral pneumonia. He diagnosed recurrent bronchitis and prescribed azithromycin with home nebulizer treatments.

The pediatrician performed an in-office nebulizer treatment, but this did not improve the child’s condition. The child was then admitted to the hospital at 11:15 a.m. The pediatrician did not accompany the child to the hospital. He prescribed nebulizer treatments, IV ceftriaxone, IV methylprednisolone, an RSV washing, chest x-ray, and supplemental oxygen if the oxygen saturations fell below 95%.

The results from the RSV washing were negative, but the chest x-ray did confirm pneumonia. Medical records show that the child's oxygen saturations fell to 88% in the early afternoon. The nurses at the hospital did not start oxygen until late in the afternoon despite orders to do so if the oxygen saturations fell below 95%.

The pediatrician’s office records do not reflect a call from the nurses at the hospital until 3 p.m. This call was taken by the pediatrician’s wife, a family physician. The note indicates that a nurse called requesting authority to give medication for an elevated temperature and this was approved. The pediatrician was not advised of this phone call. A nurse from the hospital called again at 4:30 p.m. The pediatrician was advised that the child’s respiratory status was worsening and his oxygen saturations had fallen to 88%. The pediatrician told the nurse to immediately start supplemental oxygen. He arrived at the hospital at approximately 4:45 p.m. to evaluate the child.

The pediatrician evaluated the child and determined that the treatments had not improved the child’s respiratory status. In fact, the child had steadily deteriorated. The pediatrician transferred the child to a children's hospital.

The child arrived at the facility at 6 p.m., and was evaluated by the pediatric critical care/cardiologist. The diagnosis was status asthmaticus with impending respiratory failure, recent infection, bacterial versus viral. The plan was to administer antibiotics, continue nebulizer treatments and IV steroids.

At 9:50 p.m. the child’s condition deteriorated. The pediatric critical care/cardiologist administered IV bicarbonate, but the child went into asystole and resuscitation was unsuccessful. An autopsy found the cause of death to be viral myocarditis.
Failure to diagnose viral myocarditis

Allegations
A lawsuit was filed against the pediatrician, alleging failure to diagnose and treat viral myocarditis and failure to respond to calls from the nurses advising that the child was not improving. The plaintiffs further alleged that the pediatrician should have gone to the hospital early in the afternoon to evaluate the child.

Legal implications
The nurses at the hospital documented two late entries into the nursing chart. One at 12:30 p.m. and one at 4 p.m. indicating that the pediatrician’s office had been called and was relayed information consistent with continued deterioration of the child’s status. These entries were recorded the following day. The nurses then claimed they had to initiate the chain of command and had the director of nursing call the pediatrician to get him to come to the hospital and evaluate the child. The plaintiff’s attorneys brought three of the nurses to trial to testify that the calls did occur and the chain of command had to be invoked to get the pediatrician to respond.

The defense argued that the late entries were falsified, and the pediatrician’s office had been called only two times — at 3 p.m. and 4:30 p.m. In addition, the plaintiffs argued that the pediatrician should have checked on the child between the time of admission (11:15 a.m.) and 4:30 p.m. Defense experts testified that the pediatrician’s actions were reasonable and met the standard of care. Plaintiffs presented experts that testified the pediatrician did not meet the standard of care.

Disposition
The case was mediated several times by court order before trial. The pediatrician refused to consent to any resolution of the case. The case was tried twice before a jury. The first trial resulted in a mistrial 8-4 in favor of the defense (there must be 10 out of the 12 jurors in favor of a verdict to reach a verdict). The nurses did not testify against the pediatrician in the first trial. The second trial resulted in a plaintiff’s verdict of 10-2 against the pediatrician. The plaintiff’s attorneys brought the nurses to trial the second time to testify against the pediatrician.

The hospital, the hospital accepting transfer, and the subsequent treating pediatric critical care/cardiologist were also defendants in this case. They settled their cases before the first trial. This case was again mediated after the adverse jury verdict, and it was settled for the pediatricians’ policy limits plus additional funds that were paid by the pediatrician personally.

Risk management considerations
The pediatrician’s office records were very brief. The phone call documented at 3 p.m. was taken by the pediatrician’s wife and not relayed to the pediatrician. Practices should establish telephone protocols and physicians should document phone calls from hospital staff with corresponding actions as appropriate. The pediatrician admitted to his defense team that, in retrospect, the child’s condition should have been checked on earlier.

Late entries that are suspicious should be questioned as soon as possible and documentation retained that the entries may not be accurate. The pediatrician refused to give consent to settle the case despite repeated efforts by defense consultants’ claim staff to obtain consent and resolve this case before trial.
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