the REPORTER

CME:
TMLT CLOSED CLAIMS: CARING FOR TRAUMA PATIENTS

HOW TO LEAVE OR CLOSE A MEDICAL PRACTICE

CLOSED CLAIM: DELAYED RESPONSE TO INTRACRANIAL HEMORRHAGE

CLOSED CLAIM: FAILURE TO PROPERLY EXAMINE PATIENT

LONE STAR ALLIANCE
A RISK RETENTION GROUP

Quarter 1, 2023

CONTINUING
MEDICAL
EDUCATION

CME:

TMLT CLOSED CLAIMS: CARING FOR TRAUMA PATIENTS

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The closed claim studies included in this article 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 outcome or increased the physicians' defensibility. These studies have been modified to protect the privacy of the physicians and the patients.

OBJECTIVES

Upon conclusion of this course, the physician will be able to:

1. describe three legal issues often seen in claims involving trauma care: the "willful and wanton negligence" standard, EMTALA, and informed refusal;
2. explain the importance of a thorough exam and review of systems, medical records, and imaging studies when treating a trauma patient;
3. discuss how to conduct and document an effective informed refusal discussion; and
4. summarize how to report child abuse or neglect in the state of Texas.

COURSE AUTHORS

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DISCLOSURE

Laura Hale Brockway and Wayne Wenske have no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in practical ways to increase patient safety and reduce the potential for medical liability.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. 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://lonestara.inreachce.com.

Policyholders: $10
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ETHICS CREDIT STATEMENT

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

TEST

To receive credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to http://lonestara.inreachce.com. Follow the online instructions to complete the forms and download your certificate.

RELEASE/REVIEW DATE

This activity is released on March 1, 2023 and will expire on March 1, 2026.

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

INTRODUCTION

A post on the social media platform Reddit asked users — specifically, members of the subreddit r/Medicine — if their work in urgent care or the emergency department (ED) had made them more cautious about their own everyday, "mundane" activities. The responses and anecdotes varied, but several themes emerged from the comments: no backyard swimming pools; no trampolines or visits to trampoline parks; no riding motorcycles or ATVs; installing grips and bars in showers and tubs; and no mandolin slicers.[1]

This CME activity features closed claim studies that tell the stories of patients who were engaged in "everyday activities," and at one point, needed urgent

medical care. Hopefully, less "everyday," this course also includes a case involving injury to a child that required a report to state authorities.

These case studies are provided to help you improve patient safety and reduce potential liability risks that may arise when treating trauma patients. Typical allegations in trauma care claims include failure to diagnose and treat, and failure to admit or refer.

MEDICAL LIABILITY AND TRAUMA CARE

In addition to the allegations listed above, three legal issues are often seen in claims that involve trauma care. These include: the "willful and wanton negligence" standard; the Emergency Medical Treatment and Active Labor Act (EMTALA); and informed refusal.

Willful and wanton

To prevail in a medical malpractice case in Texas, the plaintiff must show that the defendant had a duty to conform to a certain standard of care. In a claim involving emergency medical care in Texas, the plaintiff must prove by a "preponderance of evidence" that "the physician or healthcare provider, with willful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or healthcare provider in the same or similar circumstances."

When considering "willful and wanton" negligence, the burden of proof is considered heightened in an emergency care claim. The heightened burden of proof applies only to situations in which emergency medical care is rendered either in a hospital ED or in an obstetrical unit or surgical suite immediately following the patient evaluation in a hospital ED.[2]

This standard was put in place in 2003 to deter non-meritorious claims against physicians providing emergency care. The "willful and wanton" standard applies to several cases described in this activity.

EMTALA

EMTALA imposes three major requirements on hospitals that operate EDs and accept Medicare reimbursement. First, if an individual comes to the ED and requests an exam or treatment for a medical condition, the hospital must provide an appropriate medical screening exam to determine if an emergency medical condition (EMC) exists. Second, if the individual is found to have an EMC, the hospital must stabilize the medical condition, within the capabilities of the hospital, or transfer the individual to another hospital.[3]

As a third requirement, hospitals with specialized capabilities (such as burn units or trauma centers) are obligated to accept patient transfers unless the acceptance would exceed the hospital's capability and capacity for providing care.[3]

EMTALA also governs patient transfers from one hospital to another. Once it is determined that the patient has an EMC, transfers are restricted unless certain conditions are met. A transfer made under these conditions must also meet specific requirements.

EMTALA spells out obligations for the acceptance of transfer patients. Hospitals with specialized capabilities (such as burn units, shock-trauma units, neonatal intensive care units) cannot refuse the appropriate transfer of individuals who require the specialized capabilities.[3]

Physicians listed on a hospital's on-call list also have specific duties under EMTALA. These physicians must respond to the ED when requested to help determine if a patient has an EMC or to help stabilize a patient with an EMC unless circumstances beyond the physician's control prevent a response. Physicians who do not respond have violated EMTALA and may be subject to sanctions.[3]

The Centers for Medicare and Medicaid (CMS) and the Office of Inspector General (OIG) jointly enforce EMTALA. A hospital or physician that fails to meet the obligations under EMTALA is subject to civil penalties and may have its Medicare provider agreement terminated.[3]

For physicians, the most common EMTALA violation is failure to conduct a thorough medical screening exam. The second most common allegation is failure to follow appropriate transfer standards.[4]

Informed refusal

Texas law recognizes that physicians must obtain consent for treatment and that such consent be "informed." Related to informed consent is informed refusal, in which a patient refuses treatment after having been informed of the risks and benefits of the intervention.[5]

When explaining a treatment or procedure to an ambivalent or resistant patient, use clear language to avoid misinterpretation. Discuss the reasons for the patient's refusal and document this in the medical record. This documentation should include the following:

- describe the intervention offered;
- identify the reasons the intervention was offered;
- identify the potential benefits and risks of the intervention;
- note that the patient has been told of the risks, including possible jeopardy to life or health, in not accepting the intervention;
- clearly document that the patient has unequivocally and without condition refused the intervention; and
- identify why the patient refused, particularly if the patient's decision was rational and could not be overcome.[5]

CASE 1: Failure to properly treat wrist fracture and educate patient

Presentation

On June 20, 2014, a 52-year-old man fell while playing softball and fractured his right wrist. He went to the ED of a large medical center for treatment. X-rays revealed a minimally impacted fracture of his distal right radial metaphysis. The patient had a long history of steroid use for treatment of asthma and allergies.

Physician action

On June 24, the patient was seen by Orthopedic Surgeon A who diagnosed a right wrist distal radius intra-articular three-part Colles-type fracture with a slight amount of dorsal angulation. There was mild calcification in the dorsal aspect which he suspected was due to some comminution of the dorsal cortex at the fracture site.

The patient reported numbness and tingling in his hand and that he wanted to pursue a conservative treatment plan. A short arm cast was fitted with instructions to restrict activities and return for follow up in four weeks.

The patient returned on July 27, and the cast was removed. Orthopedic Surgeon A noted some mild atrophy at the right forearm distally secondary to cast immobilization. The patient had marked limitation and range of motion and palmar flexion and dorsiflexion also secondary to the cast. The patient was able to get fingertip-to-palm with all digits. His range of motion at the wrist palmar flexion was approximately 20 degrees; dorsiflexion was approximately 20-25 degrees. The patient also reported pain when reaching the maximum ranges.

There was dorsal comminution of the distal metaphyseal bone and roughly 15 to 20 degrees of dorsal angulation of the radial articular surface. The patient also had some mild limitation, especially in his supination of the forearm. He was neurovascularly intact.

The physician discontinued the cast and placed the patient in a removable wrist splint. The patient was to begin range of motion exercises and return for follow up in four weeks. Additional x-rays of the wrist were ordered.

Orthopedic Surgeon A also informed the patient that he would be taking a leave of absence from August 20, 2014, to the beginning of December 2014. In the interim, the patient's care was transferred to his partner, Orthopedic Surgeon B. Orthopedic Surgeon A noted that he would resume the patient's care upon his return, if necessary.

On August 25, the patient returned for his third visit and his first appointment with Orthopedic Surgeon B. The patient said he was about 75 percent better. Examination showed no tenderness or swelling to the right elbow; soft compartment of the forearm; no tenderness or swelling in the right wrist with full range of motion; active flexion was 45 to 50 degrees; active extension was 50 to 60 degrees; active ulnar deviation: 15 to 20 degrees. The patient's hand was noted as neurovascularly intact.

Orthopedic Surgeon B ordered x-rays of three views of his wrist, and the patient was to return in four weeks if he experienced any pain or stiffness.

On October 5, the patient returned to Orthopedic Surgeon B with increased pain. He was agitated and demanded treatment options for his wrist. They discussed the treatment options provided by Orthopedic Surgeon A at his first appointment. The discussion ended calmly, with the patient admitting some confusion about the treatment plan and anticipated outcome.

The physician noted that there was no tenderness or swelling in the elbow; the compartment of his forearm was soft; and the right wrist showed mild tenderness but no swelling. The patient had full range of motion in the right wrist; active flexion: 45 to 55 degrees; active extension: 50 to 60 degrees; active ulnar deviation: 15 to 20 degrees. His hand was again noted as neurovascularly intact. Physical therapy and occupational therapy were ordered, and the patient was again instructed to return in four weeks if he had persistent pain or stiffness.

On December 19, the patient went to a new physician, Orthopedic Surgeon C. The fracture was healed but with significant (approximately 35 degrees) dorsal angulation. The wrist was functional but appeared abnormal and the patient reported pain. Orthopedic Surgeon C suggested a corrective osteotomy. Surgery was performed on February 25, 2015.

By July 2015, it was obvious that the surgery did not produce the intended results, as non-union was evident. Orthopedic Surgeon C attributed the non-union to the patient's prolonged steroid use for chronic asthma and allergies.

On October 10, 2015, Orthopedic Surgeon C performed surgery to replace a screw that impinged on a tendon and to take down some adhesions. After surgery, the patient was noted as having a normal looking and fully functional wrist.

Allegations

The patient filed a lawsuit against Orthopedic Surgeon A with allegations of failure to properly monitor, assess, diagnose, and treat wrist fracture. He alleged these failures resulted in improper healing that required surgery to repair.

Legal considerations

Expert consultants for the defense were mostly supportive of Orthopedic Surgeon A, although more than one consultant stated that surgery should have

been recommended initially and that four weeks is too long to go between visits. These long gaps allowed for the fracture to become misaligned.

Another consultant stated that a long-arm cast instead of a short-arm cast should have been used. Consultants also pointed out that the malunion was related to the patient's chronic steroid use, and that the patient ultimately achieved a good result. There was concern among the consultants about the lack of a detailed discussion of treatment options.

An expert consultant for the plaintiff felt the patient's injury and malunion required surgical intervention. In addition, this consultant felt that Orthopedic Surgeon A should have anticipated the limitations of conservative care in this case, including the malunion, due to the patient's history of chronic steroid use.

Disposition

This case was settled on behalf of Orthopedic Surgeon A.

Risk management considerations

Orthopedic Surgeon A made treatment decisions based on the patient's desire for more conservative care. However, these treatments were not effective in light of the patient's condition and history of steroid use. In addition, the overall treatment plan was unclear to the patient. The patient may also have been uninformed about the risks of chronic steroid use, such as osteoporosis.

When conducting a discussion about treatment options, it is recommended this discussion be fully and contemporaneously documented in the patient record. In the record, document that the patient:

- was informed of the risks, benefits, and alternatives of each treatment, procedure, test, or medication;
- understood all of the information provided; and
- expressed either their desire to proceed or their refusal of care.

During this discussion, make every effort to address the patient's questions and concerns before ending the encounter. Be prepared to provide written descriptions of conditions, treatments, and risk factors, such as educational handouts, to support your conversation or your recommendations. This allows the patient time to consider the information at their own pace and to share information with family members before making a decision.

Comprehension levels differ from patient to patient, and it is not always obvious which patients fully understand medical terms or advice. In non-emergent situations, there are opportunities to educate the patient. When discussing treatment options, it is recommended to:

- speak concisely and avoid medical jargon or terms that may be too technical;
- summarize the patient's questions and responses back to him or her to ensure you correctly interpreted their questions and their responses to your questions and the intention behind them; and
- if possible, provide the patient with adequate time to consider the information. By not rushing the encounter, you help the patient feel cared for and "safe" to ask questions that may otherwise make him or her feel uncomfortable or too vulnerable to ask.

CASE 2: Failure to admit and obtain consult

Presentation

On a Saturday night, a 53-year-old man came to the ED with an ankle injury from a fall. "The problem was sustained at home, resulted from twisting." The patient had a history of hypertension, diabetes, alcohol abuse, and neuropathy.

Physician action

The patient reported his pain level as four. The left ankle was documented as tender and had deformity, swelling, and limited movement. A general skin assessment recorded no abnormalities. "No abrasion or laceration" was specifically noted.

An emergency medicine (EM) physician examined the patient and ordered x-rays. The radiologist described the injury as "comminuted fracture of the left distal fibula with lateral displacement and a fracture through the medial malleolus of the distal tibia." The EM physician noted the ankle was "grossly normal except: noted in the left lateral malleolus and left medial malleolus: abrasion, swelling, tenderness, medial mall abrasion no open wound or lac or open fx."

The EM physician splinted the ankle and noted "examined by me: post splint application: good alignment with good DP pulse palpable; all toes pink afterward." He discharged the patient with a walker and instructions to see an orthopedic surgeon in two to three days. According to the medical record, the patient was "Educated On: Follow up with Primary Care MD" and "Reporting any Change in Condition."

On Tuesday, the patient went to his family physician. The family physician documented, "He has a sugar tong and posterior splint in place. When I removed the splint and bandage there was blood dried on the bandage over the medial aspect. I removed and the skin is tight and warm, there is a small puncture over the bone that is easily palpable in the area. In viewing the CD, the ankle is trimalleolar and unstable joint."

Of note, one week after this office visit, the family physician added a late entry to the medical record: "when the splint was removed there was Xeroform dressing over the open area on his ankle to indicate the opening was present before the splint was applied."

From the family physician's office, the patient was transferred by ambulance to a hospital. His white blood count was 28.0 and his glucose was 248. He was admitted with the diagnosis of "1. Recent trimalleolar ankle, open fracture with underlying infection, 2. Diabetes mellitus." The patient was treated with open wound reduction and an external fixator. Treatment with IV antibiotics (for MRSA contaminant) and debridements was unsuccessful, and the patient's leg was amputated below the knee. The patient spent four weeks in the hospital.

Allegations

A lawsuit was filed against the EM physician, alleging failure to admit the patient and obtain an orthopedic consult for an open ankle fracture. This led to infection, sepsis, and below-the-knee amputation.

Legal implications

The plaintiff's expert stated that the patient's injury was severe, with a splinter of bone on the medial malleolus that could likely cause additional injury and infection. The patient's diabetic status made him more susceptible to infection and delayed healing. Therefore, the patient required admission to the hospital and an immediate orthopedic evaluation.

The defendant testified that he performed a thorough exam and considered the possibility of an open fracture. He believed the patient only had an abrasion to the epidermis with no injury or breach to the dermis. Defense experts agreed this was reasonable, but one EM physician stated, "Everyone involved underestimated and minimalized the injury, including the patient."

There was less support among defense experts for the EM physician's decision to splint the ankle and discharge the patient with a walker, given the nature of the injury and the patient's diabetes. Yet, an orthopedic surgeon stated that the patient had diminished tissue and healing potential because of his diabetes and may have had the same outcome with admission and timely orthopedic consultation.

There was discussion among the experts about whether the patient walked on his splint after he left the ED and before he came to his family physician. They questioned whether the severity of the fracture increased after discharge based on different documented histories and the description of the fracture changing from bimalleolar to trimalleolar. However, a radiologist who reviewed the imaging from the first ED visit confirmed that the patient had a trimalleolar fracture when he came to the ED.

Disposition

This case was settled on behalf of the EM physician.

Risk management considerations

EM physicians who reviewed this case noted that this patient visit occurred on a busy Saturday night in the ED. This — along with the radiologist's misread of the break as bimalleolar when it was trimalleolar — could explain why caregivers may have underestimated the seriousness of patient's injury.

In this case, it may have been preferable for the EM physician to request an orthopedic consult. Absent a consultation, the EM physician's care could have been more defensible if he had taken another x-ray to confirm proper splinting or discharged the patient with a wheelchair or crutches instead of a walker.

Because certain conditions can delay healing, it is important for those providing care in emergent settings to be mindful of their patients' underlying

health conditions. This patient's diabetes put him at higher risk for delayed wound healing and infection, which further complicated his injury.

CASE 3: Failure to diagnose femur fracture

Presentation

A 28-year-old man was involved in a motorcycle collision, sustaining multiple injuries. The man hit the side of a trailer and was thrown off his motorcycle.

The EMS records reflect that the patient's chief complaint at the scene of the accident was leg pain. The presumptive diagnosis from the EMS operators was possible leg injury with loss of consciousness. The patient's size (6'2" and greater than 300 pounds) prohibited EMS from fitting him with a cervical collar.

The patient was taken to the ED at a Level 1 trauma center. He was evaluated by an EM physician, two trauma surgeons, and Orthopedic Surgeon A. The following film studies were obtained: pelvic x-ray; chest x-ray; CT scan of the chest, abdomen, and pelvis; follow-up chest x-ray; CT scan of the cervical spine; CT scan of the head; x-ray of the right knee; and x-rays of the lumbar spine. Notably absent in the list of film studies was film of the femurs.

The patient was diagnosed with contusions, acute back pain, rib fractures shown on x-ray, and a sprained right knee. He was discharged later that day and directed to see Orthopedic Surgeon A in his clinic for follow up.

Physician action

Two days later, the patient saw Orthopedic Surgeon B for his knee sprain. Orthopedic Surgeon B did not have privileges within the system affiliated with the Level 1 trauma center. Therefore, he did not have access to the patient's trauma center chart or the radiographic studies.

The patient came to Orthopedic Surgeon B wearing a knee brace, which was removed for the examination. Orthopedic Surgeon B focused the exam on the right knee, but the exam was limited due to patient discomfort and the size of the patient's leg. Orthopedic Surgeon B recommended an MRI and diagnosed an acute sprain with a possible non-displaced fracture of the right knee. The patient never reported thigh or leg pain.

The MRI was performed the next day, but it did not extend high enough to detect a fracture of the femur.

Orthopedic Surgeon B saw the patient six weeks later for follow up. The patient was continuing to perform home exercises, and he was increasing his weight bearing status and ambulation. He was next seen two weeks later, at which time Orthopedic Surgeon B wrote a prescription for outpatient physical therapy to work on range-of-motion and quadriceps strengthening. He recommended that the patient use a cane, not his crutches, to assist with ambulation. Physical therapists worked with the patient for seven months for a total of 75 visits.

Nine months after first coming to Orthopedic Surgeon B, the patient indicated that he could feel a large, firm mass in his right thigh. Orthopedic Surgeon B obtained x-rays that revealed evidence of a femur fracture. The fracture was located in the mid-shaft and had developed a great deal of callus formation as the bones overlaid each other. This caused the right leg to be shorter than the left leg.

Orthopedic Surgeon B referred the patient to Orthopedic Surgeon C, who specialized in abnormal bone cases often associated with orthopedic oncology. Orthopedic Surgeon C performed the following procedures: resect the callous formation; realign the femur; remove open reduction and internal fixation hardware; and place an expandable nail. The patient continued to work as a high school baseball coach during this process.

Allegations

A lawsuit was filed alleging that the EM physician and Orthopedic Surgeon B failed to timely diagnose and treat the femur fracture. The patient claimed that the delay in treatment necessitated an extended healing process, multiple surgeries, subsequent infections, and prolonged pain.

Legal implications

Two orthopedic surgeons reviewed this case for the defense. Each expressed concern about the delay in diagnosis. The plaintiff retained an orthopedic surgeon and an EM physician who criticized the

delay in diagnosis and treatment, as well as the defendants' failure to diagnose the fractured femur.

Disposition

The case was settled on behalf of Orthopedic Surgeon B.

Risk management considerations

Orthopedic Surgeon B did not request the medical records or imaging studies from the trauma center. Relying on the patient to convey the findings from emergency and trauma physicians, as well as a series of imaging studies, can be problematic. Even if a physician suspects an injury beyond the chief complaint, he or she may have believed "everything else was normal" without knowing what was actually imaged. If physicians cannot view electronic records and images remotely, they should consider requesting the records.

When following a patient involved in a trauma, a thorough exam and review of systems may be indicated for the initial exam. Complete documentation of each patient encounter is important, including reports of pain or symptoms the patient may have beyond the primary focus of the injury.

One of the defense experts stated that the first exam could have involved measuring both legs and palpating and thoroughly examining the entire injured leg. If an exam did not reveal the injury, it would have made the physician's care more defensible. Ordering the appropriate films to augment the exam may also have identified the fractured femur. The defense expert added that the patient's abnormally slow progress may have been a red flag that should have alerted the physician and led to an earlier diagnosis of the fracture.

CASE 4: Failure to report injury to a child

Presentation and physician action

A 16-month-old girl was brought to her pediatrician for evaluation and treatment of a burn to the back. The child's mother and her boyfriend brought the child to the appointment. At the time of the accident, the mother was not home and the child was in the care of the mother's boyfriend. The boyfriend claimed the child leaned against the oven door and touched the glass window, which caused the burn.

The pediatrician examined the patient and noted a second-degree burn on the child's back that was approximately 6 x 8 inches. Silver sulfadiazine and a dressing were applied. During the exam the pediatrician asked the mother if she suspected abuse, and the mother said no. Although not documented, the pediatrician claimed she examined the child for other evidence of abuse and found none. She did not, however, remove the patient's diaper.

The child's biological father called the pediatrician later that same day and expressed concerns that the burn was not accidental. The pediatrician told the father that she thought the story given by the mother and boyfriend was plausible, but if the father thought that the patient was being abused, he should notify Child Protective Services (CPS). The patient's father made the report that day; however, the complaint was not investigated until after further injury occurred.

The following day, the boyfriend was again at home alone with the child. That evening, the boyfriend called 911 because the patient was unresponsive and not breathing. EMS arrived to find the patient in cardiopulmonary arrest. They intubated her and gave her epinephrine and atropine via ET tube. The child was brought to the ED with CPR in progress. She was admitted to the PICU.

The physical exam showed complete unresponsiveness, fixed and dilated pupils, multiple bruises (forehead, occiput, shoulder, legs, trunk, and feet), and a second-degree burn on her back, between the scapulas. Vaginal and anal bruising were also present. A head CT revealed subarachnoid blood and subdural hematomas. A skeletal survey showed a fractured second rib. An ophthalmology exam revealed bilateral retinal hemorrhages. The patient was diagnosed with battered child syndrome with molestation.

The following day, the patient had a cerebral blood flow study that revealed no flow to the brain. The patient also had an apnea test that showed no spontaneous respirations. She was later declared brain dead and removed from life support.

An autopsy revealed the following: blunt force injury to the head; external and subgaleal contusions;

subdural and subarachnoid hemorrhage; traumatic brain swelling with herniation, and multi-layered retinal hemorrhages. It also revealed a thermal burn to her back, genital and anal abrasions, contusions and superficial lacerations, contusions and abrasions to the torso and extremities, but no significant internal trauma. Focal bronchopneumonia was also noted. The autopsy report concluded that the cause of death was "blunt force trauma of head" and the manner of death as "homicide."

Allegations

The patient's biological father brought a lawsuit against the pediatrician and the entity that employed her. The allegations included:

- negligence in failing to timely, adequately, and/or properly recognize the serious condition of the patient;
- failure to timely and properly diagnose the patient;
- failure to timely and/or properly report the patient's injury to CPS; and
- failure to timely, adequately, and/or properly care for and treat the patient.

It was also alleged that the pediatric group was vicariously liable for the actions of the pediatrician.

The Texas Medical Board (TMB) also investigated the case for the possibility that the pediatrician violated the Medical Practice Act. The allegations investigated included:

- unprofessional or dishonorable conduct specifically related to failure to report child abuse/neglect of a child to CPS; and
- failure to practice medicine in an acceptable, professional manner consistent with public health and welfare, specifically not performing a thorough physical examination based on the injury.

The TMB Disciplinary Process Review Committee recommended that the investigation be closed and the recommendation was ratified by the full Board. However, the investigation included a review that indicated that the pediatrician's examination of the child lacked vital signs, weight, or a detailed description and measurement of the burn, and that the child was not examined for other injuries. It was pointed out that an active 16-month-old child rarely leans against anything. While the investigation concluded that the pediatrician should have notified CPS, the investigators also stated that it would not have made a difference in this case as CPS probably would not have begun their investigation within 24 hours.

Legal implications

The physician reviewers of this case felt that the pediatrician treated the patient's burn correctly, but failed to suspect that it was abuse. Both indicated they would probably not have suspected abuse either because the mother did not express concern about that possibility. In fact, the mother left the patient with the boyfriend again the next day. This suggests that she did not have significant concerns that the burn was due to abuse. The reviewers felt that if a more thorough physical exam had been done, there might have been enough evidence to warrant a call to CPS for inadequate supervision.

The pediatrician had taken care of this patient since she was an infant, and never saw any evidence of abuse. When asked, the mother denied any abuse. However, there were other persons who thought abuse was possible. Unfortunately, the pediatrician did not have the benefit of that information.

Disposition

This case was settled on behalf of the pediatrician.

Criminal charges were brought against the mother's boyfriend. He was convicted of murder and sentenced to life in prison.

Risk management considerations

At some point in their careers, physicians may be faced with the difficult task of determining if a child is in danger. In this particular case, there were no apparent warning signs outside of the burn incident that caused the physician to be concerned. The child's mother did not express concern about the possibility of abuse. The physician assessed the patient for other physical bruises or indications of abuse and did not find any evidence; however, this detail was not noted in the chart.

Documentation of all findings during an examination is recommended in order to provide a thorough description of the patient's health status. Additionally, the physician did not remove the child's diaper to examine her for any signs of sexual abuse.

Both reviewers for this case felt that a more thorough examination should have occurred.

REPORTING ABUSE

The State of Texas has rules and guidelines in the Family Code that address requirements for reporting child abuse or neglect. If a professional such as a physician or other health care provider has cause to believe a child is being subjected to abuse, a report shall be made no later than the 48th hour after the professional first suspects that the child has been or may be abused or neglected or is a victim of the offense of indecency with a child. It is not a violation of HIPAA to report child abuse or neglect.[6,7]

Reports of abuse or indecency with a child shall be made to:

- Texas Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child, or someone who lives in the home with the child. Call the 24-hour DFPS abuse hotline at 1-800-252-5400; reports may also be made through a secure web site at www.txabusehotline.org; or
- any local or state law enforcement agency; or
- the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or
- the agency designated by the court to be responsible for the protection of children.[8]

Reports can be made anonymously. Unless waived in writing, the identity of the physician making a report is confidential and may only be disclosed to a law enforcement officer for the purposes of conducting a criminal investigation of the report, or as defined by confidentiality provisions provided in Section 261.201 of the Family Code.

In addition, the Family Code states that reporting requirements apply regardless of professional confidentiality and licensing laws and rules for professionals. It is not a breach of physician-patient confidentiality to report suspected child abuse.[6]

If you practice outside of Texas, please refer to your state medical board for rules, information, and instruction on reporting child abuse or neglect.

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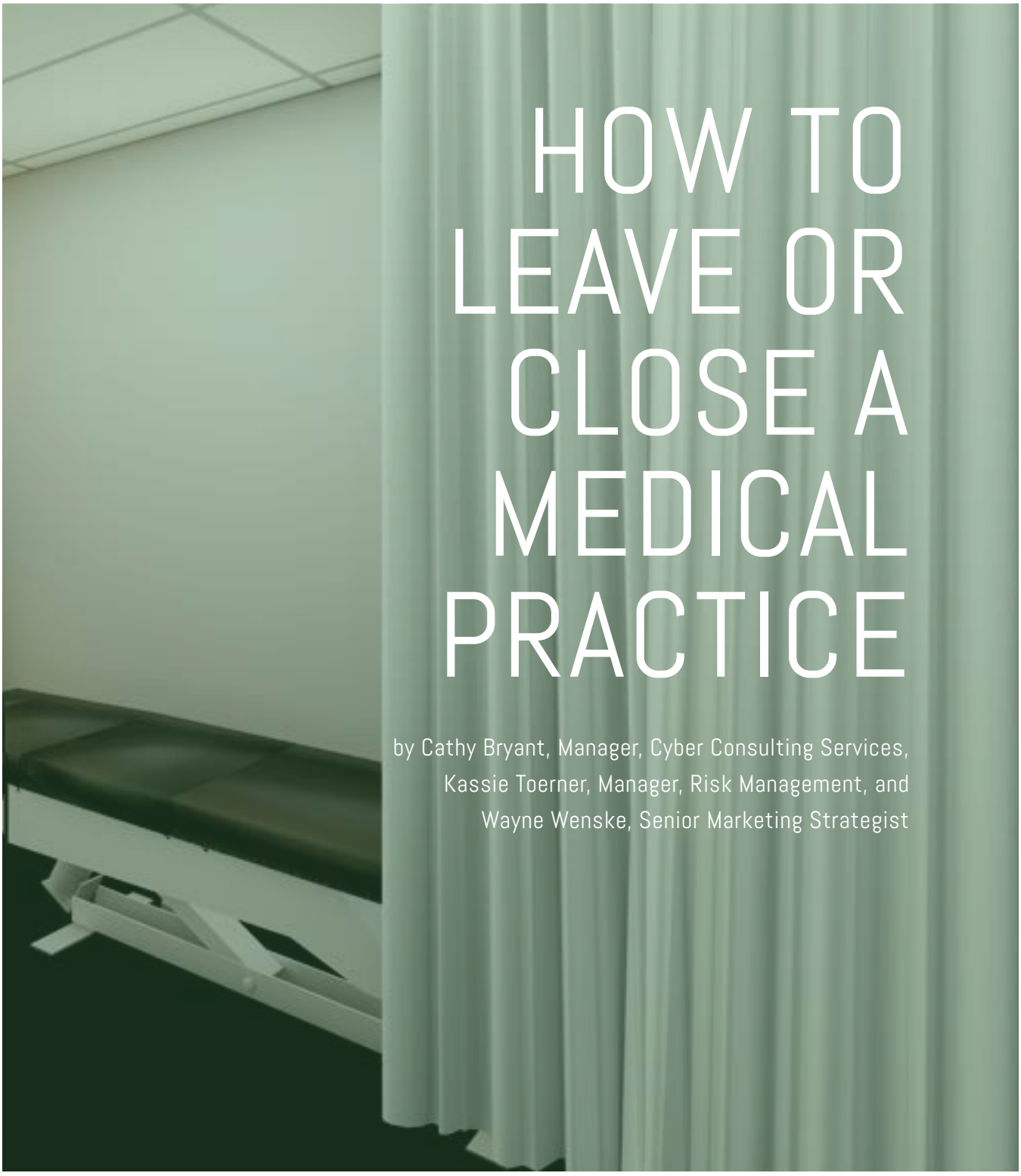

HOW TO LEAVE OR CLOSE A MEDICAL PRACTICE

by Cathy Bryant, Manager, Cyber Consulting Services,
Kassie Toerner, Manager, Risk Management, and
Wayne Wenske, Senior Marketing Strategist

A recent study conducted by the Mayo Clinic found that one in five physicians report that it is "likely" they will leave their current practice within two years. What's prompting these departures? Reasons range from COVID-19 related anxiety and depression to work overload and burnout.[1]

In Texas, physicians must fulfill several requirements before retiring, terminating employment, relocating, leaving, or closing a medical practice. These requirements — established and enforced by the Texas Medical Board (TMB) — state that in these scenarios the individual physician is responsible for:

- providing patients with reasonable notification;
- ensuring that patients can obtain copies of their records or transfer their medical records to another physician;
- notifying the TMB when the physician will no longer be available to patients due to terminating practice, retiring, or relocating;
- identifying who or what entity has custodianship of their patient records; and
- advising how copies of the medical records can be obtained.[2]

PATIENT NOTIFICATION

According to the TMB, there are three patient notification requirements. The first is a public notification stating that you are leaving the practice or that the practice is closing. Correct public notification is accomplished by:

1. either posting the written notification on the physician's or practice website OR publishing the notice in the newspaper of greatest circulation in each county in which the physician practices or practiced and in a local newspaper that serves the immediate practice area;

2. placing written notice in a highly visible or conspicuous location in the practice or physician's office announcing that you are leaving the practice, or placing notice on the façade of the physician's office if "announcing the termination, sale or relocation of the practice"; and

3. sending a notice to all patients seen by the physician in the last two years by either a letter that you physically mail to each patient's last known address or by email message. If sending an email message, it must be done "in a manner that is compliant with state and federal law."[2]

All three methods of patient notification are required and must be followed exactly as described in the Texas Administrative Code. Keep in mind that any patient seen in the last two years before leaving or closing a practice must be notified.

In addition, a copy of the posted notices must be submitted to the TMB within 30 days from the date of termination, sale, or relocation of practice. See "Notification to the TMB" on page 15.[2]

EXCEPTIONS TO PATIENT NOTIFICATION

There are exceptions to the patient notification. Physicians are not required to notify those patients if the physician:

- treated the patient while in a locum tenens position at a practice location for less than six months;
- only treated patients in a hospital setting, emergency room, birthing center, or ambulatory surgery center; or
- only provided the following services in one of the previously noted excepted settings:
  - anesthesia services;
  - radiology services based on an order by a treating physician; or
  - pathology services.[2]

OTHER CONSIDERATIONS

If you have made a good faith effort to mail notification letters to your patients, but a number of those letters are returned, you are not required to track down those patients without forwarding addresses on file.

You cannot post notification on Facebook, Twitter, or other social media sites in lieu of a website. This does not fulfill the TMB requirement of posting the notification on a physician or practice website.

Notifying a patient by email should only be done if the patient has made a specific, prior request to communicate via email. It is best to avoid patient notifications using unencrypted or unsecure email. Some physicians may consider sending notification letters to patients via a secure EHR portal. If pursuing

this route, tracking patients who fail to open portal messages and following up with a mailed letter may be required. If considering this notification method, it is recommended that you consult with the TMB or your state medical board if practicing outside of Texas.

LEAVING A GROUP PRACTICE

When leaving a group practice, it is the personal responsibility of the departing physician to execute full and proper public notification. Even in a scenario where the group says they will handle notification for the departing physician, it is still the responsibility of the departing physician to ensure these requirements are met. The departing physician may face a potential board review or fines if he or she leaves the public notification responsibility to the group, and the group fails to meet all requirements.

It is also a physician's responsibility to ensure notification requirements are met if closing, selling, or relocating a practice. Again, public notice should be placed in the physician's office in a conspicuous location or on the façade of the physician's office as a sign, announcing any termination, sale, or relocation. The sign shall be placed there for at least 30 days before the termination, sale, or relocation of a practice, and not removed until the actual date of the practice termination, sale, or relocation.

INTERFERING WITH PATIENT NOTIFICATION

The TMB has rules prohibiting the practice or any remaining physicians in the group from interfering with patient notification.

Those physicians remaining in the practice may not prevent a departing physician from posting notice and or from notifying the public of the departure. They may not withhold information — including patient contact information — from the departing physician that is necessary for patient notification. Ideally, the group or the practice will provide a departing physician with the contact information of their patients to ensure that the physician can fulfill their responsibilities according to the TMB.

Can a practice share the departing physician's new practice address with patients? The TMB does not require a group or practice to inform patients of the departing physician's new location. However, physician ethics require that if the patient asks the group, the group "must inform the departing physician's patient of the departing physician's new address."[3]

PATIENT ACCESS TO MEDICAL RECORDS

A physician leaving a practice must ensure that his or her patients can obtain copies of their records or arrange for the transfer of their medical records to another physician. In Texas, a physician and/or practice has 15 business days after a patient request to provide copies of medical and/or billing records.[1]

The patient's request to forward copies of his or her medical records to the departing physician's new practice must also be fulfilled.[4]

The copies must be in the form and format that the patient requests — paper or in a digital format. If records are not easily produced in the requested format, "the records shall be produced in a format as agreed to by the physician and the requestor."[1,5] This may necessitate providing paper files in electronic format, such as a PDF.

NOTIFICATION TO THE TMB

A departing physician is also required to notify the TMB. The physician must notify the board that he or she is terminating practice or relocated and is no longer available to patients. Notification must also specify who has the custodianship of the medical records and how medical records can be obtained.

A copy of the posted notices should be submitted to the board within 30 days from the date of termination, sale, or relocation of the practice. The TMB provides a form to help with the submission of this information. The Notification of Departure/ Closure of Practice Form is available at https://www.tmb.state.tx.us/idl/0A7DF859-ED62-FE82-6176-40CF4C8C6D5B.[6]

OTHER NOTIFICATION CONSIDERATIONS

Consider providing additional notifications 60 to 90 days before closing a practice to the following:

- your malpractice insurance provider and/or underwriter;

- employees — be prepared to hire temporary staff if current employees leave before the closing date;
- business associates;
- other physicians, especially those who refer patients to you;
- vendors, such as medical suppliers, office suppliers, cleaning services, hazardous waste disposal service, magazine subscriptions, etc.;
- the Drug Enforcement Agency (DEA) – inform the DEA of your intention to either continue or surrender your DEA registration; and
- Medicare/Medicaid and other insurance providers — inform all contracted insurance payors of the closure. Provide payers with a forwarding address to send payments that resolve after the practice closure.

MANAGEMENT OF MEDICAL RECORDS WHEN CLOSING A PRACTICE

When leaving or closing a practice, determine the custodian of your patient records. This includes ensuring the records are safe and protected, and how requests for record copies will be handled. Medical record custodians are tasked with upholding patient privacy and controlling who can access the records.

If you own the closing practice, you must arrange for the safe and secure storage of both paper and electronic medical records before closing. Make sure the storage vendor and/or facility has experience handling confidential patient information and have HIPAA agreements in place.

According to TMB rules, a patient's medical records must be retained or stored for seven years after the last date of treatment or contact with the patient. This is also true for deceased patients. Special circumstances include the following.

- For minor patients, the TMB rule is to maintain the records until the patient is 21 years old or seven years after their last treatment or contact, whichever is longer.
- For obstetric patients, it is recommended that you maintain records for these patients for 21 years.

When you join a medical practice or group, record ownership may be determined in your employment contract. Generally, in Texas, the work completed by an employee belongs to the employer. So, unless specified in the contract, the employed physician may not own any patient records.

Before joining a practice or group, the physician should agree with the practice about medical record ownership and that agreement should be documented in the employment contract.[7]

OTHER MEDICAL RECORD CONSIDERATIONS

- If a practice is closing and the patient records reside in an EHR, meet with the EHR vendor to close the account and have the vendor provide you with the records (in an electronic format such as a PDF, or as paper files). The EHR vendor is not a "default" custodian of patient records. They are not equipped to provide copies of records to patients or other entities. The EHR company will tell you how they can provide records.

- HMO insurance billing contracts may require you to keep billing records, some for up to 10 years. These billing records must also be kept along with patient records.

DOCUMENTATION AND CONTINUITY OF CARE

Develop an exit plan with your group to address any outstanding matters before your departure. Make every effort to complete all patient documentation before you leave. For test results due near your departure date, ensure those results are received by another provider in the group. This is critical for continuity of care.

A WORD ABOUT NON-COMPETES

Finally, before leaving a practice or joining a new one, make sure you understand and address any non-compete clauses that are part of your contract. Seek legal counsel if there are parts of the contract that are unclear or difficult to address. Legal counsel can help ensure that all contractual matters are clearly fulfilled.

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CLOSED
CLAIM
STUDY

DELAYED RESPONSE TO INTRACRANIAL HEMORRHAGE

by Wayne Wenske, Senior Marketing Strategist

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.

PRESENTATION

On June 16 at 12:38 p.m., a 61-year-old man with a history of hypertension was brought by ambulance to Hospital A's emergency department (ED). The patient had severe headache, vomiting, lethargy, and bradycardia. According to family members, the patient had demonstrated an altered mental status since 9 a.m. that morning.

The patient's blood pressure was 157/78 mm Hg and he was assigned a Tracking Acuity of "2" on the Emergency Severity Index (ESI). This rating requires immediate assessment and treatment due to the high risk of deterioration.

PHYSICIAN ACTION

At 12:47 p.m., Emergency Medicine (EM) Physician A examined the patient. The patient was noted as having left-sided hemiparesis; being somnolent and non-verbal; able to follow simple commands; and opening eyes to speech. It was also noted that the exam was limited by the patient's altered mental status.

The patient was assigned a Glasgow Coma Scale (GCS) score of "10," in the moderate range. An EKG was interpreted as borderline abnormal, with a sinus rhythm of 65.

At 12:59 p.m., a nurse assessed the patient and noted blood pressure of 151/80 mm Hg; an altered mental status; no verbal responses; able to withdraw to painful stimuli; and a GCS score declined to "7," in the severe range.

At 1:10 p.m., EM Physician A ordered a STAT head CT without contrast.

At approximately the same time, a "Code Red" was called in the ED that required EM Physician A's attention. He left the patient for approximately one hour to address the Code Red patient.

When EM Physician A returned to the patient, he found the head CT had not been performed. He entered the order for the CT and helped move the patient to the CT bay. The CT was completed at 2:25 p.m.

The CT scan revealed evidence of right-sided hemorrhage with subarachnoid blood. The ventricles demonstrated mass effect from the large hematoma within the right temporal and frontal regions. In the cerebrum, there was a large hematoma within the right temporal and frontal lobes. There was also mass effect with minimal midline shift.

EM Physician A planned to transfer the patient to Hospital B for a higher level of care, including neurosurgery.

At 3 p.m., EM Physician A phoned Neurosurgeon A at Hospital B to discuss the patient. During the call, Neurosurgeon A accepted the transfer and asked that the patient be given nimodipine and that the patient's systolic blood pressure be kept below 140 and his heart rate stay in the 60-100 bpm range.

Neurosurgeon A also ordered that the patient be transferred to Hospital B emergently, within the hour, for neurosurgical evaluation due to her concerns about the patient's deteriorating condition. The transfer would be completed via helicopter.

At 3:10 p.m., EM Physician A spoke with Critical Care Specialist A at Hospital B. Together, they agreed to sedate and intubate the patient for transfer to ensure his airway was protected during the flight.

EM Physician A ordered nimodipine 60 mg and labetalol 20 mg via IV be administered to the patient. He also ordered a levetiracetam drip.

At 3:21 p.m., EM Physician A discovered that his orders had not been followed. One of the nurses stated they could not administer the nimodipine because the transfer/flight team was rushing them and the patient was not alert and did not pass a swallow test. (Nimodipine may be administered via IV.) The patient's blood pressure was recorded at 155/105 mm Hg with a heart rate of 66.

At 3:31 p.m., the patient's blood pressure was 123/63 and he was given labetalol via IV. There is no record of the nimodipine being given to the patient.

The flight team from Hospital B arrived at Hospital A at 3:49 p.m. By then, the patient had been intubated and mechanically ventilated.

At 4:09 p.m., the patient's blood pressure was 164/90 mm Hg with a heart rate of 48. He could not wake

up and his GCS declined to a "3," the lowest score possible, associated with an extremely high mortality rate. Left and right pupil sizes were 3 to 4 mm with brisk reaction.

From 4:22 p.m. to 4:41 p.m., several documented medical equipment failures caused delays in transferring the patient, including a malfunctioning sedation infusion pump and transport ventilator. These malfunctions required a backup infusion system be used and the patient to be manually ventilated during the approximately 13-minute transport to Hospital B.

The flight transport team left Hospital A with the patient at 4:44 p.m., and they arrived at Hospital B at 4:57 p.m. This was almost two hours after Neurosurgeon A accepted the transfer and requested that the transfer be completed in one hour.

At approximately 5 p.m., the patient was evaluated by Neurosurgeon A and Critical Care Specialist A. Neurosurgeon A documented the patient's blood pressure as 111/67; no corneal reflex; pupils were fixed and dilated; and no withdrawal from painful stimuli while off sedation. She concluded that the patient had irreversible brain damage and was likely progressing to brain death.

At 5:48 p.m., a head CT scan revealed a new finding of intraventricular breakthrough of hemorrhage and progressive effacement of the right lateral and third ventricles. There was diffusely progressive mass effect that caused herniation to both sides of the brain with leftward shift of the midbrain. Brain death protocols were initiated.

The patient died two days later. The death certificate listed the cause of death as intracranial hemorrhage.

ALLEGATIONS

A lawsuit was filed against EM Physician A for failure to timely respond to the patient's intracranial hemorrhage and initiate Hospital A's stroke protocol. The suit alleged that the failure to respond caused delays in obtaining a head CT scan and transferring the patient to Hospital B. A lawsuit was also filed against Hospital A.

LEGAL IMPLICATIONS

Emergency medicine and neurosurgery consultants for the defense all stated that EM Physician A should have initiated a stroke protocol to expedite the CT scan. However, they stated that initiating the protocol would not likely have changed the outcome.

Consultants for the plaintiff held opposing views. They felt that the delay in initiating a stroke protocol and obtaining a CT scan directly contributed to the patient's death. One suggested that nurses or even EMT personnel usually initiate the stroke protocol, but that does not relieve a physician from initiating the protocol when encountering a patient experiencing a cerebrovascular accident.

DISPOSITION

This case was settled on behalf of EM Physician A. The outcome against Hospital A is unknown.

RISK MANAGEMENT CONSIDERATIONS

In this case, several orders to give medications and perform tests were not completed in a timely manner. These errors could be attributed to interruptions and distractions in the ED.

EM Physician A and the nursing staff were distracted by a Code Red that occurred in the ED at roughly the same time as this patient was being evaluated. This led to a delay in the completion of the STAT CT.

In addition, the nurses stated that they felt rushed when preparing the patient for transfer to Hospital B. This may have led to medication errors, such as the confusion on how to administer the nimodipine or whether it was given to the patient.

The distractions in this case may have been mitigated had EM Physician A initiated stroke protocols. The patient would have then been put in a category of care that would have helped to control the patient's environment, minimize distractions, and accelerate care.

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FAILURE TO PROPERLY EXAMINE PATIENT

by Rachel Pollock, Marketing and Brand Specialist

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.

PRESENTATION

In May 2020, a 46-year-old woman came to her internal medicine physician reporting shortness of breath, back pain, burping, and fever. The patient had a history of morbid obesity, heart disease, smoking, alcohol use, and diabetes. She had been seen by the physician five times in the last three years. The patient did not have health insurance and was noted as often non-compliant.

The physician diagnosed her with bronchopneumonia, back pain, shortness of breath, and dyspnea and instructed her to take a COVID-19 test.

PHYSICIAN ACTION

One week later, the patient returned to the clinic with a negative COVID-19 test result. She reported that her backache and burping symptoms had improved, but she was still experiencing shortness of breath and exhaustion from light activity (walking).

The physician increased her diuretics and planned to refer her to a cardiologist. There was no record that a detailed medical exam was performed.

The patient was sent home and died later that day on the way to the hospital. The autopsy stated the cause of death to be pulmonary thromboembolism (PE) due to congestive heart failure (CHF) complicated by morbid obesity and hypertensive heart disease.

ALLEGATIONS

A lawsuit was filed against the internal medicine physician, alleging failure to properly examine, diagnose, and treat the patient. The plaintiffs claimed that the failure to transfer the patient to the hospital led to her death.

LEGAL IMPLICATIONS

Poor documentation was a key element in this case. The lack of a documented physical exam made it difficult to determine whether the patient should have been transferred to the hospital.

Defense consultants were unsupportive of the physician's lack of examination and poor documentation of treatment. The patient visited the clinic during the height of the COVID-19 pandemic and the physician was reasonable in thinking her initial symptoms could have been related to COVID-19. However, both internal medicine consultants felt the physician should have sought alternative diagnosis once COVID-19 was ruled out.

Cardiology consultants noted that while PE is difficult to diagnose from a clinic visit, the patient's worsening symptoms and pre-existing conditions should have led the physician to conduct a thorough cardiac evaluation.

An expert for the plaintiff stated the physician breached the standard of care by not performing a proper work up of the patient and failing to perform necessary testing such as D-Dimer, CT angiography, and a ventilation-perfusion scan to rule out PE. He felt that PE would have been diagnosed and anticoagulation therapy or thrombectomy could have been initiated had the proper testing been completed.

The defense argued that while the patient's pre-existing CHF, obesity, and other co-morbidities put her at a higher risk for PE, her symptoms were vague and not enough to warrant suspicion of PE. The patient had no noted swelling of legs and was hemodynamically stable, making management of CHF exacerbation the most reasonable course of treatment.

Additionally, they felt that even if the patient had been immediately transferred to the hospital, there was a 50 percent chance that a workup would have been completed in time to prevent the PE from causing sudden death.

Though the defense experts had support on the course of treating a patient decompensating from CHF, the poor examination and lack of documentation were considered weaknesses in the defense of this case.

DISPOSITION

The case was settled on behalf of the internal medicine physician.

RISK MANAGEMENT CONSIDERATIONS

Complete, clear, and contemporaneous documentation is vital for quality patient care and can be a physician's best defense in the event of a claim. In this case, the physician did not conduct or document a physical exam; she did not document a clear and full history, vitals, differential diagnosis once COVID-19 was ruled out, or follow-up instructions. She also did not document whether she completed a referral to a cardiologist.

This patient's co-morbidities and lifestyle choices put her at high risk for several possible cardiac issues, which should have made a thorough exam a priority for the physician. One consultant for the defense suggested that the patient's presenting condition — consistent with both PE and CHF — may have been confusing and a diagnosis hard to determine. This made thorough exam even more necessary.

This case was further complicated because the patient did not provide an accurate medical history and was reportedly noncompliant with medications. She did not divulge her tobacco use, that she had a previous CHF diagnosis, had been previously placed in a life vest to prevent sudden death, was hospitalized for weeks due to sepsis, intubated, and then admitted to a heart failure clinic for months. The physician concluded the patient had CHF from the medications she listed but could have been more insistent on recording a detailed patient background.

Providers often do not have complete information regarding a patient's history, medications, home life, or social activity. As in this case, patients are often poor communicators or historians of their own health history and medications. This makes a complete and thorough intake, exam, and documentation even more important in high-risk scenarios.

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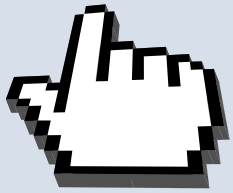

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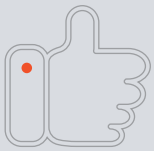

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