SHOULD YOU GOOGLE YOUR PATIENTS?

2.5 CME CREDIT ACTIVITY: TMLT’S CLOSED CLAIMS: COMMUNICATION ERRORS

TMLT 2016 SCHOLARSHIP: WINNING ESSAY

SPECIAL ISSUE: INCLUDES 2.5 CME CREDIT ACTIVITY
In 2016, many of us live our lives in a virtual space. From Facebook to Twitter to Google, we are becoming more and more accustomed to providing and seeking information online — and that extends to health care.

Surveys suggest that the majority of patients go online first to find information about symptoms, treatments, and
support, and they often arrive at their physician’s office armed with a list of possible diagnoses and treatment options. According to a 2013 Pew Research Center survey, 1 in 3 U.S. adults have gone online to diagnose their medical condition.1

In addition, patients routinely visit sites such as RateMDs.com, HealthGrades.com, and Vitals.com to write and read reviews of their physicians. Patients often make decisions on which physician to choose based on such criteria as location, what types of insurance they accept, languages spoken, or how other reviewers were treated by the receptionist.

Patients may also simply conduct a Google search on a physician to get an idea of who the physician is or if ratings of the physician can be found online. The practice of looking something—or someone—up online is so commonplace that “Google” is now officially a verb in the Oxford English Dictionary.

But what about the online habits of physicians? Health care professionals are not immune to the lure of social media or the ubiquity of Google. Current medical students have come of age on the Internet and, like most, turn to the Internet to find answers to questions both big and small.

But what happens when physicians find themselves turning to the Internet to answer questions about their patients? The term “patient-targeted Googling,” or PTG, has been coined in recent years to describe physicians conducting online searches of their patients, and the incidence of PTG is on the rise. But should professional standards and privacy issues prevent physicians from conducting PTG?

“Knowing more about my patients as people helps build empathy,” writes Haider Javed Warraich, MD, in his New York Times article, “When Doctors ‘Google’ Their Patients.” Dr. Warraich reports that Google provided him with information that did not come up in his typical patient interactions, such as learning one of his patients was a former Olympic athlete and gold medalist.

But Dr. Warraich is quick to point out that, while he feels that his generation (newer-to-practice physicians) is more apt to conduct an online search of a patient, it surprises him “that more physicians don’t pause and think about what it means for the patient-doctor relationship.” 2

Dr. Warraich recounts a story of how he was once caring for a frail, older woman who came to the hospital feeling short of breath. A drug screen was ordered to rule out accidental ingestions, and it came back positive for cocaine. The patient insisted that she had no idea why cocaine was in her system.

A quick Google search found the patient’s mug shot online with details about how she had been detained for cocaine possession 30 years earlier. In making that discovery, Dr. Warraich felt as though he violated the patient’s privacy and compromised the patient’s trust.

Dr. Warraich concludes that he believes the only legitimate reason to conduct a Google search on a patient is if there is concern for the patient’s safety, for example, if the patient is suicidal or if there is evidence of abuse. Looking for evidence online might indicate answers to some difficult questions, “but if the only reason a doctor searches online is to gather personal information that patients don’t want to share with their physicians, then it’s absolutely the wrong thing to do.” 2

However, another commonly cited case illustrates how PTG may be ethically appropriate. In this case, a young woman came to a physician requesting bilateral prophylactic mastectomy due to her considerable family history of breast, ovarian, and esophageal cancer. The patient also claimed to have recently had a melanoma removed, but the pathology report only documented the removal of a non-cancerous, atypical mole. The patient’s family history of cancer could not be verified, and there was no evidence that genetic testing had been performed.

When the physician began contacting the patient’s previous health care providers, he discovered that the patient had gone to two other facilities with the same request. Due to inconsistencies in the personal and family history provided by the patient, the physician Googled the patient and discovered that she was presenting a “cancer survivor” story at conferences; giving newspaper interviews; and blogging about her experience with cancer treatment. The patient was also raising money online to attend a national cancer conference.

As a result of his online search, the physician told the patient he felt uncomfortable providing treatment in the absence of formal genetic and psychological testing. The patient failed to return all of the physician’s subsequent calls.3

So, when is it ethical to conduct a Google search of a patient? Researchers at Penn State University call upon professional medical societies to revise their Internet guidelines to address when it is appropriate to conduct an online search of a patient and when it is not. Neither the American Medical Association (AMA) nor the Federation of State Medical Boards fully address PTG.

Without specific guidelines, these researchers point out “physicians are left to navigate this ‘Google blind spot’ independently, and to decipher on a case-by-case basis where the boundary of professionalism lies with regard to patient-targeted Googling.” 3

With regard to future guidelines, these researchers propose the following 10 situations or scenarios that may justify patient-targeted Googling:

1. The patient is suicidal or if there is evidence of abuse.
2. The patient is a former Olympic athlete and gold medalist.
3. When the physician begins contacting the patient’s previous health care providers, he discovered that the patient had gone to two other facilities with the same request.
4. Due to inconsistencies in the personal and family history provided by the patient, the physician Googled the patient and discovered that she was presenting a “cancer survivor” story at conferences; giving newspaper interviews; and blogging about her experience with cancer treatment.
5. The patient was also raising money online to attend a national cancer conference.
6. As a result of his online search, the physician told the patient he felt uncomfortable providing treatment in the absence of formal genetic and psychological testing.
7. The patient failed to return all of the physician’s subsequent calls.
8. So, when is it ethical to conduct a Google search of a patient?
9. Researchers at Penn State University call upon professional medical societies to revise their Internet guidelines to address when it is appropriate to conduct an online search of a patient and when it is not.
10. Neither the American Medical Association (AMA) nor the Federation of State Medical Boards fully address PTG.
duty to re-contact/warn patient of possible harm;
evidence of doctor shopping, or visiting different
doctors until a desired outcome is acquired;
evasive responses to logical clinical questions;
claims in a patient’s personal or family history that
seem improbable;
discrepancies between a patient’s verbal history and
clinical documentation;
levels of urgency/aggressiveness are not justified by
clinical assessment;
receipt of discrediting information from other
reliable health professionals that calls the patient’s
story into question;
inconsistent statements by the patient, or between a
patient and their family members;
suspicions regarding physical and/or substance
abuse; and
concerns regarding suicide risk.3

Going even further, the American College of Physicians
and the Federation of State Medical Boards have drafted
a position paper to provide recommendations about
professional conduct for physicians online. The paper
includes when physicians need to create clear boundaries
with patients in regard to online interactions, and
physicians’ use of public sites to post their own personal
information.

In the section, “The Patient-Physician Relationship: To
Friend (and Google) or Not to Friend (and Google),” the
authors warn that although anecdotal reports suggest some
benefits to PTG (for example, intervening when a patient is
blogging about suicide), “real potential exists for blurring
professional and personal boundaries. Digitally tracking
the personal behaviors of patients, such as determining
whether they have indeed quit smoking or are maintaining
a healthy diet, may threaten the trust needed for a strong
patient-physician relationship.”

The paper encourages physicians to “consider the intent
of the search, whether it affects continuing therapy for the
patient, and how to appropriately document findings with
implications for ongoing care.”4

The implications of PTG are numerous. While the most
troubling implication is a physician’s disregard for
patient privacy, PTG also suggests that communication
and trust have broken down between physician and
patient. If a physician believes that a patient is not being
straightforward with clinically important matter, it may be
more productive to ask the patient in person in a clinical
setting.

ADDITIONAL READING
• “Social media for physicians,” the Reporter,
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Reporter/2013_Volume2.pdf
• “Online reputation for physicians,” TMLT
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tmlt-resources/newscner/blog/2013/Online-
reputation-management-for-physicians.html.
• “Saving face: Facebook for physicians,” TMLT
website. Available at https://www.tmlt.org/tmlt/
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for-physicians.html.

SOURCES
Available at http://www.pewinternet.org/2013/01/15/health-
online-2013/.
com/2014/01/06/when-doctors-google-their-patients-2/?r=1.
Blind Spot: An Emerging Need for Professional Guidelines
to Address Patient-Targeted Googling.” Springer Link.
September 17, 2014. Available at http://link.springer.com/
article/10.1007%2Fs11606-014-3030-7.
Professionalism: Patient and Public Relationships: Policy
Statement From the American College of Physicians and the
Federation of State Medical Boards.” Annals of Internal Medicine.
April 16, 2013. Available at http://annals.org/aim/article/1675927/
online-medical-professionalism-patient-public-relationships-
policy-statement-from-american.

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TMLT’S CLOSED CLAIMS:
COMMUNICATION ERRORS

Since 2000, Texas Medical Liability Trust (TMLT) has published closed claim studies, based on actual TMLT malpractice claims, to promote opportunities for learning. These studies are provided to help physicians and other health care professionals improve patient safety and reduce potential liability risks.

In most professions, communication errors can have serious consequences, from tarnished reputations to lost revenue. But in health care, communication errors take on greater consequences, including loss of life. Errors in diagnosis, medication, or treatment can often be traced to miscommunication, misunderstanding, or a lack of communication between physician and patient, or between physician and physician. Avoiding or effectively managing communication errors is a crucial component of risk management for all health care professionals.

The closed claim studies published in this article contain errors in communication, such as failing to inform or follow up; making medication errors; or failing to create or maintain accurate documentation. Each case describes how actions or inactions on the part of physicians led to allegations of professional liability, and how risk management practices may have either prevented the outcome or increased the likelihood of successfully defending the physician.

These closed claims are designed to protect the identities of patients and physicians involved in any given claim. For example, names have been removed, dates have been changed, and other potentially identifiable elements altered. Again, these claims are presented solely to emphasize the issues of the case and present physicians with an opportunity to learn.
2.5 CME CREDITS

OBJECTIVES
Upon completion of this course, the physician will be able to:
1. describe the importance of good communication between providers for continued patient care;
2. summarize the physician’s responsibility for following up on test results and describe a process for ensuring receipt of all patient reports;
3. discuss why it’s important to educate patients and verify patient understanding of treatment options before making informed consent decisions; and
4. list the requirements for adequate patient records, as described by the Texas Administrative Code.

TARGET AUDIENCE
This 2.5-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for medical liability.

CME CREDIT STATEMENT
Physicians are required to complete and pass a test following a CME activity in order to earn CME credit. A passing score of 70% or better earns the physician 2.5 CME credits.

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. TMLT designates this enduring material for a maximum of 2.5 AMA PRA Category 1 Credits.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PRICING
The following fee will be charged when accessing this CME course online at http://tmlt.inreachce.com.  
Policyholders: $25  
Non-policyholders: $100

ETHICS CREDIT STATEMENT
This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

CME DISCOUNT
TMLT policyholders who complete this program may earn a 3% discount that will be applied to their next eligible policy period.

INSTRUCTIONS
CME test and evaluation forms must be completed online. After reading the article, go to http://tmlt.inreachce.com. Log in using your myTMLT account information to take the course. Follow the online instructions to complete the forms and download your certificate. To create a myTMLT account, please follow the on-screen instructions. Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY
It should take approximately 2.5 hours to read this article and complete the test questions and evaluation form.

RELEASE/REVIEW DATE
This activity is released on November 1, 2016, and will expire on November 1, 2019.

DISCLOSURE
The authors of this course have no commercial affiliations/interests to disclose related to this activity. TMLT staff, planners, and reviewers have no commercial affiliations/interests to disclose related to this activity.

FINDING TO INFORM OR FOLLOW UP 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 not 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 did not return 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.

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. He underwent surgery and chemotherapy, and the PMP has not recurred. However, the patient tested positive for signet ring cells intraoperatively, which signaled 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 TMLT 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 before 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**

This case was taken to trial and the jury returned a verdict in favor of the plaintiffs. They assigned 35% of the negligence to the gastroenterologist and 65% to the surgeon. The defense team for the gastroenterologist planned to appeal the verdict. However, a settlement was reached during post-verdict mediation.

**Risk management considerations**

Comprehensive communication and documentation is the foundation for effective physician-patient and physician-physician relationships. 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 continuity of care should be clearly understood. If a patient is not an active participant in his or her medical care, it may be caused by lack of understanding, reluctance to ask for clarification, or fear of the unknown. Physicians are expected to educate patients and verify their understanding of the necessary information to make informed decisions.

Was the patient truthful about the disclosure of PMP? Due to lack of documentation, the answer to that question is unclear. Medical records need to represent an accurate chronology of patient care and communication, eliminating the potential for these types of “he-said, she-said” allegations.

**FAILURE TO FOLLOW UP AND COMMUNICATE**

**Presentation**
On December 16, a 39-year-old woman came to her family physician for treatment of left shoulder pain. The pain had been present for two weeks.

**Physician action**
The family physician ordered an MRI and gave the patient an injection of methylprednisolone and lidocaine. The MRI was completed at an imaging facility on January 14.

On January 24, the patient returned to her family physician, reporting continued joint and bone pain, particularly in the lower back. She was given another injection of methylprednisolone and lidocaine.

According to the patient, the family physician did not discuss the results of the MRI, even after she asked him for the results. She later testified that she assumed the MRI did not find anything, since the family physician did not discuss it after he said he would check on it.

The patient returned to the family physician on June 4, reporting continued bone and joint pain and a scalp lesion. A series of radiographic and imaging tests were ordered and performed at the same imaging facility. At this point, facility staff realized that the MRI study performed in January had not been interpreted or reported.

The January MRI was interpreted and it was reported to the family physician that the study demonstrated marrow signal abnormalities. The abnormalities involved the coracoid process and glenoid cavities, consistent with a variety of diagnoses including metastatic disease and subacromial and subdeltoid bursitis.

The repeat imaging in June led to a diagnosis of widespread metastatic angiosarcoma that showed metastatic disease had replaced the coracoid process and glenoid cavity when compared to the January MRI. Imaging also demonstrated lesions of the scapula, ribs, and proximal left humerus, as well as widespread bony metastatic disease encroaching on the spinal canal with multiple liver lesions.
The patient was referred to an oncologist and was treated with chemotherapy and radiation therapy. Her back pain was due to multiple fractures in the lumbar spine and sacrum, which compressed the spinal cord and nerve roots. The patient underwent L3 cementing to stabilize the collapsed vertebrae. After six weeks in a wheelchair, she was able to walk.

The patient died 11 months after she was diagnosed with angiosarcoma.

**Allegations**
The patient’s family filed a lawsuit against the family physician, alleging failure to follow up on the January imaging study. The radiologist who owned the imaging facility was also sued for failure to timely interpret and report on the imaging study. The plaintiffs claimed that the patient may have lived longer and had a less difficult course of treatment had her cancer been diagnosed and treated earlier.

**Legal implications**
The defense was unable to find expert support for the family physician. All who reviewed this case stated that if a physician orders a study, it is the physician’s responsibility to obtain the results. The defendant family physician had no explanation about why he did not seek the results of the January MRI, and admitted that it “fell through the cracks.”

The radiologist who owned the imaging center stated it was a technician’s duty to ensure studies were reviewed and a report written. The technician testified that he reviewed the picture archiving and communication system (PACS) the day after the study. A radiologist had opened the study, but closed it since that radiologist only read pediatric cases. That radiologist also inadvertently checked off that a report had been written, which explained why the technician dismissed the study as complete.

As a result of this case, the radiologist who owned the imaging center changed the PACS and added a redundancy in reporting procedures to prevent this type of error from happening again.

The plaintiff’s medical experts and the patient’s treating oncologist testified that, although the cancer would have eventually caused the patient’s death, had she obtained treatment five months earlier, her pain and deterioration would have been reduced. This would have allowed her to be more comfortable and resulted in a higher quality of life. An earlier diagnosis would have prevented her spine from collapsing, thereby avoiding surgery and reducing the time she spent in a wheelchair.

**Disposition**
This case was settled on behalf of the radiologist and the family physician.

**Risk management considerations**
Providing quality patient care with an emphasis on patient safety and a decrease in medical errors should be the objective of all practice venues. Radiology practices need to develop and implement processes for timely dictation and transcription of findings and protocols whereby abnormal results are communicated to the ordering physician. Likewise, the family physician who ordered the MRI had a responsibility to establish a follow-up process for tests to ensure that results are received and reported to the patient. Implementing follow-up processes in each practice decreases the opportunity for medical errors.

**FAILURE TO ACCURATELY DOCUMENT AND ORALLY COMMUNICATE**

**Presentation**
A 70-year-old woman with a history of hypertension, hyperlipidemia, and atrial fibrillation came to the ED of a large hospital with a left front scalp laceration. The patient sustained the injury after falling in her home due to a syncopal episode. The on-call emergency medicine physician noted that the patient’s pulse was irregular, and an EKG showed new onset atrial fibrillation. CT scans of the patient’s head were ordered.

**Physician action**
A hospital radiologist reviewed the CT scan, and identified a left frontal scalp hematoma and a 4 mm right frontal subdural hematoma with no mass effect. This information was documented in the body of the radiology report. The patient sustained the injury after falling in her home due to a syncopal episode. The on-call emergency medicine physician noted that the patient’s pulse was irregular, and an EKG showed new onset atrial fibrillation. CT scans of the patient’s head were ordered.

The emergency physician received the report and read the “Impression” section, which reflected a subcutaneous hematoma. The patient was admitted to the hospital with a diagnosis of syncope due to atrial fibrillation. The admission note indicated that the CT scan showed a “thin, right-sided frontal subcutaneous hematoma” with no mention of subdural blood.

The laceration was closed with primary sutures in the ED. A carotid ultrasound was performed and found negative. To treat her atrial fibrillation, the patient was given enoxaparin sodium and warfarin by a hospital cardiologist.

The patient continued to do well for the next two days. The morning of the third day, the patient complained of a headache, followed by nausea and vomiting. The patient was given ondansetron. The patient then experienced a decreased level of consciousness and an increase in blood
pressure. The responding physician ordered a STAT CT of the head and the patient was transferred to the ICU.

The CT scan showed a substantial increase in size of the right frontal subdural hematoma with acute and sub-acute features, measuring 18 mm in thickness with a 6 mm midline shift from right to left, and early uncal herniation.

The patient became semi-comatose with unequal and fixed pupils. The patient aspirated and was intubated. The anticoagulation medications were discontinued. Mannitol, vitamin K, and fresh frozen plasma (FFP) were given to the patient.

A neurosurgeon performed a right frontoparietal craniotomy for evacuation of the subdural hematoma. Excessive bleeding from the scalp occurred, and four more units of FFP were administered. A right frontal brain contusion was also noted. A subdural drain was placed. Estimated blood loss was more than 500 ml.

The patient’s neurological status improved. A few days later she suffered one or more ischemic infarctions, possibly embolic in nature, that caused her condition to deteriorate. The patient also developed renal insufficiency. She was later moved to a skilled nursing facility.

The patient eventually returned home in stable condition, after lengthy stays at the skilled nursing facility and a rehabilitation facility. She continued to experience mild neurocognitive impairment, depression, dizziness, fatigue, weakness, and headaches.

Allegations
A lawsuit was filed against the radiologist alleging:

- failure to create an accurate radiology report; and
- failure to orally communicate the presence of a subdural hematoma to treating physicians.

It was further alleged that these failures to communicate resulted in inappropriately aggressive anticoagulation therapy, which led to the expansion of the subdural hematoma, subsequent neurological decline, and permanent impairments.

Legal implications
Three consultants for TMLT felt the radiologist breached the standard of care by 1) not documenting the subdural hematoma in the “Impression” section of the radiology report, and 2) not orally notifying the ED of this significant finding. A subcutaneous hematoma is non-life-threatening as opposed to a subdural hematoma, which indicates intracranial bleeding that requires close monitoring.

Because the ED physicians were unaware of the subdural hematoma, they administered anticoagulants to treat the patient’s atrial fibrillation. Anticoagulation was contraindicated with subdural hematoma and may have increased the size of the hematoma. However, two of the consultants pointed out that it was not possible to confirm that the anticoagulation caused the enlarging hematoma and subsequent complications. One of the consultants also pointed out that the ischemic infarctions suffered by the patient were more likely related to the patient’s atrial fibrillation as opposed to the subdural hematoma.

The radiologist believed that the hospital’s voice recognition transcription system caused the error in the CT scan radiology report, leading to an incorrect dictation entry in the “Impression” field. The radiologist admitted that he did not catch the error when he proofread the report.

These admissions led the plaintiff’s attorney to claim that the radiologist negligently failed to inform the hospital administration about problems with the voice recognition transcription equipment. In addition, the attorney intended to use American College of Radiology (ACR) guidelines and the hospital’s own written policy on communicating urgent findings to strengthen the allegations.

Disposition
The case was settled on behalf of the radiologist.

Risk management considerations
It is the responsibility of the physician to proofread the report or entry he or she is creating. Although time consuming, it is important to check that the patient information is accurate and conveys the intended message. In this case, placing “subdural hematoma” in the “Impression” section of the radiology report may have saved a succession of assumptions and errors. If the physician is aware of problems with the voice recognition transcription equipment, timely notification to the facility’s administration is vital and proofreading all the more essential.

An ACR guideline states that findings that suggest a need for immediate or urgent intervention include “Findings that the interpreting physician reasonably believes may be seriously adverse to the patient’s health and may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome.” It is impossible to determine how the outcome of this case would have been altered had this guideline been followed.

However, the subsequent physicians had the correct information in the body of the report had they taken the time to read beyond the “Impression” section. It is a good practice to read the full report.
2.5 CME CREDITS

FAILURE TO COMMUNICATE EMERGENT FINDINGS

Presentation
A 42-year-old man who was 5’11” in height and weighed more than 426 pounds underwent Roux-en-Y gastric bypass surgery. His history included severe obstructive sleep apnea, continuous positive airway pressure (CPAP) treatment, and a family history of heart disease.

Physician action
A bariatric surgeon performed the Roux-en-Y procedure without complication, and the patient was transferred to the ICU. Two days later, the nurses noted that the patient exhibited signs of difficult breathing. The patient was not using a CPAP. When notified, the surgeon was concerned that the patient may have congestive heart failure (CHF) or a collapsed lung exacerbated by the abdominal binder being too tight. The surgeon ordered the binder removed and a chest x-ray.

A radiologist, the defendant, interpreted the chest x-ray, via teleradiology. The radiologist’s findings included atelectasis, infiltrates with pleural effusions, vascular congestion with possible CHF, and radiolucencies identified at the lung apices that raised the possibility of pneumothorax. The radiologist indicated that he sent the preliminary report via teleradiology. The hospital claimed that they did not receive the report. In addition, the transcription company had no record of the report. There was no documentation that the radiologist notified the referring physician.

The following day, the patient’s condition worsened. The patient had decreased oxygenation and was experiencing chest pain. The nursing staff noted audible rales in the lungs. The surgeon evaluated the patient and felt that his breathing had improved. Later that day, a nephrologist consulted the patient and noted that the patient was less short of breath with scattered rhonchi present in the lungs. The nephrologist ordered a chest x-ray that was interpreted by the radiologist via teleradiology.

The radiologist reported low lung volume; bilateral interstitial prominence suggestive of vascular congestion; CHF with possible bibasilar small pleural effusions; bilateral perihilar and basilar markings with mid-to-lower lung field; diffuse hazy densities, greater on the right than the left; atelectasis; and infiltrates. He noted small radiolucencies over the lower neck and chest bilaterally that were suspicious for subcutaneous emphysema and pneumomediastinum. The radiologist noted that he sent a preliminary report. No report was found in the medical record, and there was no indication that the radiologist notified the ordering physicians.

Due to the patient’s worsening condition, several lab studies and tests were ordered. The nephrologist ordered a CT scan of the patient’s chest. The patient requested to ride in a wheelchair instead of a gurney to the radiology department and was accompanied by a respiratory therapist. The patient was not connected to a monitor to check his blood pressure, heart rhythm, or oxygen saturation. The CT scan was performed.

While the patient was being assisted back into the wheelchair he collapsed and slid to the floor and went into cardiac arrest. A code was called and an ED physician arrived and intubated the patient. Efforts were made to revive the patient but he did not survive. The family was present during resuscitation efforts.

The radiologist read the CT scan after the patient’s death. He reported large 38–40% right-sided pneumothorax with large right pleural effusions and shift of the mediastinal structure on the left suggestive of tension pneumothorax. The notes indicated that the radiologist notified the physicians immediately after his interpretation. The autopsy performed on the patient revealed a large right spontaneous tension pneumothorax with mediastinal shift along with an acute pleuritis on the right side.

Allegations
A lawsuit was filed against the radiologist alleging the following:

- failure to properly interpret the chest x-rays;
- failure to properly and timely communicate chest x-ray findings to the treating physicians; and
- failure to recognize the chest x-rays contained findings that required emergent treatment and emergent communication to the treating physicians.

The surgeon, the nephrologist, and the hospital were all named in the lawsuit.

Legal implications
Radiologists who reviewed the case were unable to support the defendant’s actions. They agreed that the defendant should have immediately notified the treating physicians after reading the chest x-rays indicating a possible pneumothorax. Had he done so, timely and reasonable treatment could have been initiated. The consultants also stated that the defendant’s handwritten chest x-ray report was too vague and did not contain any definitive findings.

Disposition
The case against the radiologist was settled during mediation. The hospital and the co-defendant physicians also contributed to the settlement.

Risk management considerations
While some culpability existed on the part of the physicians for not following up on the imaging studies, effective
communication by the radiologist may have altered the outcome of this case. According to the ACR, “in emergent or other nonroutine clinical situations, the interpreting physician should expedite the delivery of a diagnostic imaging report (preliminary or final) in a manner that reasonably ensures timely receipt of the findings. This communication will usually be to the ordering physician/health care provider or his/her designee. When the ordering physician/health care provider cannot be contacted expeditiously, it may be appropriate to convey results directly to the patient, depending upon the nature of the imaging findings.”  

Documenting discussions with the referring physicians assures accuracy regarding the event and provides increased defensibility in the event of a bad outcome. Systems and policies should be in place to ensure that abnormal findings are reviewed and acted upon quickly. Consider maintaining a list of critical results that requires some form of direct communication. If a finding is unusual or unexpected, do not assume that the physician will see the results.

Another important factor in this case centered on the quality of the teleradiology system used by the hospital and the radiologist. The radiologist indicated that he sent the reports to the hospital, but the hospital had no record of ever receiving the reports. There was no record of the transcription. Likewise, the transcription company had no record of receiving a report from the radiologist. Written policies and procedures should be in place for monitoring and evaluating the effectiveness of the teleradiology system and include periodic testing to ensure that the system is operating effectively.

MEDICATION ERRORS
Medication error leading to overdose and death

Presentation
On October 13, a 39-year-old man was brought to the ED of a local hospital after he fell from a motorcycle.

Physician action
The ED record indicated that the patient had lost consciousness, but he was alert and neurologically intact when he was examined. The results from CT scans of the head, chest, abdomen, and pelvis were normal. An x-ray of the left shoulder showed a small fracture/dislocation of the acromioclavicular joint.

The patient was given injections of hydromorphone and ondansetron, and an IV line was placed. General Surgeon A admitted the patient for observation at 10 p.m. He ordered hydromorphone and ondansetron as needed.

At 9:29 a.m. on October 14, General Surgeon A discontinued hydromorphone and prescribed hydrocodone as needed. At 10:20 p.m., he added a 50 mcg fentanyl patch to be placed on the back of the patient’s left shoulder and 1-2 mg of morphine as needed. He also prescribed 30 mg of ketorolac by IV.

At 10 a.m. on October 15, General Surgeon B examined the patient and noted normal vital signs. The patient offered no complaints. General Surgeon B stated that the patient could be discharged when he was walking, voiding, tolerating food, drinking water, and when his pain was under control with oral medication. His plan was to prescribe an oral pain medication and a muscle relaxant at discharge. The patient was instructed to follow up with his primary care physician.

The patient was discharged between 1 and 2 p.m. According to General Surgeon B’s instructions, all hospital-prescribed pain medications — including the fentanyl patch — were to be discontinued. Discharge notes indicated the medications were discontinued.

Once the patient left the hospital, the discharge nurse realized she had not removed the fentanyl patch. She immediately contacted the charge nurse and General Surgeon A. Because the patient was supposed to follow up with his primary care physician, General Surgeon A chose not to call the patient about the patch.

Shortly after his discharge, the patient called his primary care physician and reported that he had not been given any pain medication. The primary care physician called General Surgeon A, who said he would see the patient before he went home. However, the patient had already been released and General Surgeon A did not see him.

That afternoon, the primary care physician examined the patient and noted that he was pale, but seemed stable otherwise. He referred him to an orthopedic surgeon for follow up on the shoulder injury. The primary care physician also prescribed hydrocodone/APAP 10/500.

The patient’s wife stated that she slept on the couch that evening because her husband was snoring heavily. At 2 a.m. on October 16, she found him not breathing. She called EMS and the patient was taken to the ED. He could not be resuscitated and died.

An autopsy was performed and the medical examiner described the presence of a fentanyl patch with a serial number on the patient’s posterior shoulder area. The patient had an elevated level of fentanyl and hydrocodone in his blood. He also had diffuse pneumonia consistent with a hypoventilation state. The cause of death was listed as narcotic overdose and pneumonia.
Allegations
A lawsuit was filed against General Surgeon A, alleging negligence in prescribing a fentanyl patch for acute pain in a non-opiate tolerant patient. It was also alleged that the patient should have been contacted once it became clear that he left the hospital with the patch.

The hospital and the patch manufacturer were also sued.

Legal implications
Two general surgeons reviewed this case for the defense. Both stated that the patient should not have been given the patch. Its use was contraindicated in a patient with acute pain unless the patient is opiate tolerant. The reviewers concluded that the order for the patch was below the standard of care.

Of additional concern to the defense was that General Surgeon A did not take any action when he was told that the patch had not been removed. The plaintiffs argued that he should have called the patient and told him to remove the patch.

Lastly, reviewers were critical of General Surgeon A’s poor documentation. It was illegible in many places and he did not document the patient’s history and physical.

Disposition
This case was settled on behalf of General Surgeon A. The hospital and patch manufacturer also settled their cases.

Risk management considerations
While the primary allegation was that the prescribing of the opioid patch fell outside of the standard of care, many other factors made the case difficult to defend.

General Surgeon B ordered all medications, including the opioid patch, be discontinued upon discharge. While the nursing record reflected that all hospital prescribed medications were discontinued, the patch was never actually removed by the nurse. Each medication should be reconciled and reviewed to ensure that “discontinuation” actually occurs before the patient leaves the facility. A patch left on the patient’s body offers a particular challenge, as there is no way to ensure “discontinuation” unless the patient is actually observed during removal of the patch.

When the nurse realized the error, General Surgeon A was notified, but chose not to take action. The safer course would have been to promptly notify the patient and the patient’s primary care physician of the error, advise removal of the patch, and give appropriate warnings. This action, had it been taken and documented, could have changed the outcome of the case — or at least offered a better defense for the physician. Without knowledge of the patient’s opioid patch, the primary care physician prescribed the patient additional opioid pain medications.

General Surgeon A’s poor documentation also presented a challenge to the defense. The record was noted to be illegible, and no history and physical examination were documented in the record.
Patients may be more susceptible to medical errors during the transition of care between inpatient and outpatient settings. Physicians are encouraged to consistently communicate with the outpatient provider, particularly if there is critical information that could affect the patient’s care.

**FAILURE TO MANAGE POSTOPERATIVE PAIN MEDICATIONS**

**Presentation**
A 38-year-old woman came to a neurosurgeon for evaluation of lower back pain and right leg radiculopathy. The patient was referred by a pain management physician, who was treating the patient with a fentanyl patch. The patient’s fentanyl patch dosage was 50 mcg every 48 hours. The patient had a history of fibromyalgia, bipolar disorder, depression, alcohol abuse, cannabis abuse, generalized anxiety disorder, and generalized pain disorder.

At the appointment with the neurosurgeon, the patient provided her list of current medications as duloxetine, sumatriptan, acetaminophen and hydrocodone, amitriptyline, carisoprodol, alprazolam, and sertraline. There was no mention of the fentanyl patch.

The neurosurgeon recommended surgery based on the clinical findings, the results of the MRI, and the patient’s lack of success with conservative treatment.

**Physician action**
The neurosurgeon performed an outpatient minimally invasive transforaminal lumbar interbody fusion at L4-L5-S1, bilateral percutaneous pedicle instrumentation at L4 through S1, left posterior lateral fusion at L4-L5-S1, and left decompressive laminotomy and foraminotomy at L4-L5-S1. The patient experienced wheezing in the recovery room and was treated with albuterol.

At 12:30 p.m., the patient was discharged and given an incentive spirometer. She was advised to take deep breaths at home and use the spirometer frequently. The neurosurgeon prescribed acetaminophen and oxycodone 10/325 mg, two pills every 4 to 6 hours “as needed” with a maximum of eight pills per day, and diazepam 5 mg, every eight hours “as needed.”

At 7:30 p.m. the following day, the patient’s husband called the neurosurgeon’s office to report that the patient was sleepy but arousable and responsive. The patient’s husband had been waking her up to give pain medication, but had not given her anything since 1:30 p.m. He said he was administering the medications as prescribed, except that he had given her alprazolam instead of diazepam. She preferred alprazolam, which she had acquired from a different physician.

The nurse from the neurosurgeon’s office told the patient’s husband not to wake her up to give her pain medication, to monitor her until she became less sedated, and not to give her any pain medication until she was responsive. The nurse also said to take her to the ED if she became less arousable. He indicated he understood the instructions.

The patient’s husband reported that he checked on her every hour, and at 10:30 p.m. he found her not breathing. She was taken to the ED where she later died.

The autopsy and toxicology report indicated the presence of multiple drugs, including amitriptyline, cyclobenzaprine, duloxetine, fentanyl, alprazolam, hydrocodone, and oxycodone. The conclusion was that the patient died as a result of multiple drug toxicity.

**Allegations**
A lawsuit was filed against the neurosurgeon, alleging that he should have had the patient stop using the fentanyl patch postoperatively. This would have allowed the patient’s pain to be safely controlled with oxycodone.

The plaintiffs also alleged the neurosurgeon should have immediately instructed the patient’s husband to take her to the ED when he called with concerns about her sleepiness. They were also critical of the pharmacy for filling the oxycodone when they knew the patient was also using a fentanyl patch.

**Legal implications**
The plaintiffs had a qualified expert who was critical of the neurosurgeon for continuing to use the fentanyl patch during the postoperative period and for not immediately directing the patient’s husband to take her to the ED to make sure she was not overly sedated.

Consultants who reviewed this case for the defense did not support the neurosurgeon’s actions. They stated that the neurosurgeon should have contacted the patient’s pain management physician to discuss the postoperative pain medication. The neurosurgeon prescribed a large dose of oxycodone without knowing the patient had a history of addiction, had signed an opioid agreement with her pain management physician, and had been instructed by her pain management physician to contact his clinic for pain medication after surgery.

However, the patient’s pain management physician stated that if the neurosurgeon had contacted him, he would have approved the oxycodone prescription, but would have advised against prescribing diazepam. He also stated that the patient’s fentanyl patch needed to stay on during and after surgery for continuous pain relief. The pain management physician did not understand how the
Patient’s death could be related to the oxycodone if she had not taken it in the last nine hours before her death.

As evidenced by the pill count collected by the police, there was a question of whether the patient took more medication than was prescribed. The husband claimed he was monitoring her medication, but the patient may have taken medication without his knowledge.

The plaintiff’s attorney indicated he would focus on the phone call between the neurosurgeon’s nurse and the patient’s husband. The husband denied that he described the patient as “arousable,” and that he was told to take her to the ED if her condition worsened.

Disposition
This case was settled on behalf of the neurosurgeon. Though there were defensible elements in this case, the damages associated with the death of a 38-year-old woman led to the decision to settle the case.

Risk Management Considerations
The neurosurgeon’s physician assistant documented a history and physical report six weeks before the surgery. A report dated four weeks later appeared word-for-word in the medical record. The patient was seeing a new pain management physician with a changed pain medication regimen. Accurately updating a medical record benefits the surgeon to best prescribe post-op medications.

Due to dissatisfaction with her current pain management physician, the patient called the neurosurgeon’s office four weeks before surgery for a new pain management referral.

Documenting and following up with referrals can assist in keeping up with new findings and updating a medical record. The new pain management specialist increased the dosage and frequency of the patient’s fentanyl patch. The post-op discharge instructions did not include how the patient was to manage her home medications including the fentanyl patches.

In this case, the neurosurgeon could have safely managed the patient by calling the pain management specialist to discuss the patient’s postoperative pain medication regimen.

**Failure to Manage Medications**

**Presentation**
In December, a 76-year-old woman came to an internist to establish a primary care relationship and to seek treatment for itching. The patient had a history of diabetes, renal failure, and stroke. A month earlier, the patient had undergone a total colectomy with placement of ileostomy for ulcerative colitis. During the hospitalization, she developed portal vein thrombosis.

**Physician Action**
The internist noted that the patient’s vital signs were normal. Lab findings indicated a BUN level of 28 (normal range 7-25); elevated creatinine level of 5.61 (normal range .5-1.2); potassium level of 5.9 (normal range 3.5-5.3); and uric acid level of 9.1 (normal range 2.5-7). The internist also noted that there was no evidence of gout or uric acid nephropathy. There was no documented skin exam or treatment plan to address the itching. Two weeks later, labs were repeated with findings of BUN 47, uric acid 12.4, and creatinine at 3.57.

On January 6, the patient returned to her nephrologist for management of her renal failure. The nephrologist noted stable blood pressure, diminished breath sounds, and no recent urinary tract symptoms. The nephrologist’s impression was that the patient had renal disease and that the acute renal dysfunction was attributed to volume depletion. The nephrologist started the patient on allopurinol 200 mg per day. In correspondence with the internist, the nephrologist explained that the patient had hyperuricemia with uric acid level of 12.4 and no history of gout. The nephrologist attributed the elevated uric acid level to the patient’s volume depletion.

On January 29, the patient returned to the internist. The internist noted that the patient’s uric acid level had decreased to 5.5 and the allopurinol was increased to 300 mg per day. The physical exam results were normal. The internist’s assessment was uncomplicated type 2 diabetes; hypertension; cerebrovascular disease late effects; aphasia; long-term use of anti-coagulants; ulcerative colitis; and stage 4 kidney disease. The internist prescribed pioglitazone.

The patient returned to the internist for a follow-up visit on February 17 with a rash and bruising. During the office visit, the patient’s husband reported that he had discontinued the patient’s anti-coagulation therapy that day due to the patient’s bruising. The medical assistant documented 12 medications and vitamins; allopurinol was not verified during the medication reconciliation.

The physical exam revealed diffuse, mostly confluent, red, slightly raised soft rash over the trunk, arms, legs, neck, and face. Some trace edema bilaterally was noted along with mostly normal cardiovascular, chest, and lungs. The patient was instructed to discontinue pioglitazone; return in one week for follow up; and contact her hematologist for anticoagulation management.

Five days later, the patient came to the ED with complaints of fever, chills, sore throat, and difficulty swallowing. The physical examination noted erythema of the pharynx, dry
and bleeding lips, decreased breath sounds, tachycardia, and skin rash. The clinical impression of the ED physician was Stevens-Johnson Syndrome, acute renal failure, and metabolic acidosis. The patient was admitted to the ICU.

On February 23, the patient’s labs indicated a decrease in white blood cell count. The nurses noted a bright red rash from the ears to the chest and a bright pink rash to the lower legs and feet. The patient was seen by the hospitalist who noted patient allergy to allopurinol.

Over the course of several days in the ICU, the patient showed improvements with her rash, Stevens-Johnson Syndrome, and acute renal failure. On March 1, the hematologist resumed anticoagulation therapy. Two days later, the patient’s temperature increased to 102 degrees. The patient’s fever initially responded to treatment with acetaminophen. However, on March 5, the fever returned and the rash worsened. An infectious disease physician suggested that the worsening condition was due to the Stevens-Johnson Syndrome.

On March 6, a pulmonologist noted that the patient had progressed to toxic epidermal necrolysis (TEN) with 60-70% of her total body surface involved. The family agreed to place the patient on comfort measures only. A DNR order was written and dialysis was withheld. On March 8, she was pronounced dead. No autopsy was requested, and the death certificate listed Stevens-Johnson Syndrome as the cause of death.

**Allegations**
A lawsuit was filed against the internist. Allegations included:

- failure to discuss the allopurinol with the nephrologist;
- failure to review and document the patient’s current medications;
- failure to properly evaluate, assess, and diagnose the cause of the patient’s rash; and
- failure to discontinue the allopurinol.

**Legal implications**
Experts who reviewed this case for the plaintiff felt strongly that had the internist stopped the patient’s use of allopurinol at the February 17 appointment, the patient would have survived. The experts alleged that the internist should have known that it could take 6-8 weeks for some patients to develop an adverse reaction to allopurinol.

Furthermore, the experts indicated that there has never been a documented case of Stevens-Johnson Syndrome caused by pioglitazone. Therefore, the more likely cause of the rash was the allopurinol, and it should have been immediately discontinued. The experts were also critical that the allopurinol was not verified and documented in the patient’s medical record at the February 17 appointment.

Experts for the defense criticized the internist’s documentation of the initial encounter, as there was no record of a skin assessment or treatment plan to address the patient’s itching. They also felt that the one-week follow-up appointment to check if the patient’s rash had resolved should have been scheduled sooner. The experts also described the internist’s care of the patient’s renal failure as “marginal” due to his delays in reviewing laboratory results and not taking action on her worsening kidney function.

**Disposition**
This case was settled on behalf of the internist.

**Risk management considerations**
In one study in the *New England Journal of Medicine*, 63% of potentially remediable adverse drug events were attributed to the physician’s failure to respond to medication-related symptoms. Medication discrepancies can adversely affect patient outcomes. Accurate documentation in the patient’s record of all medications is critical in managing and monitoring adverse drug reactions. Additionally, medications should be reviewed and updated at each visit to monitor compliance and to help prevent adverse drug reactions.

A complete, contemporaneous medical record is the foundation of a successful defense. In this case, documentation by the internist was found to be deficient, which created concerns about the quality of care that the patient received.

**IMPROPER PERFORMANCE**
**Implantation of dorsal column stimulator**

**Presentation**
A 42-year-old woman was injured in a car accident resulting in neck and lower back pain. She came to orthopedic spinal Surgeon A, who performed a cervical fusion that provided relief of her neck pain. She continued to see the surgeon for her lower back pain and was provided conservative treatment (injections) with little effect.

The patient was then referred to an anesthesiologist and pain management specialist for trial placement of a dorsal column stimulator (DCS), which provided effective relief of her lower back pain. The patient was referred back to Surgeon A for permanent placement of a DCS.

**Physician action**
Two weeks later, the patient came to a surgical center for the permanent DCS placement. She signed a consent form for the procedure that listed another surgeon, Surgeon B,
as her physician. Handwritten above Surgeon B's name on the consent form was the name of Surgeon A. The operative report, dictated by Surgeon A, listed Surgeon B as the primary surgeon and Surgeon A as the assistant.

The operative report stated that Surgeon B performed a T8 and T9 laminectomy and placed the laminectomy lead on top of the dura. The patient was admitted to the hospital for an overnight stay and discharged the next day. No complications were reported.

The patient came to Surgeon A's office for a three-week, follow-up visit. It was noted that the stimulator was not active because the patient had not met with the manufacturer representative for programming instructions. She was still suffering from general thoracic pain. No other issues were noted.

Over the next three months, the patient returned for multiple follow-up visits. The stimulator was not working, despite the patient's numerous attempts to program it. At the last visit, Surgeon A noted that the purpose of the visit was to discuss the possible removal of the spinal cord stimulator. He instructed that the patient was to call if she decided to have the stimulator removed and referred her to a pain management physician for long-term narcotic treatment options.

The patient came to another physician, Surgeon C, to obtain a second opinion for her lower back pain. Her exam was consistent with bilateral sacroiliac joint dysfunction. The patient returned to Surgeon C three weeks later; she rated her back and hip pain at a 9 and 10 respectively. Surgeon C believed that the patient's lower back pain was caused by her sacroiliac joint. Within a few days, a bilateral sacroiliac joint block was performed.

After six weeks, the patient returned to Surgeon C's office. It was determined that since she had experienced relief from the bilateral SI injection, her primary source of pain was her SI Joints. Surgeon C established a treatment plan to perform another injection and then an SI joint fusion.

The SI joint fusion was performed six weeks later without complications. The patient experienced relief of her lower back pain, but had persistent pain at the stimulator battery site in her upper back.

**Allegations**
A lawsuit was filed against Surgeon A. The allegations included:

- failure to diagnose the patient's sacroiliac joint as the origin of her pain;
- failure to recommend nonsurgical options; and
- fraudulently misrepresenting the type of surgery required and who would perform it.

**Legal implications**
One defense consultant reported that the patient did not fit the criteria for a dorsal column stimulator. Also, the patient signed a consent form for a laminectomy with a percutaneous spinal cord stimulator thin lead placement. However, a T9-T10 laminectomy with an epidural placement of a paddle lead was performed and documented.

There was confusion about Surgeon A's involvement in the surgery. The patient indicated that she was told Surgeon A would perform her surgery, but on the date of the procedure, another physician appeared and was listed on the consent form. When the patient objected, Surgeon A's name was added to the form, but neither surgeon could specifically recall who did what during the procedure. The implantation was performed by a surgeon, for a procedure to which the patient had not given consent.

**Disposition**
The lawsuit was settled on behalf of Surgeon A.

**Risk management considerations**
Offering the patient alternatives to surgery helps ensure that the patient is fully informed of all treatment options. The office is a conducive setting to conduct the discussion, as the patient is given time to accept an alternative or proceed with surgery. It is recommended that the discussion be documented in the medical record. If the patient chooses to proceed with surgery, a consent form can be signed that includes the primary surgeon's name, the procedure to be performed, and the risks of the procedure.

The operative report is a legal record that should clearly identify the name of the primary surgeon, the assistant surgeon, if appropriate, as well as the correct procedure performed. Accuracy in these areas is an important matter in medical record keeping and helps avoid confusion after pertinent details are forgotten.

**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 transient ischemic attacks (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 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 cerebrovascular accident (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.
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 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 form. 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 diagnosis.

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 was able to find an expert supportive of the radiologist’s diagnosis, but this expert was not perceived as a 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 dismissed.

Risk management considerations
The communication in this case broke down at every level. 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 similar problems 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 may argue that each person in the chain had an opportunity to correct this problem, and no one did.

The carotid ultrasound was not 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 also subject themselves to potential litigation. It should be documented if patients choose not to follow the physician’s recommendations.

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 there is a question, 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 previous diagnosis. Including differential diagnoses and recommending further studies to confirm or rule out each one will help guide the ordering physician to arrive at the correct diagnosis.
SURGERY PERFORMED ON THE WRONG SIDE

Presentation
A 78-year-old woman came to her family physician for treatment of occasional dizziness. She was referred to a cardiologist who ordered an angiogram.

The angiogram revealed the patient had 95-99% stenosis of the right internal carotid artery and 30% on the left. Another study done four days later revealed 80% stenosis of the right internal carotid artery and 30% on the left.

The cardiologist referred the patient to a general surgeon who scheduled the patient for a right carotid thromboendarterectomy.

Physician action
With the patient in the operating room and just before beginning the procedure, the general surgeon reviewed the films in the catheterization lab. He asked the lab technician to pull up the patient’s films on the computer. After reviewing them, the general surgeon noted that there was significant stenosis on the left side. He returned to the operating room and told the patient the problem was on her left side.

According to hospital records, the patient told the general surgeon that she believed the surgery was to be on her right side. However, he told her it was on the left. He spoke with her family and obtained a new consent for the left side.

After he started the surgery, a nurse came in and told him to stop the procedure because he was operating on the wrong side. She told him that the films he reviewed were those of a different patient. Since the patient had some stenosis on the left, the general surgeon proceeded with surgery on the left side.

While in the PACU, the patient was found to have weakness in her right arm. The surgeon took the patient back to surgery and found a clot at the entrance of the left internal carotid artery. The clot was removed and a left carotid Hemashield patch was placed.

A CT scan done the next day revealed an acute to subacute evolving stroke in the left middle cerebral arterial distribution involving the superior left frontal lobe and parietal lobe.

The patient was transferred to the ICU. After a 14-day hospitalization, she was transferred to a rehab facility for physical, occupational, and speech therapy. She has severe right hemiparesis, sensory deficits, expressive aphasia, and difficulty swallowing.

Allegations
A lawsuit was filed against the general surgeon, alleging that he disregarded his preoperative plan, the preoperative diagnostic test, the cardiology referral, the statements from the patient and her family, and the request of the nurse to stop the procedure.

Legal implications
Two consultants reviewed this case and were critical of the surgeon for operating on the wrong side. They stated there was no indication for operating on the left carotid artery and that the patient’s entire cerebral circulation was compromised by not operating on the most diseased side. This led to the stroke.

The consultants also criticized the surgeon for giving 3,000 units of heparin instead of 6,000 (based on the patient’s weight) and for the timing of the shunt placement. They also stated that a patch should not have been used for arterial repair. They believed this contributed to the postoperative thrombosis.

The plaintiffs identified a qualified expert whose opinions matched those of the consultants. The hospital also criticized the surgeon, and the surgeon criticized the hospital and the hospital lab technician.

Disposition
This case was settled on behalf of the general surgeon. The non-supportive consultant reviews and finger pointing between the hospital and surgeon led to the decision to settle the case.

Risk management considerations
In spite of protocols that exist—to identify the correct patient, mark the operative site, and conduct a time out—wrong site surgeries continue to occur. The surgeon had an opportunity to review the angiogram findings after being questioned by the patient and the patient’s family, and receiving the updated report from a nurse.

Identifying the correct patient when reviewing films preoperatively ensures the precise surgical site is marked and assists in preventing an irreversible event. Also, active communication among all members of the surgical team assists in creating the intended patient outcome.

FAILURE TO DIAGNOSE CORNUAL PREGNANCY

Presentation
A 33-year-old woman came to the ED complaining of bilateral abdominal pain, back pain, and shortness of breath. She reported that she was nine to ten 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 ED 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.

The patient 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 documented 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 did not request 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 initiated. She was sent to the OR for an emergency laparotomy due to a 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 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. 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.

TMLT 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 second 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 consult. A pelvic exam would have yielded additional information to make the diagnosis. An OB 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 OB 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 significant 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 documented that the radiologist reported a “normal intrauterine pregnancy,” 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 patient 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
Communication issues, both written and oral, influenced the outcome of this claim. Had the first radiologist followed up his phone call with a timely, dictated report to the ED physician, the findings of the initial ultrasound may have been clarified. Are there protocols in place to determine when the on-call radiologist comes in to the facility?

If a patient refuses to be hospitalized against the physician’s recommendation, include the patient’s refusal for care in the discharge information. This documentation would indicate the physician determined that the patient required further supervision, not that the patient could manage his or her own care at home.

With the second radiologist, timely follow up instructions, including when to contact the patient, may have influenced the outcome. As stated in a previous claim within this CME, ACR has established practice parameters for documenting non-routine communication in the radiology report or department log. Follow-up actions and instructions in the radiology report demonstrate it is part of the radiologist’s plan to provide quality care and ensure that important findings are timely communicated.
The most powerful communication and risk management tool is proper medical record documentation. Creating and maintaining complete and accurate records facilitates greater continuity of care between health care providers and alleviates worry of liability in the event of a claim.

According to the Texas Administrative Code, include the following information in your patient documentation:

1. The documentation of each patient encounter should include:
   a) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   b) an assessment, clinical impression, or diagnosis;
   c) plan for care (including discharge plan if appropriate); and
   d) the date and legible identity of the observer.

2. Past and present diagnoses should be accessible to the treating and/or consulting physician.

3. The rationale for and results of diagnostic and other ancillary services should be included in the medical record.

4. The patient’s progress, including response to treatment, change in diagnosis, and patient’s non-compliance should be documented.

5. Relevant risk factors should be identified.

6. The written plan for care should include when appropriate:
   a) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
   b) any referrals and consultations;
   c) patient/family education; and
   d) specific instructions for follow up.

7. Include any written consents for treatment or surgery requested from the patient/family by the physician.

8. Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

9. Billing codes, including CPT and ICD-10-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.

10. All non-biographical populated fields, contained in a patient’s electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics or assessments as documented by the physician.

11. Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

12. Salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient’s medical records.

13. The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient’s status. Paragraphs (1) - (12) of this subsection may be modified to account for these variable circumstances in providing medical care.

This section of the code also includes information about the maintenance of medical records, including how long physicians must keep patient records and the conditions for transferring ownership of records to another physician.
Presentation
A 72-year-old woman was referred by her primary care physician to a gastroenterologist for evaluation of right lower quadrant abdominal pain.

Physician action
The gastroenterologist performed a colonoscopy that revealed a 3 mm sessile polyp in the sigmoid colon and a 25 mm pedunculated polyp in the recto-sigmoid colon. Both polyps were removed. The pathology report noted that the specimen labeled “sigmoid colon polyp” demonstrated villous adenoma with focal areas of high-grade dysplasia.

Two weeks later, the gastroenterologist performed a flexible sigmoidoscopy and partially resected a 30 mm polyp in the sigmoid colon with a hot snare. This polyp, labeled as “rectum hot snare,” was biopsied and interpreted as invasive well/moderately differentiated adenocarcinoma arising from a pre-existing villous adenoma.

During an office visit a month later, the gastroenterologist handwrote that the patient’s chief complaint was “rectal CA” with a further handwritten note stating “F/U Rectal CA.” However, his handwritten impression was “colon cancer.” The patient was told that she had sigmoid colon cancer, and a referral was made to a general surgeon.

The next day, the general surgeon saw the patient and noted a history of a mass in the sigmoid colon and that she was referred to him for a colon resection. The records sent from the gastroenterologist included the colonoscopy report, a handwritten impression of colon cancer, and the pathologist’s report from the sigmoidoscopy. The surgeon diagnosed the patient’s condition as sigmoid colon cancer. He planned a laparoscopic sigmoid resection, after cardiac clearance and CT scan.

Four days later, the patient underwent an abdominal CT scan that revealed “nonspecific irregular wall thickening in the right lateral aspect of the rectum, adherent stool versus infiltrating mass.”

Three days later, the patient was admitted for a sigmoid colon resection. During the surgery, the surgeon noted there was nothing in the sigmoid colon specimen. He then performed a rigid protoscope and found the tumor in the rectum. He tried to perform a rectal resection, but was unable to take it as low as he needed. Believing the patient needed an abdominoperineal resection, he placed a colostomy and deferred further surgery until he could talk with the patient. The surgeon also believed she would benefit from chemo-radiation therapy, which would allow him to preserve her sphincter complex.

The pathology report showed the sigmoid colon segment was negative for dysplasia, malignancy, or metastatic disease. The rectum segment was also negative for metastatic disease. The patient was treated for a wound infection and then underwent chemotherapy and radiation therapy.

Four months later, the patient was admitted for surgery, and the surgeon was able to further resect her rectum. The surgeon then performed a diverting ileostomy.

The rectum specimen revealed a poorly differentiated, high-grade adenocarcinoma with therapy effect.

Five months later, the surgeon took down the patient’s ileostomy and repaired the incisional hernia. A second incisional hernia repair was performed nine months later.

Allegations
A lawsuit was filed against the gastroenterologist. The allegations included:

- failure to properly work up the patient for her condition before recommending colon surgery;
- failure to properly perform and interpret colonoscopy procedures;
- failure to properly interpret the pathology report that stated cancer was found from a rectal biopsy; and
- improperly informing the patient and surgeon that the patient had sigmoid colon cancer.

A lawsuit was also filed against the surgeon. The allegations included:

- failure to properly interpret the pathology report stating cancer from a rectum biopsy;
- failure to properly prepare for surgery, including failure to determine cancer location; and
- failure to properly perform surgery.

Legal implications
The plaintiff’s experts testified that the gastroenterologist breached the standard of care by mistakenly citing the location of the tumor in the colon when referring the patient to the surgeon. Plaintiff experts also testified that the surgeon breached the standard of care by failing to confirm the location of the mass and diagnose rectal cancer prior to the first surgery.

Defense consultants agreed that the weakness of the gastroenterologist’s documentation included varying descriptions of the location of the tumor. The documentation was also described as inaccurate and inconsistent.

Defense consultants were critical of the surgeon for not confirming the location of the mass prior to surgery.
There were indications that the tumor was in the rectum/rectosigmoid colon, rather than more proximal in the colon/sigmoid colon region. However, the surgeon either ignored or failed to notice such indicators as the specimen from the flexible sigmoidoscopy being labeled as “rectum hot snare” or the gastroenterologist’s handwritten note of the patient’s chief complaint as being “rectal cancer.”

The surgeon testified that the CT scan was performed without bowel prep, thus he believed the thickening to be retained stool. He also stated that if he had been given a diagnosis of rectal cancer, he would have performed a rectal exam.

Disposition
Due to the documentation and communication issues, the case was settled on behalf of both physicians.

Risk management considerations
When working up a potential colonic malignancy, it is imperative that all physicians involved clearly document the location of the tumor. This is particularly important when dealing with rectum versus rectosigmoid versus sigmoid colon cancers.

Inadequate communication between the physicians was a key element in this case. Failure to properly communicate can result in conflicting care, ignored recommendations, and delays in addressing medical conditions. It is beneficial for every referring physician to speak directly with the consulting physician to discuss the patient’s history and the expectations for the consultation and to record this in writing.

Adequate and clear documentation can prevent confusion and potentially avoid adverse outcomes. A clear and consistent medical record makes it easier to defend a physician’s actions in the event of a claim. The Texas Medical Board requires that a physician document any communication made or received by the physician regarding a patient, about which the physician makes a medical decision.3 Documenting all physician-patient and physician-physician conversations helps assure the medical record is complete and accurate.

SOURCES

These closed claim studies are based on actual malpractice claims from Texas Medical Liability Trust. These cases illustrate how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcomes or increased the physicians’ defensibility. These studies have been modified to protect the privacy of the physicians and the patients.
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TMLT 2016 SCHOLARSHIP: WINNING ESSAY

Texas Medical Liability Trust (TMLT) is proud to announce Tiffany Chen as the recipient of the 2016 TMLT Scholarship. Ms. Chen is a fourth-year medical student at The University of Texas Health Science Center at San Antonio. She earned her Bachelor of Arts degree in biochemistry and cell biology at Rice University.

“I’m so thrilled to be selected for this honor and generous scholarship,” stated Ms. Chen. “This recognition has given me the encouragement and support to persevere in my medical school endeavors. I strive to one day become a physician who will consistently ensure my patients’ safety and well being.”

The TMLT Scholarship was established to recognize Texas medical students who are interested in finding creative and effective ways to enhance patient safety. TMLT awards one $5,000 scholarship in October. Scholarship recipients are chosen based on the student’s financial need and a written essay.

The TMLT Business Development Committee (BDC) evaluated the applications and chose the recipient. The BDC is made up of TMLT physician policyholders and board members.

For the essay portion, applicants for the scholarship were asked to write risk management considerations for a closed claim study provided by TMLT. The following is the closed claim followed by Ms. Chen’s risk management considerations.
DELAY IN DIAGNOSIS AND TREATMENT
By Laura Brockway, ELS, Assistant Vice President, Marketing

Presentation
A nine-year-old girl was brought to the emergency department (ED) after she injured her left arm while jumping in an inflatable castle.

Physician action
The ED physician ordered an x-ray of the patient’s elbow and interpreted it as negative for fracture. He diagnosed strain/sprain, ordered a sling, and prescribed ibuprofen. The patient was then discharged.

The patient’s father was told about the results of the x-ray and the need to follow up with an orthopedic surgeon. The parents were also instructed to have the patient re-evaluated if her symptoms worsened or persisted. The discharge instructions stated, “if there is any change in the x-ray diagnoses or a positive culture, we will contact you.”

The next day, the x-ray of the patient’s left elbow was over-read by a radiologist. She diagnosed a laterally displaced dorsal radial head fracture and sent her report to the hospital. There was no indication that anyone from the hospital reviewed the radiologist’s report or that anyone from the hospital reported the radiologist’s findings to the child’s parents. The radiologist did not notify the ED of her findings.

Three weeks later, the patient came to her pediatrician and was referred to an orthopedic surgeon. The orthopedic surgeon documented that the patient was unable to fully extend her elbow and had pain with flexion. X-rays revealed a consolidated/healed fracture of the radial neck on the left elbow.

The patient was referred to another orthopedic surgeon. He noted that on the first x-rays the alignment was off 70 degrees and the radial head was sitting completely lateral to the shaft — completely dislocated from the joint. Current x-rays revealed the same findings along with now abundant callus.

The patient underwent an osteotomy to reduce the radial head back into position. Due to incomplete healing, a second procedure was performed. The patient now has 20 degrees supination and no pronation. A CT scan showed “post traumatic deformity of the radial head with fusion of the physis sclerosis and contour deformity.”

Allegations
The patient’s parents filed a lawsuit against the ED physician, the radiologist, and the hospital. The allegations were:

• failure to correctly read the x-rays and diagnose the fracture (ED physician);
• failure to properly communicate the diagnosis of fracture to the ED (radiologist); and
• failure to review the radiology report and advise the patient’s parents of the fracture (hospital).

Legal implications
The plaintiffs obtained credible expert support for their allegations, mainly that the patient suffered permanent impairment and deformity due to the delay in diagnosis and treatment of the left arm fracture.

Regarding the actions of the ED physician, both defense and plaintiff’s experts stated that this was the type of fracture that an ED physician should be able to diagnose. Further, the ED physician had a duty to notify the patient’s family after the radiologist diagnosed and reported the fracture.

During the investigation of this claim, it was discovered that the hospital had a policy that clearly stated ED physicians have a duty to identify discrepancies in x-ray interpretations and to ensure the patient is contacted for proper follow up. This policy was not followed by the ED physician or hospital staff.

Radiologists who reviewed this case had mixed opinions about the actions of the defendant radiologist. Specifically, whether or not she had a duty to contact the ED physician to report the fracture. One radiologist stated that it is not common practice for radiologists to personally contact the ED for “obvious fractures” and that only “subtle fractures” warrant direct contact.

Another radiologist stated the defendant should have contacted the ED physician. “Even though this type of fracture would normally be seen by most emergency room physicians, one cannot assume that this fracture was identified by the emergency room physician.” This reviewer also faulted the hospital for not having a procedure in place for the radiologist to be aware of the ED physician’s initial interpretation, and a procedure for the radiologist to notify the ED of any discrepancy.

Patient accountability was a factor in this case. Had the patient’s parents followed up with an orthopedic surgeon as instructed upon discharge, the fracture may have been discovered and treated earlier.

Disposition
Given the communication issues and the lack of expert support for the defendants, this case was settled on behalf of the ED physician and the radiologist. The hospital also settled their case.
Risk management considerations
The following is written by scholarship recipient Tiffany Chen.

When I first learned about non-maleficence, I could not comprehend why physicians would do anything to harm their patients. Yet, tragic stories such as the presented case made me realize that mistakes of omission are frequently the subtler ways in which maleficence exists in medicine. While such unfortunate situations may occur again, physicians should continuously strive to minimize the risk of harming patients.

Allegations of medical malpractice can be made against those who never meant any harm to their patients, such as in the presented case. By discharging the patient before the radiologist’s report returned, the emergency physician risked the patient’s final results being lost to follow up. When the radiologist did not call the emergency physician with the x-ray results, she risked no one reading her report and informing the family of the correct diagnosis. Lack of communication and follow up turned well-intentioned physicians into subjects of malpractice allegation.

Several risk reduction strategies could be proposed from this case. If I had been the emergency physician, I would have kept the patient in the hospital until Radiology read the x-ray. If the patient load was high or no radiologist could read the film promptly, I would discharge the patient using my best judgment but ensure that I document my radiological interpretation. I would then add the patient to a list and include the reason for follow up. Also, I would make sure I read the radiologist’s report by setting an alert on the EMR that would notify me of unviewed results. Had I made the same misdiagnosis as the emergency physician, I would have apologized to the family for my carelessness while they consulted the other physicians. Mistakes occur, and while verbal apologies cannot undo the physical harm, a sincere admission of wrong could have decreased the chances of medical malpractice allegations being filed.

If I had been a radiologist, I would have first checked for any documentation of a radiological interpretation by the emergency physician so that if there was a discrepancy, I could have notified the emergency physician immediately. If no documentation was available, I would deem the patient’s case “unresolved” and add it to a personal list of those to follow up. I would also set up the EMR to notify me of new documents, such as the emergency physician’s patient note with the assessment and plan. While these strategies add work to physicians’ responsibilities, ensuring appropriate patient care is worth the extra effort, even after patients have been discharged.

Though hospitals have made it easier for different departments to work together using EMRs that can be accessed from any computer, there are more opportunities for risk when doctors on the same patient care team assume that the other members have read certain documents. As providers, we have to deliver adequate care to the best of our abilities, as well as ensure good interdepartmental communication and patient follow up. In this way, we can uphold our ethical duty of non-maleficence and reduce malpractice allegations.

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This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. This study has been modified to protect the privacy of the physicians and the patient.
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