the REPORTER

2-HOUR CME:
CASE CLOSED: ODD CASES, VOLUME 2

LONE STAR ALLIANCE
A RISK RETENTION GROUP

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CONTINUING
MEDICAL
EDUCATION

2-HOUR CME: CASE CLOSED: ODD CASES, VOLUME 2

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OBJECTIVES

Upon completion of this educational activity, the participant should be able to:

1. summarize the need for clear communications with patients, including obtaining adequate informed consent for off-label prescriptions;
2. discuss the importance of comprehensive office policies and procedures; and
3. explain how good documentation can help defend or prevent malpractice claims.

COURSE AUTHORS

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DISCLOSURE

The authors of this activity 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 2-hour activity is intended for physicians of all specialties who are interested in learning practical ways to reduce the potential for malpractice 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 2 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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 2 CME credits.

PRICING

The following fee will be charged when accessing this CME course online at http://lonestara.inreachce.com.

Policyholders: $25
Non-policyholders: $100

INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to http://lonestara.inreachce.com. Log in using your myPortal account information to take the course. Follow the online instructions to complete the forms and download your certificate. To create a myPortal account, go to lonestara.com, click the log in button, and follow the on-screen instructions.

RELEASE/REVIEW DATE

This activity is released on June 1, 2024 and will expire on June 1, 2027.

CME DISCOUNT

Lone Star Alliance policyholders who complete this program may earn a 2.5 percent discount that will be applied to their next eligible policy period.

INTRODUCTION

Texas Medical Liability Trust (TMLT) publishes several closed claim studies each year based on actual TMLT malpractice claims. By providing "real life" examples of closed professional liability claims, physicians in all specialties can learn how to reduce liability risks and improve patient safety.

Case Closed: Odd Cases, Volume 2 is the second collection of medical malpractice case studies that involve unexpected patient presentations, circumstances, or outcomes. Though these cases feature odd scenarios, they also include several clear and relevant risk management issues.

The closed claim studies published in this article describe 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 a successful defense.

TMLT closed claim studies are written 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.

CASE ONE: FIRE IN THE OPERATING ROOM

Presentation and physician action
A 29-year-old woman came to a surgical center for removal of an infected epidermoid cyst on her neck.

The patient was taken to the operating room (OR), where an anesthesiologist started her on oxygen, four liters per-minute by nasal cannula. During the procedure, the general surgeon used an electrocautery device on a bleeding vessel. This caused a flash fire under the surgical drapes, which were positioned around the patient's neck and face.

The fire was immediately extinguished with hand pressure and by pouring saline on it. The procedure was stopped, and the patient was awakened for a full examination.

The patient had burns on her forehead, nose, cheeks, and lips. She was transferred to a nearby medical center burn unit. She underwent skin grafting but had residual scarring from the burns.

Allegations
The patient filed a lawsuit against the anesthesiologist, alleging failure to ensure the area around the surgical drapes was free of oxygen before the surgeon used a cautery device. The surgeon and the manufacturer of the electrocautery device were also sued.

Legal implications
The plaintiff's experts claimed that the anesthesiologist and the surgeon breached the standard of care by failing to:

- stop the patient's oxygen with sufficient time before using the cauterizing tool;
- arrange the drapes so oxygen could drain away from the operative site;
- properly apply an incise drape to isolate the patient's head and neck; and
- use a lower oxygen level before using the cauterizing tool.

Defense consultants had mixed opinions about the defendants' actions. One consultant stated that fires are a well-known complication of surgery when using electrocautery devices around a patient's head and neck area, as oxygen can pool under the drapes allowing a fire to start in the oxygen-rich area.

This consultant stated that the anesthesiologist and the surgeon overlooked the risks and did not follow common precautions for using electrocautery in a heavily oxygenated environment.

Another consultant stated that this was an inadvertent incident that occurred despite the good care and intentions of the anesthesiologist, surgeon, and OR staff. The anesthesiologist documented that he stopped oxygen before the surgeon began using electrocautery. However, he did not document how much time passed between when he stopped the flow of oxygen and when the surgeon began to cauterize the blood vessel.

Disposition
This case was settled on behalf of the anesthesiologist, the surgeon, and the manufacturer of the electrocautery device.

Risk management considerations
According to the Food and Drug Administration, approximately 600 surgical fires occur in the United States annually. While this number may be small compared to the large number of surgeries performed each year, a surgical fire can have severe consequences for patients, including serious injury, disfigurement, or death.[1]

The Joint Commission specifically points to "using electrosurgical devices in ENT surgery with the patient under mask or nasal cannula oxygen administration" as a potential contributing factor to surgical fires. The commission also states that 70 percent of surgical fires are caused by using electrosurgical devices.[2]

Risk of fire in the OR can be lessened by creating greater awareness among surgical staff about ignition sources (electrosurgical devices, defibrillators, lasers, and fiber optic light cords) and fuel sources (drapes, towels, sponges, gauze, alcohol-based wipes, and the patient's body hair.) Oxidizer sources include oxygen, nitrous oxide, and anesthesia machines/ventilators. It is important for all surgical staff members to strictly adhere to the recommended uses, care, and/or disposal of all materials and equipment in the OR.

Hospitals and surgical facilities should develop written policies and procedures that directly address fire safety in the OR to help lessen the risk of surgical fires. Physician and staff awareness and training in these fire risk reduction protocols will help to provide a safer environment. Safety measures include the following.

- Incorporate a fire risk assessment in the surgical time out. Along with reviewing the patient's identity, procedure, and surgical site, add a review of any potential ignition sources, fuel, and oxidizers in the surgical environment and where they are located in relation to the surgical site on the patient. This will heighten awareness of any risks and put staff on high alert around these materials and conditions. Also review the location of fire extinguishers and saline in the OR.
- Encourage all members of the surgical team to continuously assess potential fire hazards during surgery and to immediately speak up if they identify any risk of a possible fire.
- Conduct staff training on fire prevention in the OR. Assign specific roles and responsibilities to each member of the surgical team to perform in the event of a fire. Include fire drills and emergency evacuations of staff and of the patient. Identify an evacuation location for the patient who may need emergency care or whose surgery cannot be stopped for an extended period.
- If working in a hospital or surgical center, report any surgical fire to your facility's incident reporting system. These reports help identify potential areas of improvement that can further reduce fire risk.[2]

The Anesthesia Patient Safety Foundation offers educational videos and resources on surgical fire prevention, available at https://www.apsf.org/videos/preventing-surgical-fires/. Physicians and other health care professionals who work in ORs are encouraged to take advantage of these opportunities to reduce risk.

CASE TWO: UNNECESSARY SURGERY AND PATIENT DEATH

Presentation

A 46-year-old man came to the emergency department (ED) on August 9 reporting left flank pain. The patient had a history of kidney stones. Imaging revealed he had a 4 mm stone in the left ureter. The patient was transferred to another hospital and placed under the care of a urologist.

Physician action

On August 11, the urologist took the patient to surgery and attempted to remove the stone via ureteroscopy. The procedure was unsuccessful because the urologist could not safely reach the stone. He placed a ureteral stent to dilate the ureter for a second attempt at stone extraction. The urologist documented that he planned to discharge the patient and that he would remove the stent in the office one week later.

The patient continued to report pain and remained in the hospital. On August 17, the urologist took the patient back to surgery for a second attempt at stone extraction. He could not reach the stone, but he did remove the stent.

Following the surgery, the urologist and patient discussed a plan to wait and see if the patient could pass the stone without further intervention. The patient was discharged on August 18.

The patient went to the ED on September 9 with bilateral flank pain. The emergency medicine (EM) physician documented that the patient passed a kidney stone while in the ED. The patient did not tell the EM physician of his previous treatment with the urologist.

On September 13, a scheduler from the urologist's practice called the patient to schedule surgery to remove the stent. The patient understood that the stent had already been removed on August 17 while he was in the hospital. As a result of this phone call,

the patient sent a text message to his wife stating, "I guess I'm going to have to sue the urologist." A later text message from the patient indicated that he had been called again to schedule surgery to remove the stent, "they swear it's still there."

The patient came to the hospital on September 21 for surgical removal of the stent. During the induction of anesthesia, the patient's heart stopped. He could not be resuscitated and died. An autopsy revealed a 95 percent occlusion of the left anterior descending artery. The cause of death was a sudden myocardial infarction from pre-existing severe atherosclerotic and cardiovascular disease.

Allegations

A lawsuit was filed alleging that the urologist failed to meet the standard of care in taking the patient back to surgery for stent removal when the procedure was not indicated or necessary. The plaintiffs also alleged that staff at the urology practice should have known the planned stent removal had already been performed while the patient was in the hospital.

Legal implications

The plaintiff's expert made credible arguments that the urologist should have inquired about whether the patient had already passed the kidney stone and should have been aware that he had already performed the planned procedure on the patient. The plaintiffs also criticized office staff for scheduling a procedure that had already been done. The urologist's operative report from the procedure to remove the stent — which occurred on August 17 — was not timely scanned into the patient's office chart.

The defense argued that the patient shared responsibility for the outcome because he did not tell the urologist during pre-op that there was a question of whether the stent remained and that the stone had passed during an ED visit two weeks earlier. Did the patient know he was about to undergo an unnecessary procedure? If so, why did he proceed?

Regarding causation, the defense asserted that the patient's reaction to the induction of anesthesia could not have been predicted or anticipated. The results of the patient's preoperative work-up were normal, and the patient had undergone a cardiac work-up six months earlier. The results of that cardiac work-up were also normal. The patient had twice recently undergone anesthesia without issue.

Disposition

This case was settled on behalf of the urologist and his practice.

Risk management considerations
Delay in documentation and incomplete records were issues that greatly affected the defense of this claim. The operative report that confirmed the removal of the stent had not been promptly added to the patient's record. This led office staff to schedule the patient for a procedure that had already been done.

Ideally, operative reports, hospital discharge summaries, consultant reports, and other external documentation should be added to patients' office records contemporaneously. This ensures the information needed for diagnosis and treatment is available to all members of the health care team.

Additionally, office staff should be trained on what actions to take if there is a discrepancy between what a patient reports and what is documented in the patient's record. Are these conversations documented in the medical record? Does appropriate follow up occur if a patient's operative history is unclear? Does follow up include alerting the treating physician? Does staff understand the critical nature of this type of discrepancy?

The defense of this case was also compromised by lapses in communication between the patient and his providers. The patient was not forthcoming about his medical history and the procedures performed by the urologist when he went to the ED on September 9. He was equally uncommunicative with the urologist before the second procedure, as the patient did not report that he passed the stone in the ED or that he believed the stent had already been removed. If this had been reported to the urologist, he could have confirmed the stent removal by reviewing the patient's hospital records.

CASE THREE: DELAY IN OBTAINING MRI

Presentation
On June 22, a 58-year-old man came to the ED of hospital A. He reported fatigue, nausea, vomiting, difficulty with balance and walking, chest pain, weakness, and flu-like symptoms for one week. The patient had a history of poorly controlled type 2 diabetes mellitus, hypertension, morbid obesity, alcoholism, and smoking.

The patient was examined by an emergency physician and diagnosed with diabetic ketoacidosis (DKA) and left leg weakness. The patient was admitted to the hospital under the care of an internal medicine physician.

Physician action
Just after being admitted, the patient reported numbness and weakness in both legs. The internal medicine physician ordered a neurology consult. In turn, the neurologist ordered an MRI, but the patient complained of chest discomfort and could not breathe when lying flat. The MRI study was rescheduled for the next morning. An additional CT scan was also ordered.

The next morning, June 23, the patient refused to have the MRI. The neurologist documented that the MRI was again not performed, and that the patient would need sedation before an MRI could be attempted. The neurologist also documented that the results of the CT scan did not explain the patient's symptoms.

On June 24, a pulmonologist saw the patient and suggested an MRI, but the patient again refused. The pulmonologist documented that the MRI could not be performed because the patient's weight prohibited him from fitting into the hospital's MRI machine.

Calls were made to numerous hospitals to transfer the patient to a facility with an MRI machine that could accommodate him and that had the staff and resources to sedate the patient.

On June 26, the patient was transferred to hospital B. The results of the MRI revealed an epidural fluid collection with associated spinal cord injury from T1 to T5. The patient's condition was classified as an "A" on the American Spinal Injury Association (ASIA) Impairment Scale. The A rating represents "complete" impairment, with no sensory or motor function below the injury level.

A neurosurgeon at hospital B discussed the findings with the patient and the need for spinal decompression. He advised the patient that the procedure would not reverse the condition and paraplegia was unavoidable. Eight days after surgery, the patient was discharged to a rehabilitation facility with persistent paraplegia.

Allegations
The patient filed a lawsuit against the internal medicine physician, the neurologist, the pulmonologist, and hospital A.

The allegations included delay in obtaining MRI to diagnose a spinal epidural abscess. It was further alleged that the delay allowed the spinal epidural abscess to grow and cause the patient's permanent paralysis.

Legal implications
Consultants who reviewed this case for the defense were mostly supportive of the care provided by the physicians.

Most of the consultants felt the logistics involved with transferring a patient whose condition was rapidly deteriorating and who could not physically be tested in the facility were the major factors in the outcome of this case. During his admission at hospitals A and B, the patient experienced multiple complications, including hip abscess, colostomy, renal failure, and decubitus ulcers. Several of these complications prevented transfer and/or surgery.

The patient's size and need for sedation before the MRI prevented the test from being performed at many facilities. Six hospitals refused to admit him. It was noted that once the patient was stabilized, every effort was made to obtain the scan. Yet, by the time he was stable for transport and the scan, it was probable that surgical intervention would not reverse the paraplegia.

A consultant for the plaintiff criticized the emergency medicine physician and the internal medicine physician for not recognizing the possibility of a spinal epidural abscess when the patient first came to hospital A. She felt this oversight contributed to the delay in diagnosis. She also noted that the internal medicine physician did not see the patient for 36 hours after ordering the neurology consult.

Another consultant felt the neurologist could have been more proactive and aggressive about obtaining the MRI, and that he should have consulted with a neurosurgeon earlier. The patient's poor condition and size, combined with the lack of an appropriate MRI machine delayed the process. These consultants also noted a lack of communication between the various providers seeing the patient.

An accusation of bias due to the patient's obesity was noted as a possible contributor to the delay and alleged lack of urgency by the providers.

Disposition
The case was settled on behalf of the physicians.

Risk management considerations
When multiple providers are involved in the care of a patient, continuity of care can become a greater challenge. That challenge can be overcome with increased direct communication between providers and with more detailed documentation. Unfortunately, lapses in communication between providers contributed to the poor outcome for this patient.

In this case, the different physicians were communicating primarily through the patient record, and the neurologist did not fully document his examinations, findings, or communications with the patient.

For example, the pulmonologist stated that he was not aware that the patient could not fit into or breathe lying flat in the MRI machine until he first met the patient on June 24. This was two days after the patient had been admitted and one day after the patient's first scheduled MRI had been cancelled. When reviewing the record before seeing the patient, the pulmonologist had assumed the patient refused due to anxiety.

While the patient could be seen as non-compliant in this case, his reasons for non-compliance were reasonable. His refusal was due to an inability to breathe while lying down and not being able to fit in the machine.

While the Americans with Disabilities Act (ADA) does not currently recognize obesity as a disability, the definition of the term "disability" has been expanded to make it easier for obese individuals to make disability claims.

Obese patients often do not seek health care services due to feelings of embarrassment, stigma, and disrespect in health care settings. Negative bias exists in our society — including the health care sector.

It is important to approach obese patients with empathy and respect, and to maintain a clinical

setting with suitable equipment and supplies. For obese patients, this could include providing sturdy, wide exam tables; extra-large patient gowns; restrooms with high, easy-rise toilets and extra space around the toilets; large adult blood pressure cuffs; and a discreetly located scale with the capacity to weigh patients who weigh more than 400 pounds.

The staff members at hospital A also lost time because they did not know which facilities in their area could accommodate the patient. They attempted to transfer the patient to multiple facilities but were refused, likely because those facilities also did not have adequate equipment to treat the patient.

In addition to transfer protocols, most facilities maintain a record of medical resources available in the area, including specialists, equipment, and locations. In this case, better knowledge about available equipment at local facilities might have helped staff members at hospital A find appropriate services for the patient in a timely manner.

CASE FOUR: FAILURE TO DIAGNOSE LEGIONELLA PNEUMONIA

Presentation

On June 14, a 65-year-old woman came to an urgent care clinic with fever, body aches, chills, and an abrasion on her leg. Her medical history included high cholesterol, obesity, sleep apnea, hypertension, GERD, and sinusitis.

The patient had also been treated for an upper respiratory infection with cough and fever for three weeks in March.

Physician action

The urgent care physician's assessment was negative for cough, dyspnea, fatigue, nasal congestion, wheezing, sinus pressure, nasal drainage, and sinus pain. The patient tested negative for influenza. The physician diagnosed her with flu syndrome and prescribed 75 mg oseltamivir and silver sulfadiazine topical cream (for the leg abrasion). The patient was instructed to keep her appointment with her primary care provider (PCP) scheduled for the following day.

The patient came to her PCP's group practice on June 15 and was seen by a physician assistant (PA). The patient continued to report fever, body aches, and chills. Her temperature was 99.3 degrees and her O2 saturations were 98 percent. The PA noted that the patient's lungs were clear to auscultation bilaterally, with no wheezes, no rales, and good air movement. The patient again tested negative for influenza. A chest X-ray was not performed.

The PA diagnosed the patient with influenza. She was started on cephalexin and instructed to fill her oseltamivir prescription and follow up in 10 days.

On June 17, the patient called the office and told the receptionist she still had fever and did not feel any better. The receptionist spoke to a medical assistant, who spoke to the PA, who advised the patient to give the medicine more time to take effect. (Recollections of these conversations are not entirely clear, and this telephone encounter note was not documented until three weeks later.)

On June 18, the patient went to a hospital ED, where she was found to be severely hypoxic. She was intubated and transferred to the ICU for management of her advancing respiratory failure. She was diagnosed with legionella pneumonia.

The patient's treatment was complicated by acute respiratory distress syndrome, septic shock, and multisystem organ failure. Despite ventilator support, the patient's oxygenation could not be maintained. She died from cardiopulmonary arrest on June 24.

Allegations

A lawsuit was filed against the PA and the internal medicine physician who supervised him. The allegations were:

- failure to diagnose and treat a patient with symptoms consistent with legionella pneumonia;
- failure to perform diagnostic testing, including X-rays;
- failure to rule out legionella pneumonia;
- diagnosing the patient with the flu despite contrary indicators;
- negligent supervision of the staff nurses and PAs (internal medicine physician); and
- vicarious liability (internal medicine physician).

Legal implications

Physicians who reviewed this case stated that

legionella pneumonia is an extremely rare condition. Symptoms include high fever, cough, shortness of breath, muscle aches, and headaches. According to these experts, the patient did not have these symptoms when she was seen by the PA, and she did not have symptoms that would have warranted a chest X-ray or any suspicion of pneumonia. "Any reasonably prudent health care provider would not have been expected to have Legionnaire's within the differential."

However, these experts were critical of the flu diagnosis. The patient should not have been diagnosed with the flu when the diagnosis was "uncertain." The chance of a patient having the flu in the summer with no upper respiratory symptoms and two negative flu tests is extremely low. Further, operating on the assumption that the patient had the flu led to staff giving inappropriate phone advice to the patient when she called to report that she did not feel better.

The issue of the phone call was further complicated by a late entry in the patient's medical record on July 10, three weeks after the patient's death. The entry documented that the patient was instructed to go the ED over the weekend if she did not feel better.

Disposition
This case was settled on behalf of the internal medicine physician.

Risk management considerations
Pneumonia caused by *Legionella* is similar to other forms of pneumonia. It is fatal in 10 percent of cases overall, and in 25 percent of health care associated cases. According to the U.S. Centers for Disease Control and Prevention (CDC), health departments reported nearly 10,000 cases of legionella pneumonia in the United States in 2018. However, because Legionnaires' disease is likely underdiagnosed, this number may underestimate the true incidence.[3]

The COVID-19 pandemic added challenges to the diagnosis and reporting of legionella pneumonia. The similarities in presentation of the two diseases led to diagnostic difficulties for health care providers. Co-infections occurred, but physicians may have declined to perform additional tests once COVID-19 was diagnosed. Or physicians may have suspected COVID-19 even with negative tests and delayed testing for other conditions, such as legionella pneumonia.[4]

Predominant symptoms of legionella pneumonia include fever, cough, and shortness of breath. Symptoms typically begin two to 10 days after exposure to contaminated water or soil. Fever and fatigue often occur before the cough or shortness of breath. Rales may also be present on physical examination.[5, 6]

"The index of suspicion for Legionella infection should be particularly high during known outbreaks, which are often associated with contamination of water supplies in large facilities such as hospitals, hotels, or apartment buildings. Other epidemiologic factors that should heighten suspicion for Legionella infection include known or potential exposure to a contaminated water source (e.g., hot tubs, birthing pools, fountains) and exposure to soil or potting mix in areas where the incidence of *L. longbeachae* is high." [6]

Risk factors for legionella pneumonia include older age (50 years or older), smoking, chronic respiratory disease, diabetes mellitus, and other immunocompromising conditions.[3]

In this case, when the patient was seen in the office, she did not exhibit symptoms that would have alerted the PA to the need for further testing. Yet, as the experts reviewing the case stated, the diagnosis of influenza was "uncertain" and unlikely.

The patient called two days later to report that she was not improving. This persistence of symptoms along with the two negative flu tests in a 65-year-old patient was concerning. Further investigation — including a chest X-ray, urinalysis, and CBC — may have been warranted. Recommending prompt follow up when the patient called the office may have led to a different outcome.

Three other risk management issues in this closed claim study are worth noting.

Late entries
The patient's phone call and the PA's instructions were not documented in the medical record contemporaneously. Rather, an entry about instructing the patient to visit the ED was added after

the patient's death. This entry was perceived as an alteration to the medical record.

It is appropriate to make a late entry or addendum in the medical record, but only with proper identification and the reason for the delayed entry. The entry should be clearly labeled as "late entry" or "addendum" and include the date of the addendum and the date to which it relates. "Correcting" the medical record without clearly indicating that you are doing so is considered altering the medical record, and is easily discovered in an electronic health record. While there may be no breach of the standard of care, attempted record alterations are difficult to defend and can damage a defendant's credibility.

Telephone triage
It is a good risk management practice to have well-defined telephone triage protocols in place and to make sure they are followed by staff. Physicians are cautioned not to place too much responsibility into the hands of unlicensed or unqualified staff.

Protocols should have a low threshold for escalation and should encourage transfer or review of calls to a physician when needed. The content of calls, including specific date, time, symptoms, and what instructions were given to the patient, should be documented.

Phone call protocols should be included in the practice's policy and procedure manual. Make sure that staff members are aware of all policies and procedures and have them sign and date their acknowledgement and understanding of these policies.

Supervision of the PA
Though the internal medicine physician did not see the patient, as the supervisor of the PA, she was responsible for the care the PA provided. Ensuring that everyone understands their roles and responsibilities, maintains open lines of communication, and addresses challenges together are essential to the successful collaboration of physicians and advanced practice providers (APPs).

One way to enhance this collaboration is to establish written protocols. In some states, including Texas, written delegation protocols or collaborative agreements are required by law. These protocols should define the role of the APP in detail and describe the main types of cases the APP will see.

These protocols can further provide general clinical parameters, such as limiting the number of times a patient can see the APP without seeing the physician or specifying the types of injuries or symptoms that must be examined by a physician within 24 hours or other defined time period.

Knowledge of and adherence to these protocols builds a good foundation for collaboration and ensures that patients receive quality care.

CASE FIVE: FAILURE TO PERFORM A THOROUGH WORK UP

Presentation and physician action
On June 11, a 42-year-old man passed out while jogging on a treadmill at the gym. Employees at the gym called paramedics who took the patient to the ED. He was examined by an emergency medicine (EM) physician.

The patient told the EM physician that he had been outside in the heat all day and drank a beer before working out at the gym. He had not had any water that day. The patient's vital signs and EKG results were normal. He was diagnosed with dehydration. After receiving fluids, the patient was discharged.

The patient's history included aortic stenosis (AS) that had been diagnosed several years before. He was under the care of a cardiologist, who had performed yearly exams and echocardiograms on the patient for the last five years. The patient's AS had progressed and was considered severe; however, the patient did not have any symptoms. In previous conversations between the cardiologist and the patient, the option of a valve replacement surgery was discussed but not acted upon.

Upon release from the ED, the patient called his cardiologist to inform him of the syncope episode and the EM physician's diagnosis of dehydration. The cardiologist documented the conversation, including his advice to stay hydrated and to call back if he experienced any additional episodes. The cardiologist did not ask the patient to come in for an examination.

For the next three months, the patient continued his regular routine of work and heavy exercise. He did not report any additional syncope episodes. On September 8, the patient passed out again on the treadmill. Paramedics were called, but the patient could not be revived. He was pronounced dead.

The medical examiner attributed the patient's death to cardiovascular disease. It was also discovered that the patient was taking anabolic steroids without the cardiologist's knowledge.

Allegations
The patient's family filed a lawsuit against the cardiologist and the EM physician. Allegations included failure to perform a thorough work-up on June 11 for a patient with aortic stenosis and syncope (EM physician) and failure to refer the patient for surgery for severe aortic stenosis (cardiologist).

Legal implications
Defense consultants stated that when the patient experienced the syncope episode on June 11, he was no longer asymptomatic and should have undergone more testing.

Further, the fainting episode should have prompted the cardiologist to obtain the ED records; talk with the EM physician; examine the patient and perform an echocardiogram and stress test; and instruct the patient to abstain from strenuous activity. Referral to a cardiac surgeon for valve replacement was also recommended.

Another consultant felt the ED records did not support the diagnosis of dehydration and that the EM physician's treatment was below the standard of care. This consultant stated the patient should have been instructed to follow up with his cardiologist upon discharge. Instead, the patient took it upon himself to do so.

However, other consultants agreed with the cardiologist's position that careful monitoring was a more appropriate treatment strategy because the patient did not have recurring or worsening symptoms. The fainting episode was not necessarily related to the patient's AS, and the cardiologist's acceptance of the dehydration diagnosis was reasonable. One consultant pointed out that the patient's use of steroids may have caused hypertrophy and sudden death via cardiac arrhythmia.

Disposition
This case was settled on behalf of the cardiologist and the EM physician.

Risk management considerations
The defensibility of this case might have been better if the cardiologist had reviewed the ED records, spoken with the EM physician, and established a reasonable probability that the syncope episode was not related to the patient's AS. This was especially true because the patient continued to exercise strenuously for months after the episode without additional symptoms.

The patient was discharged from the ED without orders to follow up with his cardiologist. Had the EM physician given the patient a formal recommendation for cardiology follow-up, involvement from both physicians may have prompted additional testing.

CASE SIX: RETAINED CATHETER

Presentation
A 77-year-old man was admitted to a local hospital for pneumonia. He was treated successfully with ventilation, IV antibiotics, bronchodilators, and IV steroids.

As he was being discharged, a nurse pulled the IV catheter out of his arm and the catheter tip broke off. He was bleeding profusely from the site, and the nurse applied pressure.

The patient's physician thought he could feel the catheter underneath the skin immediately adjacent to the wound. A general surgeon — the defendant in this case — was called.

Physician action
The general surgeon examined the patient and ordered X-rays. X-rays revealed a 2 cm curvilinear foreign body near where the catheter had been placed. The general surgeon gave the patient local anesthesia, placed a tourniquet above the object, and made an incision. He could not retrieve the catheter. The general surgeon extended the incision but could not locate the catheter tip.

The general surgeon repeated the X-rays, and the catheter tip could no longer be seen. The patient was taken to the operating room for a more thorough exploration. Two superficial veins were completely dissected. X-rays were repeated with fluoroscopy, and the tip could not be found. The general surgeon extended the incision but could not locate the tip. He irrigated and closed the incisions.

The patient was discharged the next day. X-rays were repeated two days later, but the catheter was not seen on the film. The sutures were removed, and the wound was completely healed one month later.

The patient reported that he was experiencing constant pain, a burning feeling, and a dead feeling in his left arm. He claimed the procedure caused limited use of his left hand, including difficulty doing yard work or heavy lifting.

Allegations
A lawsuit was filed against the general surgeon alleging negligence in:

- failing to obtain informed consent from the patient for the use of a tourniquet;
- failing to properly use a tourniquet to arrest the flow of venous blood and to stop further migration of the broken catheter;
- failing to visualize the broken catheter by X-ray or fluoroscope; and
- failing to obtain informed consent regarding surgery.

The hospital and manufacturer of the catheter tip were also named in the suit.

Legal implications
The plaintiffs claimed that the pain in the patient's arm was caused by nerve damage. Their expert argued that the surgeon should have consulted a radiologist before the surgery to remove the catheter. He was also critical of the use of the tourniquet, claiming that a venous tourniquet should have been in place the entire time of the procedure.

Defense experts maintained that the surgeon met the standard of care. The attempt to remove the catheter was justified, and the use of the tourniquet and X-rays was appropriate. The expert also stated that he did not see where any damage would come from the surgery. The dissection of the veins in the subcutaneous space was superficial. There are no arteries, nerves, ligaments, tendons, or muscle in this space. Therefore, damage by the dissection was limited to scarring.

Disposition
The case was taken to trial and a jury returned a verdict in favor of the defendant general surgeon. The case against the hospital and catheter manufacturer was settled.

Risk management considerations
The defense consultants were supportive of the general surgeon, and felt he met the standard of care in his choice of X-ray, fluoroscope, tourniquet, and surgery.

While the physician prevailed at trial, there were weaknesses in the informed consent process. Obtaining informed consent is an ethical obligation of physicians. The process ensures an understanding by the patient of their diagnosis, planned procedures, risks, and therapeutic alternatives – both medical and surgical. Failing to obtain informed consent outside of a true emergent situation, where implied consent is appropriate, may render a physician potentially vulnerable to a medical liability claim.

CASE SEVEN: FAILURE TO DIAGNOSE CORNUAL PREGNANCY

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

The patient's vital signs were normal, but she had tenderness along her abdomen. Blood work indicated that she had a white blood cell count of 8,000 and mild anemia. The emergency medicine (EM) 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 EM physician.

However, the EM physician claimed that the radiologist reported that the ultrasound showed a normal intrauterine pregnancy. "Normal intrauterine pregnancy" was written in the ED records.

The EM 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 PID. She was told to rest at home and follow up with her obstetrician. The EM physician later stated that the patient was discharged because she refused hospitalization, but this was not indicated in the medical record.

A second radiologist reviewed the ultrasound images when he arrived at 8 a.m. He noted that the ultrasound showed an intrauterine cornual pregnancy, a pregnancy in which implantation occurs in the uterus at its junction with the fallopian tube. He recommended that the patient be brought back in for further studies to evaluate the position of the pregnancy.

According to his testimony, he asked the radiology technician to call the patient and have her return. The patient was never called. The technician stated that the radiologist never requested that she call the patient.

The patient continued to experience abdominal pain at home before calling EMS at 9:44 a.m. When she arrived at the hospital, she reported acute pain and difficulty breathing. Ten minutes later she coded, and CPR was started.

She was sent to the OR for an emergency laparotomy due to suspected ruptured ectopic pregnancy. CPR was continued throughout the surgery. The surgeon located and removed the cornual pregnancy from the left side of the uterus and noted between 1.5 and 2 liters of blood in the abdominal cavity. Despite CPR and several defibrillations, the patient was pronounced dead at 12:17 p.m. The pathologist found the cause of death to be ruptured ectopic cornual pregnancy complicated by acute shock and exsanguination.

Allegations

A lawsuit was filed against the radiologists and the EM 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 (EM 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 that the final diagnosis of intrauterine pregnancy was incorrect. The patient did not have an obvious extrauterine ectopic pregnancy, but a pregnancy in an unusual position that was neither extrauterine nor intrauterine. In any case, according to the plaintiff's expert, the failure to diagnose the cornual pregnancy led to the patient's inappropriate discharge from the hospital and her death.

Radiology consultants for the defense 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 EM 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 EM physician. In his deposition, the radiologist said that if he had been certain the patient had an ectopic pregnancy, he would have contacted the patient immediately. Since this diagnosis was a "gray area" and since he was informed that the patient had been discharged from the ED, he asked the technician to contact the patient.

Regarding the actions of the EM 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, the experts felt that he should have performed a pelvic exam and obtained an ob-gyn consult. A pelvic exam might have yielded additional information to make the diagnosis. An ob-gyn consult should have been ordered because he had a pregnant patient in severe pain without an ectopic pregnancy.

Defense experts argued that a pelvic exam was not necessary since an ultrasound had been ordered. An obstetric consult was also not necessary because the patient was already under the care of an obstetrician and it was determined, based on the ultrasound, that her condition was not life threatening.

Of great concern in this case was the poor communication between physicians and the apparent lack of documentation about what was discussed. The first radiologist should have documented his interpretation by transmitting a report to the hospital immediately. Though the EM physician did document 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 EM physician advising him of the need for follow-up studies might have been more appropriate than dictating the need for call back in the report.

Disposition

This case was settled on behalf of the EM physician and the two radiologists.

Risk management considerations

In hindsight, actions that might have made a difference in the outcome of this claim have been mentioned above. Are oral reports without quick follow up with a written report acceptable in teleradiology? Was the impression clearly understood when the physicians spoke? It seems unlikely that the EM physician would ignore the word "abnormal." That is not what he heard. A report transmitted to the ED would alert him to "intrauterine but abnormal."

Are images of poor quality satisfactory for interpretation away from the facility? What protocols are in place to determine when the on-call radiologist comes in?

Communication and timely action may influence outcomes when studies are abnormal and follow up is required. The practice of radiology lends itself to well-defined systems that guide when the ordering physician is told of abnormal findings and any recommendations for further studies. Document this contact.

The American College of Radiology (ACR) has developed guidance for radiologists on communicating and documenting "nonroutine" or emergent results, including findings that suggest a need for immediate or urgent intervention, discrepancies with preceding interpretations, and significant unexpected results. This guidance discusses both methods for communication and the need to document nonroutine communications.[7]

Employing sound risk management techniques and implementing well-designed systems to observe the standards of care will promote quality health care and reduce the exposure a radiologist encounters on a daily basis.

CASE EIGHT: NEGLIGENCE IN PRESCRIBING BOWEL PREP MEDICATIONS

Presentation
On June 23, a 71-year-old woman came to a gastroenterologist for evaluation of colon polyps. The patient had no constipation but reported right lower quadrant pain. Her medical history included hypertension, osteopenia, hyperlipidemia, and renal artery stenosis. She had undergone a colonoscopy six years earlier during which five polyps were removed.

Physician action
The gastroenterologist recommended an EGD and colonoscopy to evaluate the patient for erosive esophagitis and Barrett's esophageal disease and to rule out colon polyps and malignancy. During this visit, the patient was given instructions for her bowel prep. The notes list: "Bisacodyl 4 tabs BID" and sodium phosphate enema "60 ml x 3." She was given an instruction sheet to take home.

The gastroenterologist performed the EGD and colonoscopy on July 20. The results of the EGD were normal. The colonoscopy revealed three rectal polyps and sigmoid diverticulosis, but no other abnormalities.

On July 22, the patient was brought to the emergency department of a local hospital after having diarrhea for three days. She reported ongoing lightheadedness and an episode of syncope after she was given medication to clean out her bowel. She had produced a large volume of stool in the previous days.

The patient was diagnosed with acute renal failure. The presence of muddy brown casts in her urine led physicians to consider that acute tubular necrosis caused her renal failure.

The nephrologist documented that the patient's serum creatinine was 9.3 mg/dL and her blood urea nitrogen (BUN) was 62 mg/dL upon admission. The initial impression was that the acute tubular necrosis was likely the result of diarrhea and diminished oral intake leading to volume depletion. The plan was to infuse normal saline, monitor electrolytes and fluid balance, and consider dialysis if her BUN approached 100 mg/dL.

After a complicated hospital course, the patient was discharged on August 9. She required chronic maintenance hemodialysis. She received a kidney transplant two years later.

Allegations
A lawsuit was filed against the gastroenterologist, alleging that he prescribed an excessive amount of bowel prep before the colonoscopy. This excessive amount caused the patient to become dehydrated and led to her renal failure. The plaintiffs further alleged that the gastroenterologist did not warn the patient about the risks of the bowel prep and did not clearly instruct her about the need to stay hydrated.

Legal implications
After attending a national meeting and learning about a study in which physicians were using greater than the manufacturer recommendation of the sodium phosphate bowel prep, the defendant began using the amount from the study. His patients began experiencing better results for a while, but the gastroenterologist decided on his own to increase

the bowel prep. This patient was the only patient to experience an adverse reaction from the bowel prep.

The defense of this case was complicated by the defendant's off-label use of bowel-prep medications. Two gastroenterologists who reviewed this case for the defense did not support the dosage of bowel prep. "Although there is reasonable justification for use of a greater than 2 dose (90 ml) regimen of sodium phosphate in preparation for colonoscopy, the regimen prescribed (three 60 ml doses, 180 ml total) would be considered by most practicing gastroenterologists to be of the level that may pose a higher risk of inducing significant dehydration as well as other adverse effects such as electrolyte disturbance and renal insufficiency."

Disposition

This case was settled on behalf of the gastroenterologist.

Risk management considerations

When a medication is prescribed for an off-label use or in a dosage exceeding the recommended dose, the physician's rationale should be documented in the medical record. Documentation of the discussion that occurred informing the patient of the risks, benefits, and alternatives when ordering a bowel prep greater than the manufacturer recommendations would have been beneficial and indicated that the patient was informed and involved in the decision-making process. Providing clearly written instructions to the patient about dehydration and the need to maintain a certain volume intake may have been helpful to the patient and the physician.

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