2015 RISK MANAGEMENT TRENDS ANALYSIS

CME ACTIVITY: TREATING AND ACCOMMODATING PATIENTS UNDER THE AMERICANS WITH DISABILITIES ACT, PART ONE

CLOSED CLAIM STUDY 1: FAILURE TO DIAGNOSE BREAST CANCER

CLOSED CLAIM STUDY 2: FAILURE TO USE CORRECT SURGICAL HARDWARE
Each year, TMLT’s Risk Management department conducts an analysis of the trends we see in the questions, concerns, and requests received by policyholders. We use this data to modify or enhance our existing services or to create new risk management activities and products. Our trends analysis helps to ensure that TMLT’s programs remain relevant for policyholders in today’s rapidly evolving health care environment.
For the 2015 analysis, data was collected and analyzed in the following areas:

- top recommendations made by TMLT’s risk managers to policyholders following a practice review;
- most requested CME program topics by physician groups; and
- most frequent topics addressed with policyholders during phone and e-mail consultations.

The data is categorized by the following TMLT services.

**PRACTICE REVIEWS**

A practice review is designed to assist physicians with determining and addressing their medical liability risks. During a practice review, a risk management professional:

- evaluates medical record documentation to increase defensibility;
- reviews practice policies and procedures to ensure protocols are appropriate;
- tours the practice or provides a remote assessment; and
- provides customized feedback with a confidential, written summary containing recommendations and strategies for risk reduction.

Below are the top ten topics and recommendations given in 2015 by risk managers to a physician practice after review.

**1. Documentation of diagnostic report review**

*Document the physician’s review of incoming consultant reports, diagnostic results, or outside tests.* Whether in electronic or paper format, document the timely review of films, tests, or reports in the patient’s record prior to scanning or filing. When appropriate, document the actions or inactions taken on specific results and the decision rationale in the patient’s record. Documentation of the physician’s review demonstrates that results were seen in a timely manner.

**2. Pre-formatted text or templates in the electronic health record (EHR)**

*Edit text or templates in the electronic health record (EHR).* When using pre-formatted text or templates in the EHR, edit entries as necessary to ensure the record accurately reflects the clinical care delivered. Inconsistent or contradictory information in the record, due to defaulting of text or carrying over of information from one visit to the next, could be a challenge in the defense of a claim or medical board complaint.

**3. EHR policies and procedures**

*Maintain written policies for EHR processes, and keep policies current.* Federal privacy and security rules require that practices develop protocols to protect the integrity and security of electronic protected health information (PHI). EHR policies may include topics such as:

- privacy/security training for staff;
- security measures including:
  - limitations on individual staff access to areas of the medical record;
  - prohibition of sharing passwords;
  - encryption;
  - firewalls; and
  - backup methods;
- procedure for signing/locking entries;
- procedure for record addendums; and
- documentation of privacy and security risk analysis.

Physicians must sign the policies and include implementation dates. Require staff members to sign and date their acknowledgment of policy review and understanding.

**4. Documentation of person accompanying patient**

*Clearly note in the medical record any person(s) that accompanies the patient during an office visit.* Because important instructions and education regarding the patient’s assessment and treatment plans are discussed, it is important to note who is present during the visit. Documenting this information in the record can be helpful should a question arise regarding the care provided.

**5. Documentation of after hours calls**

* Clearly document after hours patient telephone calls and instructions given to patients in their medical records.* This information can serve the physician and subsequent caregivers in providing patient care. Documentation can also serve as evidence of instructions provided to a patient in response to specific medical complaints.

**6. Tracking system**

*Maintain a consistent process to track consultant referrals, lab, or diagnostic tests.* When patients are referred to consultants or to an outside source for lab or diagnostic tests, a tracking system is recommended to ensure the patient is seen and results are received.

**7. Medications**

*Review and document a patient’s current medications in their record.* Encourage new patients to bring all current medications with them to an initial visit for evaluation. At each visit, review and update prescription and over-the-counter medications in
the record to monitor compliance and help prevent adverse drug reactions. If your clinic is providing patients with visit summaries, and medications have not been updated, erroneous medication information could be given in writing to the patient. This could be a challenge to the defense of a claim in which medication errors are alleged.

8. **Practice policy and procedure manual**

   Develop and maintain a current policy and procedure manual for patient care. Provide basic policies and procedures to direct staff in such practice areas as:

   - telephone communications with patients;
   - refills of prescription medications;
   - tracking orders;
   - missed appointments; and
   - emergency procedures.

   These are critical areas that lend themselves to standardization. Once policies and procedures are in place, display the implementation date and subsequent revision dates as appropriate. Policies and procedures signed by the physician indicate that the policies are authorized and important to the practice. It is recommended that all staff members sign and date their acknowledgment and understanding of relevant policies.

9. **Patient return visit**

   Document a patient’s recommended return visit in the medical record. It is important for the continuity of patient care to document when the patient is advised to return for a follow up visit. This enables office staff to schedule the visit, preventing possible allegations of failure to diagnose and treat.

10. **Blank areas in documentation**

   Complete all templates or forms used to document patient encounters. Areas that are left blank or unanswered in the medical record may be open to conjecture by others reviewing the records. It is recommended that all blank or incomplete areas on forms or templates be reviewed and completed or marked “N/A.” If using an EHR, practices can review and revise templates to tailor them to each physician’s specialty and needs. Well-developed templates can help minimize potential blank areas.

**CME PROGRAMS**

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. A variety of risk management CME options are available for policyholders, including online courses, live seminars, and publications, such as the Reporter newsletter and Case Closed books, TMLT’s award-winning series featuring closed claim studies.

In 2015, the top ten CME programs requested by and provided for physician groups were:

1. closed claims: a review of malpractice cases;
2. Texas Medical Board rules and complaints;
3. current trends in risk management and malpractice allegations;
4. regulatory and legislative updates;
5. appropriate termination of the physician-patient relationship;
6. physician-patient communication;
7. unlawful employment practices, such as discrimination or harassment;
8. best practices in EHR;
9. HIPAA compliance; and
10. the Affordable Care Act.

**PHONE AND EMAIL CONSULTATIONS**

TMLT risk management professionals are available Monday through Friday during business hours for confidential consultations.

The top ten phone call and e-mail consultation topics in 2015 were:

1. how to appropriately terminate the physician-patient relationship;
2. HIPAA compliance;
3. general office questions;
4. medical records;
5. Texas Medical Board compliance and regulatory issues;
6. selling or closing a practice;
7. prescriptions;
8. release of medical records;
9. fees/billing/collection issues; and
10. treatment of minors.
To reduce medical liability risk, TMLT encourages policyholders to take advantage of risk management services including practice reviews, CME programs, phone/e-mail consultations, and the utilization of sample forms and resources.

As an added incentive, discounts are available for TMLT policyholders. Physicians who complete a practice review may be eligible for a 5% premium discount once practice review recommendations are met. One ethics CME credit can also be earned for participating in a practice review wrap-up session.

Physicians can earn a 3% discount by participating in a TMLT CME course. Two courses can be taken per policy year for up to a 6% discount. Courses must be at least 2.5 hours in length to qualify.

Contact the Risk Management Department at 800-580-8658 for more information regarding services, discounts, and scheduling.

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TREATING AND ACCOMMODATING PATIENTS UNDER THE AMERICANS WITH DISABILITIES ACT, PART ONE
In 2015, the Americans with Disabilities Act of 1990 (ADA) celebrated its 25th anniversary. Enacted by the U.S. Congress, the ADA was signed into federal law by President George H. W. Bush on July 26, 1990 with the intention of protecting individuals with disabilities against discrimination. Since its introduction, questions remain on what exactly the law entails; who is entitled to protection under the law; and what constitutes “best practices” for providing reasonable accommodations to the disabled.

ADA: A BRIEF HISTORY
The ADA is the result of years of hard work by thousands of people who make up the disability rights movement. For years prior to the passage of the ADA, the disabled, their families, caregivers, friends, neighbors, physicians, and health care providers worked to advance the cause of equal rights and protection for the disabled. They talked to business owners, schools, service providers, and employers. They organized protests, drafted legislation, and lobbied to promote equal rights and protections for the disabled.

To gain visibility with politicians and the public, the disability rights movement adopted many of the strategies of the civil rights movement that came before it. Like civil rights advocates who staged “sit ins” at segregated lunch counters in the 1950s and 60s, people with disabilities and their supporters also staged “sit ins” at federal buildings; parked their wheelchairs in front of inaccessible buses; and filed lawsuits in the courts to gain equal rights.

In 1964, the passage of the Civil Rights Act prohibited employment discrimination against women and racial and ethnic minorities and banned discrimination against minorities in public accommodations. The disabled community sought to gain similar legal protections.
The first significant gain in U.S. disability public policy occurred in 1973 with the passage of Section 504 of the 1973 Rehabilitation Act. This section banned discrimination on the basis of disability by recipients of federal funds and was modeled after previous civil rights laws.¹

Most importantly, the passage of Section 504 represented two profound shifts in public perception:

1. **For the first time, the exclusion and segregation of people with disabilities was viewed as discrimination.** Previously, it was a widely held construct that the problems faced by people with disabilities, such as unemployment or lack of education or transportation issues, were simply the unfortunate realities of being disabled.

2. **For the first time, people with disabilities were viewed as a distinct minority group, deserving of basic civil rights protections.** Section 504 recognized that while significant variations exist between different disabilities, people with disabilities as a whole face similar discrimination in employment, education, and access to society.¹

After four years of intense legal and political wrangling, the Department of Health, Education and Welfare issued the Section 504 regulations on May 4, 1977. These regulations would go on to form the basis of the ADA.

Throughout the 1980s, the disabled community focused their political and legislative efforts on reinstating civil rights protections that had been stripped away by previous, negative Supreme Court decisions. Bills were introduced and passed in an effort to overturn or amend laws that fostered discrimination in housing, federal funding, employment, and access. These legislative victories further advanced the reputation of the disabled community and its advocates in Congress.

**THE DISABLED COMMUNITY HAD BECOME A POLITICAL FORCE TO CONTEND WITH AT ALL LEVELS OF THE GOVERNMENT.¹**

During the ADA legislative process, the disability rights movement set out to communicate and educate Congress and the American people about the need for civil rights protections for all people — including the disabled. Their message being that accommodating a person with a disability should no longer be considered a charity, but a basic issue of civil rights.

The first version of the ADA was introduced in April 1988 in the 100th Congress. The underlying principle of the ADA was to extend the basic civil rights protections extended to minorities and women to people with disabilities.

The ADA was finally passed in July 1990. The law, as it went into effect, guaranteed that people with disabilities would have the right to continue to seek and maintain work and access to housing and physical structures. However, in 2008 the ADA was amended with the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), which became effective on January 1, 2009. The Equal Employment Opportunity Commission (EEOC) issued final regulations implementing the ADAAA on March 25, 2011.

Among the important changes made by the ADAAA to the ADA was the expansion of the definition of the term “disability.” Prior to the ADAAA, Congress found that many types of impairments — including epilepsy, diabetes, multiple sclerosis, depression, and bipolar disorder — did not meet the ADA’s definition of “disability.” Congress believed that individuals with these and other impairments should be covered by the ADA. As a result of the ADAAA, it is much easier for individuals with these impairments to prove that they have a disability and are entitled to ADA protections.³

**DEFINITIONS: WHO IS CONSIDERED “DISABLED?”**

Under the ADA, an individual is considered to have a disability if he or she has at least one of the following three criteria:

1. “a physical or mental impairment that substantially limits one or more major life activities of such individual;
2. a record of such an impairment; or
3. being regarded as having such an impairment.”³

The ADAAA expanded the criteria for the definition of disability to “be construed in favor of broad coverage...to the maximum extent permitted...”³

**Criteria 1: “a physical or mental impairment that substantially limits one or more major life activities of such individual”**

A physical or mental impairment is defined for an individual when his or her condition is at its most severe. The rules of the ADA state, “An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.”³ For an individual with only sporadic impairment, his or her disability is evaluated when symptoms are most acute.⁴

Under the U.S. Code of Federal Regulations, a physical impairment is any “physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine.”⁵
A mental impairment is any “mental or psychological disorder, such as an intellectual disability (formerly termed ‘mental retardation’), organic brain syndrome, emotional or mental illness, and specific learning disabilities.”

The ADA regulations have identified examples of specific impairments that should readily be considered disabilities. These examples include HIV/AIDS and its symptoms; alcoholism; asthma; blindness or other visual impairments; cancer; cerebral palsy; depression; diabetes; epilepsy; hearing or speech impediments; heart disease; migraine headaches; multiple sclerosis (MS); muscular dystrophy; orthopedic impairments; paralysis; complications from pregnancy; thyroid gland disorders; tuberculosis; and loss of body parts.

There are some conditions that are temporary, non-chronic with little or no residual effects that are not considered disabilities. Examples include the common cold or flu; a sprained joint; broken bones expected to fully heal; or minor and non-chronic gastrointestinal disorders.

“Alternative lifestyles,” including homosexuality, bisexuality, and transsexualism, are also not considered disabilities. Other conditions not considered disabilities include compulsive gambling, lack of education, poor judgment, old age, or pregnancy. A person currently engaged in the illegal use of drugs is not considered to be an individual with a disability. This refers both to the use of illegal drugs, such as cocaine or heroin, as well as illegal prescription drugs.

The ADA describes “major life activities” as “caring for oneself (including bathing, dressing, shaving, preparing a meal, and going to the restroom), performing manual tasks, eating, sleeping, standing, walking, lifting, reaching, bending, seeing, hearing, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working.”

With the amendments made by the ADAAA, major life activity also includes the “operation of major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive (procreation) functions.”

The ADAAA loosened restrictions on the term “substantially limits” and the term may be defined very broadly in favor of expansive coverage. The determination of what constitutes “substantial limits” may be measured on a case-by-case basis. The facts of an individual case will determine whether or not major life activities are substantially limited. How long a specific impairment lasts is also not a factor. For example, an impairment that lasts fewer than six months can be substantially limiting.

Examples of substantially limiting impairments include:

- a person suffering paralysis is substantially limited in the major life activities of lifting and walking;
- a person with chronic depression may be substantially limited in sleeping, eating, and thought processes; and
- a person who has a stutter could be substantially limited in the major life activity of communicating.

Moreover, the ADA considers a person whose impairment is episodic or in remission to be disabled if the impairment substantially limits a major life activity when active. Therefore, an individual may be determined as disabled whether or not symptoms are currently present. Examples of episodic impairments include epilepsy, hypertension, asthma, diabetes, major depressive disorder, bipolar disorder, and schizophrenia. An impairment such as cancer that is in remission is also a disability if it may possibly return in a substantially limiting form.

The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of corrective or mitigating measures, such as medication, hearing aids, wheelchairs, oxygen therapy equipment, or even treatments such as psychotherapy or physical therapy. Thus asthma, depression, and allergies are still considered disabilities under the ADA, even if symptoms are controlled by medication or other measures.

The positive effects of corrective or mitigating measures must be ignored in determining the definition of disability. Instead, the determination of disability is based on whether the individual would be substantially limited in performing a major life activity without the corrective or mitigating measure.

An exception to the mitigating measures rule is the use of ordinary eyeglasses or contacts. If an individual is substantially limited in seeing, but not when wearing corrective lenses, the individual is not considered disabled.

Criteria 2: “a record of such an impairment”

A “record” of a substantially limiting physical or mental impairment refers to either:

- a substantially limiting impairment an individual had in the past; or
- a misdiagnosis or misclassification of a substantially limiting impairment.

An individual would fall into this category if medical records showed that he or she once had a disability, but was now recovered or if the individual was classified incorrectly as being disabled. An example of discrimination against an individual with a “record” of impairment includes an
individual with a history of mental illness being turned down for a job due to their medical history, even though the individual has recovered sufficiently to perform the essential functions of the job. An individual also can meet the “record of” definition if he or she was once classified as having a learning disability when they did not.³

**Criteria 3: “being regarded as having such an impairment”**
When it comes to being “regarded” as having a physical or mental impairment, the ADA states that individuals meet this requirement if the individual has been subjected to discrimination because of an “actual or perceived” impairment “whether or not the impairment limits or is perceived to limit a major life activity.”³

An individual may be considered disabled under the “regarded as” definition because he or she is denied services, benefits, or employment due to fears and stereotypes about disabilities. These individuals may also experience such discriminations as demotions, being placed on involuntary leave, termination, or harassment.⁹

Examples of discrimination against an individual with the “being regarded” definition include:

- A man has controlled high blood pressure. However, his employer demotes the man to a less strenuous job in fear that the man will suffer a heart attack.
- A woman with asthma is denied access to an exercise class in fear that she will not be able to breathe during the class.
- A man with MS in remission is not hired for a new job because the employer feels that if the man were to experience MS symptoms again, it would lead to increased absenteeism or a decline in performance.

The ADA stipulates that this definition does not apply to “transitory and minor” impairments. The ADA defines “transitory” as an “actual or expected duration of 6 months or less.”³

**TITLE III: WHAT IS REQUIRED OF PHYSICIANS OR HOSPITALS?**
The ADA is divided into three Titles:

- Title I prohibits discrimination by public employers;
- Title II prohibits state and local governments and any affiliated entity from discriminating against
qualified individuals with disabilities in all programs, activities, and services; and
• Title III prohibits discrimination in “places of public accommodation” (businesses and non-profit agencies that serve the public) and “commercial facilities” (other businesses).10

According to Title III, a “professional office of a health care provider” and “hospital” fall under the term “public accommodation.” 11

There are several broad principles that underlie the ADA’s nondiscrimination requirements as presented in Title III. These include: equal opportunity to participate; equal opportunity to benefit; and receipt of benefits in the most integrated setting possible. Title III guarantees that individuals with disabilities are offered full and equal “enjoyment of the goods, services, facilities, privileges, advantages, or accommodations” offered by a place of public accommodation—such as a physician’s office or hospital.12

The principles of Title III are implemented by the following specific requirements:

1. removing physical or architectural barriers in offices and buildings;
2. making auxiliary aids and services available; and
3. modifying policies, practices, or procedures.

These principles are all in the service of creating “reasonable accommodation” for people with disabilities. It is important that people with disabilities receive medical services equal to those services received by a person without a disability in the most integrated setting possible.

It is very important to note that these modifications must be made unless the provider can demonstrate that making the modifications would fundamentally alter the nature of the services rendered. However, making such a demonstration to the satisfaction of the EEOC is considered difficult.13

In addition, it is not considered an undue burden even if the cost of the modification, aid, or service exceeds the amount the physician or hospital will receive for treating the patient. The physician or hospital may not impose a surcharge on disabled patients for any provisions as required by the ADA.14

Removing physical or architectural barriers in offices and buildings
For a physician managing a practice, the first responsibility is to ensure that people with disabilities can physically access and use your office building and suite. Physical barriers to access must be removed if alterations that are “readily achievable” can be made.

The term “readily achievable” means “easily accomplishable and able to be carried out without much difficulty or expense.”15 For example, a “readily achievable” alteration may be to remove or relocate filing cabinets, plants, and rugs from hallways so they don’t impede a person with disabilities. Rearranging furniture to allow for greater access to wheelchair users is another example.

ADA regulations also mandate the removal of architectural barriers, including structural communication barriers, where removal may be easily accomplished without much difficulty or expense. Examples of steps to remove architectural barriers include installing ramps; making curb cuts in sidewalks and entrances; widening doors to accommodate wheelchairs; installing accessible/ lower door hardware; and removing high-pile, low-density carpeting. Examples of steps to remove structural communication barriers include installing flashing alarm lights for the deaf or adding raised markings on elevator control buttons for the visually impaired.16

The ADA provides the following priority list for taking measures to comply with access requirements:16

1. Provide access from public sidewalks, parking, or public transportation. This includes installing an entrance/ exterior ramp; widening entrances; and providing accessible parking spaces.
2. Provide access to public areas where services are provided. This includes rearranging furniture; providing signage in Braille or raised characters; widening doors; providing visual as well as audible alarms; and installing interior ramps.
3. Provide access to restrooms. This includes installing grab bars in toilet stalls; rearranging toilet partitions to increase maneuvering space; installing a raised toilet seat; insulating lavatory pipes under sinks to prevent burns; installing a full-length bathroom mirror to accommodate wheelchair users; and repositioning the paper towel dispenser.
4. Make any other necessary measures to provide access to goods and services.17 If barrier removal options are not viable or readily achievable, the physician must find a way to provide service to disabled patients in an alternate method. For example, a physician could treat patients, at no additional charge to the patient, at the patient’s home or at a hospital where the physician has privileges.7

Making auxiliary aids and services available
This requirement intends to “ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to companions who are individuals with disabilities.” Auxiliary aids and services for the hearing impaired include

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qualified interpreters, note takers, computer-aided transcription services; written materials; telephone handset amplifiers; assistive listening devices; telephones compatible with hearing aids; telecommunications devices for deaf persons (TDDs); and closed caption decoders. Auxiliary aids and services for the visually impaired include taped texts; audio recordings; materials and displays in Braille; large print materials; optical readers; and secondary auditory programs (SAP).  

It should be noted that public accommodations are not required to provide personal or individually prescribed devices or services, such as wheelchairs, prescription eyeglasses, or hearing aids.

When it comes to auxiliary aids and services, a public accommodation may not make demands on disabled individuals in the following ways:

- require a disabled individual to bring his or her own interpreter;
- rely on a companion accompanying the disabled individual to interpret or facilitate communications with the following exceptions:
  - in an emergency where there is no other interpreter available; or
  - when the disabled individual specifically requests that the companion interpret or facilitate communications; the companion agrees; and the reliance on that companion for assistance is appropriate under the circumstances.
- rely on an accompanying child to interpret or facilitate communication, except in an emergency and if no other interpreter is available.

Modifying policies, practices, or procedures

A public accommodation shall make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to provide services to individuals with disabilities. For health care providers, Title III provides specific guidelines in two areas.

1. Specialties: A physician can refer a patient with a disability to another provider, if the treatment sought is outside the physician’s specialty, and if the physician would make the same referral if a non-disabled patient sought the same services. For example, a physician who exclusively treats burn patients may refer a patient—disabled or not—to another provider if the patient is not seeking or requiring burn treatment.

However, “a physician who specializes in treating only a particular condition cannot refuse to treat an individual with a disability for that condition, but is not required to treat the individual for a different condition.” To extend the previous example, the same physician specializing in burn treatment cannot refuse to treat a patient who is seeking burn treatment because that patient is HIV positive or has cerebral palsy. However, the physician is not required to treat the same patient for another, non-burn related condition.

2. Service Animals: Policies, practices, or procedures shall be modified to permit the use of a service animal by a disabled patient. These patients are permitted to bring a service animal into all areas of public accommodation where the public, clients, customers, or invitees are allowed to go. The service animal must be under control of the handler by leash, harness, voice command, signals, or other effective means. If it is not apparent, the physician or provider is allowed, without asking about the nature of the person’s disability, to ask if the animal qualifies as a service animal and if the patient requires the animal. Proof or documentation is not required.

A public accommodation is not allowed to ask or require an individual with a disability to pay a surcharge for allowing the service animal into the building or office, or to comply with any other requirement not generally applied to people without pets or animals. However, based on its current policies, a public accommodation may charge a disabled individual for any damage caused by the service animal.

A public accommodation may ask an individual with a disability to remove a service animal from the premises if the animal is out of control and the handler does not effectively control it, or if the animal is not housebroken. Access for a service animal may also be denied if the animal would compromise health and/or safety standards, such as in an operating room. If the service animal is properly removed from the premises, the public accommodation is required to give the disabled patient an opportunity to obtain treatment or services without the service animal present.

CONCLUSION

The intention of the ADA is to provide equal protection for people with disabilities when it comes to employment, housing, federal funding, and access to services, such as health care. The breadth of the ADA’s definition of disability and the resulting requirements can be daunting. Adhering to guidelines for removing barriers, providing aids and services, and modifying policies are only the first steps to providing fair and equitable treatment for these patients.

The next issue of the Reporter will contain Treating and accommodating patients under the Americans with
Disabilities Act, Part Two. This 1-hour CME activity will review frequently asked questions and answers on treating patients with disabilities such as hearing impairment or HIV infection.

SOURCES


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PRESENTATION
In October 2008, a 73-year-old woman came to a multi-physician practice with complaints of a lump in her right breast. The patient had a history of COPD, obstructive sleep apnea, hypoxia, hypocapnia, hypertension, diabetes, anxiety, and heavy cigarette smoking (three to four packs daily).

PHYSICIAN ACTION
A family physician examined the patient and ordered a bilateral diagnostic mammogram related to a lump found in the right breast at the six o’clock position. The patient, who told the physician she had never had a mammogram before, went to a local hospital for the imaging.

Because the order was for a “diagnostic” mammogram, the radiology technician performed both a mammogram and ultrasound. While the results of the mammogram were reported as normal, the ultrasound revealed a “complex 3.8 x 4.2 cm chest wall mass” that was “noted anteriorly just inferior to the breast.” An impression for the mass indicated, “neoplastic process is suspected.” A chest CT was recommended for further evaluation. The reports were faxed to the family physician’s office where a staff member filed them in the practice’s electronic health record (EHR) system.

The family physician reviewed the normal mammogram, but there is no indication in the patient record that he reviewed the ultrasound. The patient returned to the family physician for a follow-up within a week of testing. There was no documentation of a discussion regarding the test.
results. The patient continued to see the family physician for treatment of her other conditions.

In March 2011, the patient returned to the family physician with complaints of coughing and congestion. The physician ordered a bilateral screening mammogram. The test revealed an “anterior chest wall mass on the right projecting into the right breast. This is better documented with right anterior chest wall ultrasound dated 10/30/2008. Repeat ultrasound examination is indicated to verify stability versus change comparing to previous examination.”

An ultrasound was then ordered that revealed a “large mass in the posterior aspect of the right breast measuring 7.3 x 4.4 x 6.8 cm. It is mostly solid with a few small areas that are cystic or possibly necrotic.” The report also stated, “this mass was also seen on the exam of 10/30/2008. At that time, it measured 4.2 x 2.4 x 3.8 cm.” The impression was “Class IV, suspicious finding” with a recommendation for biopsy.

In April 2011, the family physician created a “consultation note” after meeting with the patient’s family to discuss the patient’s condition. In the note, the physician outlined that the practice received the test results from 2008, but the ultrasound was not brought to his attention and was placed in the patient’s electronic record. He then reported that the family members did not believe the patient was a good candidate for surgery due to her COPD and respiratory conditions.

Two days after meeting with the patient’s family, the patient was admitted to the hospital for shortness of breath. An oncologist examined the patient and made the presumptive diagnosis of breast cancer with possible metastasis to the lungs. The oncologist also noted that the patient was not clinically stable for a needle biopsy.

The patient was discharged to hospice and died within two weeks of her diagnosis. The death certificate lists the primary cause of death as respiratory failure followed by COPD, complex pleural effusion, and breast mass.

**ALLEGATIONS**

Lawsuits were filed against the family physician, his practice, the radiology technician that conducted the tests in 2008, and the hospital where he worked. Allegations included:

- failure to review abnormal ultrasound;
- failure of the radiology technician to notify the physician of the abnormal ultrasound results;
- failure to notify the patient of abnormal ultrasound results; and
- failure to timely diagnose breast cancer.

**LEGAL IMPLICATIONS**

TMLT consultants were critical of the family physician for his oversight of the 2008 ultrasound. Furthermore, because the patient had a palpable lump with a normal mammogram, it would have been reasonable for the physician to request additional studies rather than accept the normal mammogram result.

The physician was also criticized because he continued to see the patient many times between 2008 and 2011, and never discovered the 2008 ultrasound in the patient’s chart. The physician had an aversion to the EHR and relied on staff members to alert him of abnormal test results. In this case, a staff member indexed the reports, but did not notify him directly.

**DISPOSITION**

This case was settled on behalf of the family physician and the practice. The lawsuits against the radiologist and hospital were dismissed based on a legal technicality.

**RISK MANAGEMENT CONSIDERATIONS**

The practice that employed the family physician did not have a written protocol regarding incoming test results. It is recommended that practices adopt a policy to track and ensure that outside tests are reviewed. Any instructions given to a patient need to be documented, with signature and date, in the record. The policy may also require that no test can be “filed” by anyone in the practice until it is properly reviewed.

When test results are initialed and dated by the physician, it is clear the results were reviewed in a timely manner. If the feature is available in the EHR, opt to electronically sign and date lab and diagnostic imaging results. Check with your software vendor to see what features are available for electronic tracking of referrals and testing. It is also appropriate to maintain a paper tracking form or “diary” of tests ordered and when results are received.

A written policy to track referrals, tests, and procedures helps to ensure quality care. A comprehensive policy includes instructions for staff to notify individual patients of test results in a timely manner.

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FAILURE TO USE CORRECT SURGICAL HARDWARE

PRESENTATION
In April 2006, a 68-year-old woman was referred to Orthopedist A for evaluation of right hip pain. The patient reported that the pain had worsened over time since she had fallen in her home a year before. She reported pain with rising, lifting, walking, and standing for long periods of time.

The patient’s history included COPD, obstructive sleep apnea, asthma, allergic rhinitis, diabetes mellitus type II, hyperlipidemia, hypertension, depression, anxiety, plantar fasciitis, and cigarette smoking.
Orthopedist A examined the patient and noted her range of motion as 0 to 90 degrees in flexion, 20 degrees abduction, 10 degrees adduction, 10 degrees internal rotation, and 20 degrees external rotation. Imaging showed severe degenerative arthritis of the right hip, and the orthopedist recommended right total hip arthroplasty. Risks and benefits of the surgery were discussed with the patient, who indicated that she understood the risks and agreed to proceed.

On May 15, 2006, Orthopedist A performed a right total hip arthroplasty on the patient using a 32 mm femoral head component and a 32 mm acetabular cup liner. Postoperative films taken on May 20 showed good anatomic alignment and a stable postoperative hip. The patient was discharged to a rehab facility.

While in rehab, the patient dislocated the hip while bending over to put on a shoe. The patient was returned to surgery, and a partner of Orthopedist A performed a closed reduction of the patient’s right hip arthroplasty. A postoperative x-ray confirmed reduction in the dislocated femoral head prosthesis. The patient was discharged on June 19, 2006.

Two days later, the patient came to the hospital’s ED via EMS with complaints of right hip pain. X-rays confirmed another dislocation of the arthroplasty with the femoral component being displaced both proximally and laterally 6 cm. The ED physician performed a closed reduction of the dislocation. Post procedure x-ray showed the right hip arthroplasty to be in good alignment and position. The patient was discharged home with instructions to follow up with Orthopedist A.

On June 24, 2006, the patient returned to the ED with complaints of right hip pain. X-rays showed interval superolateral dislocation of the component femoral head of the component acetabulum. A closed reduction in the ED was attempted, but unsuccessful. Orthopedist A was contacted.

On June 27, 2006, Orthopedist A returned the patient to surgery and revised the total hip replacing the femoral head with a 36 mm component. The acetabular cup (32 mm) was not replaced. The patient did well post-operatively and was transferred to rehab for extended therapy.

In rehab, the patient suffered an acute myocardial infarction. She was returned to the hospital and taken to the catheterization lab for a left heart catheterization with stenting of the left anterior descending artery and diagonal.

The patient sustained another hip dislocation on July 12, 2006. Orthopedist A attempted a closed reduction, but was not successful. He referred the patient to Orthopedist B.

Orthopedist B revised the hip on August 29, 2006 and determined that the femoral and acetabular cup components were mismatched. Orthopedist B dictated a letter to Orthopedist A informing him of his surgical findings, including: “Mismatch of the acetabular liner (32 mm inner diameter) and femoral head (36 mm diameter).”

That October, the patient dislocated her hip again, and Orthopedist B again performed a revision placing new head and cup components. The patient subsequently suffered a deep seeded wound infection and was placed on an extended course of IV antibiotics.

**ALLEGATIONS**

The patient filed a lawsuit against Orthopedist A. The suit alleged negligence when using mismatched femoral and acetabular components during the June 27 arthroplasty revision.

**LEGAL IMPLICATIONS**

TMLT consultants were critical of Orthopedist A for erroneously using mismatched hardware in his revision of the total hip arthroplasty. One consultant noted that the mismatch would continue to cause recurrent dislocation, even though dislocations were occurring with this patient before the revision of June 27.

The plaintiff’s expert argued that Orthopedist A violated the standard of care when using the mismatched hardware and not visually observing the mismatch during the procedure or on the x-ray. The consultant also noted that he violated the standard of care when he failed to diagnose the mismatch during the operation when he tested the hip for stability. These violations necessitated additional surgeries that produced further impairment, disability, and infection.

**DISPOSITION**

This case was settled on behalf of Orthopedist A, who conceded that he should have replaced both the femoral and acetabular hardware during the June 27 revision.

**RISK MANAGEMENT CONSIDERATIONS**

Ensuring that any items to be used in the surgery—blood products, implants, devices, hardware, or special equipment—are appropriate and correct is the responsibility of the surgeon. To help surgeons and other health care professionals provide safe and effective care, the Joint Commission has established a universal protocol, called the SpeakUP guidelines, for preventing surgical errors.

The guidelines include a pre-surgery checklist with the following line items, among other instructions:
• Identify the items that must be available for the procedure.
• Use a standardized list to verify the availability of items for the procedure. (It is not necessary to document that the list was used for each patient.) At a minimum, these items include:
  • relevant documentation;
  • labeled diagnostic and radiology test results that are properly displayed; and
  • any required blood products, implants, devices, special equipment.
• Match the items that are to be available in the procedure area to the patient.¹

SOURCE

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