the REPORTER

CME: DELEGATION TO MEDICAL ASSISTANTS: RISKS, REWARDS, AND SAFETY STRATEGIES

CLOSED CLAIM STUDY: FAILURE TO PROPERLY PERFORM GYNECOMASTIA LIPOSUCTION

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CME: DELEGATION TO MEDICAL ASSISTANTS: RISKS, REWARDS, AND SAFETY STRATEGIES

by Tanya Babitch, Assistant Vice President, Risk Management

The closed claim study used in this article 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.

OBJECTIVES

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

1. discuss appropriate roles and scope for medical assistants working in outpatient physician practice;
2. identify potential areas of medical liability risk when supervising medical assistants; and
3. apply risk management strategies to increase patient safety when supervising and delegating to medical assistants.

COURSE AUTHOR

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DISCLOSURE

Tanya Babitch has 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 learning practical ways to reduce the potential for malpractice liability.

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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.

ETHICS CREDIT STATEMENT

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

TEST

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

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RELEASE/REVIEW DATE

This activity is released on September 1, 2025, and will expire on September 1, 2028. 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

Medical assistants (MAs) have become an integral part of the health care team in both inpatient and outpatient settings. The use of MAs in outpatient physician practices has become widespread, with almost 90 percent of primary care practices employing MAs.[1] The majority of MAs (56 percent) work in outpatient physician practices. Employment of MAs is estimated to grow 15 percent from 2023 to 2033.[2]

With many new MAs entering the workplace, it is not uncommon for training to occur onsite after employment by a physician practice. MAs' educational opportunities vary widely, from an associate's degree and certification to no formal training. Certification or formal education by an accredited institution is not required for MAs working in some states, including Texas, but some states do have training or educational requirements. In 2023, data from the American Association of Medical Assistants (AAMA) and the Bureau of Labor Statistics indicated that approximately 10 percent of MAs were certified by such organizations as the AAMA, the National Healthcareer Association (NHA), and the American Medical Technologists (AMT).[3]

In many practice scenarios, even if an MA has formal education and/or certification, a significant portion of their training occurs on the job. The quality of this on-the-job training, along with appropriate selection of delegated tasks, detailed protocols, ongoing monitoring, and effective communication within the health care team, can ensure that MAs have clear guidance on how to function well within your practice.

For physicians, there is potential liability for the actions of MAs — as with other non-physician members of the health care team. Liability may arise from allegations of vicarious liability or negligent supervision. These claims may involve allegations that the physician practice (as the employer) was responsible for acts of their employees, or that the physician should have been more active in supervision of the care provider. In both these scenarios, a medical practice's prior implementation of appropriate delegation protocols, training, and observation of the health care team can prevent claims, mitigate liability, and increase defensibility in the event of a claim.

SCOPE OF PRACTICE

Outside of state-specific regulations, an MA's scope of practice may, to a certain extent, be determined by the physician. This scope may be dependent on the skill level, certification, and experience of the MA.

MAs may not exercise independent medical judgment or perform independent medical assessments, but may perform delegated tasks that do not require clinical judgment. Some of the duties commonly performed by MAs include administrative and clinical tasks, such as:

- scheduling appointments;
- escorting patients to the exam room;
- conducting patient history interviews;
- taking and recording vital signs;
- preparing patients for examinations;
- entering information into the medical record;
- transmitting prescriptions to pharmacies;
- communicating with patients via telephone or EMR portal (with protocols to determine the acuity of the patient's concern);
- assisting with medical examinations/surgical procedures;
- setting up/cleaning patient rooms;
- maintaining inventory;
- restocking supplies in patient rooms;
- performing venipuncture;
- collecting and preparing laboratory specimens and performing basic laboratory tests;
- administering immunizations or other medications as directed;
- removing sutures and changing dressings;
- performing electrocardiograms (with specialized training);
- notifying patients of laboratory results (as directed by protocol);
- assisting with patient education and instruction; and[4]
- tracking laboratory and diagnostic test orders.

DELEGATION LAWS AND RULES

Appropriate delegation by physicians to staff (including MAs) is critical. Rules regarding who can delegate duties to MAs vary from state to state. For more information on rules and regulations regarding delegation and scope of practice, the American Association of Medical Assistants (AAMA) offers a listing by state of applicable laws. Physicians are encouraged to review their state's specific laws and rules to ensure compliance.[5]

For example, in most outpatient settings in Texas, MAs may not perform medical acts without delegated authority from a physician. If working in a practice setting that also employs nurses, registered nurses (RNs) may delegate

certain nursing tasks, such as taking and documenting vital signs, to MAs.[6] Tasks that require independent medical or nursing judgment should not be delegated to MAs, but Texas law does allow a certain amount of latitude to physicians determining what tasks are delegable to their MAs.

The Texas Occupations Code states that a "physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician", the act:

- can be properly and safely performed by the person to whom the medical act is delegated;
- is performed in its customary manner; and
- is not in violation of any other statute.

Importantly, the "delegating physician remains responsible for the medical acts of the person performing the delegated medical acts".[7]

Physicians must determine what acts can be performed safely by MAs within their practices. Again, the MA's training, experience, and skillset must be considered before determining what acts may be appropriately delegated. MAs working in your practice may be delegated different tasks depending on these factors. If so, be sure that the protocols that outline who can do what are clearly delineated.

If you practice outside of Texas, please check the AAMA listing and your state laws for further guidance.

PROCEED WITH CAUTION AND PLANNING

A review of TMLT's medical liability claims involving the actions of MAs reveals certain "danger" areas. As physicians are burdened with more tasks, it may be tempting to allow MAs to take on more responsibilities and expand the scope of their duties within the practice.

Additionally, there may be instances when a trusted MA with a long-term relationship with the physician may be encouraged to take on tasks that are outside of their role or to manage tasks independently. Taking steps to monitor duties and ensure that MAs are not working outside their scope is essential.

> **Common areas of risk seen in medical liability claims include lack of training and supervision, [medical assistants] performing duties outside of their scope, and communications with patients without appropriate protocols or guidance.**

Common areas of risk seen in medical liability claims include lack of training and supervision, MAs performing duties outside of their scope, and communications with patients without appropriate protocols or guidance. Allowing or encouraging MAs to perform tasks outside of their scope can be a risk to your patients, your practice, and you. Taking appropriate steps at the beginning of an MA's employment, and re-assessing regularly, can help clarify roles and reduce risks.

RISK MANAGEMENT AND SAFETY STRATEGIES FOR TEAM SUCCESS

Training, observation, and revisiting skills checklist regularly

Establishing good training protocols when a new MA joins your practice can set them up for success. The following steps may help you realistically assess an MA's strengths and weaknesses and identify what training is needed before your MA begins participating in patient care.

- When a new MA joins the practice, provide them with a detailed job description, practice policies and procedures, and applicable protocols. Give them time to review, ask questions, and share any concerns. Encourage open dialogue and let your team know that there are no "stupid questions." Once their review is complete, obtain their signature and date to indicate their acknowledgment.
- Maintain documentation of any certifications, education, or training your staff has participated in, whether externally or within your practice. If MAs are recertified or participating in ongoing training, continue to collect and maintain these records.
- During onboarding, realistically assess your MA's training, experience, and skill level before determining readiness to perform assigned tasks. If additional training is needed, allocate time and personnel to perform the training.
- While performing initial training, conduct an observation period during which you watch the MA performing essential tasks. Document your observations, such as dates, number of patients/cases, task(s) observed X number of times, task(s) performed successfully or additional training needed, etc. Use a skills checklist to record their competency in each task. Skills checklists may include tasks such as taking vital signs, obtaining a patient history, reviewing and updating medications, documenting in the EMR, administering and documenting vaccines, and other duties.
- Take time to regularly reassess the role of individual MAs within your practice. Revisit the skills checklist biannually, annually or more frequently if needed.
- When delegating new tasks, consider first whether they are within the MA's scope, and whether your MA has any prior experience performing that task. If not, ensure training is thorough and observe and monitor new tasks as you would for a new MA.

TRANSPARENCY REGARDING MAs WORKING IN THE PRACTICE

Clarity within your practice and with your patients about the role of MAs will help set reasonable expectations. In addition, protocols that demonstrate patient awareness of who is involved in their care and that no one was represented dishonestly, can protect you and your staff in the event of a claim.

- Do not refer to MAs as nurses. Train front desk personnel or staff taking phone calls to refer to everyone in the practice by name and appropriate designation. For example, staff should not say "Let me transfer you to Dr. X's nurse" when transferring a call to an MA. If a patient asks to speak to "Dr. X's nurse," they can be gently corrected by stating, "Let me transfer you to Dr. X's medical assistant, Beth" (or something similar).
- The use of name tags or visible identification for all staff in your practice is recommended. It helps patients develop relationships with your team and clarifies staff roles.
- MA entries and signature in the record should include their role, i.e. "Beth Smith, MA", and any certification if applicable; "Beth Smith, CMA."

DELEGATION AND PROTOCOLS

The physician should develop clear delegation protocols regarding tasks performed by MAs. These protocols should include detailed instructions on performing tasks, so it is clear that MAs are not expected — or allowed — to exercise clinical judgment. Protocols should be reviewed and updated regularly or as needed, and the delegating physician(s) and MAs should review and acknowledge via signature and date when changes are made. Protocols may include guidance on many (or all) of the MA duties. Outlined below are areas of risk that have been identified in medical liability claims.

VACCINE AND MEDICATION ADMINISTRATION

If MAs in your practice administer vaccines or other medications, your protocols should include specifics about how to appropriately perform and document these tasks. Points to cover may include how to safely draw and administer injections, infection control measures, distribution and documentation of Vaccine Information Statements (VIS), and precautions for patient safety such as pre-injection questions/screening and post-injection patient observation.

RESPONDING TO PATIENT CALLS OR QUESTIONS

It's important to remember that triage is not within the scope of an MA's duties. In fact, only physicians, advanced practice providers (APPs), or RNs can perform triage that involves independent clinical judgment. In many practices, MAs may be the "front line" in managing patient calls and messages. If this is the case, consider these steps to reduce your risk.

- If taking patient calls or reviewing EMR portal messages, MAs should have clear written protocols developed by the physician(s) to guide their actions. A protocol may be as simple as, "Any clinical question is forwarded to Dr. X or APRN X."
- If physicians allow MAs to respond directly to inquiries from patients, protocols should be more detailed, comprehensive, and problem-specific. For example, if a patient contacts the practice about certain symptoms they are experiencing, protocols should address whether the call should be escalated to a physician or APP, and what symptoms are considered emergent, urgent, or necessitate referral to the emergency department or same-day appointment.
- When applicable, MAs should be supplied with specific screening questions to ask the patient to determine next steps (escalation or patient instructions). These screening questions should not require independent analysis or clinical judgment.
- MAs should be encouraged to consult with a physician, APP, or RN if they are unsure about a response.

MEDICATION REFILL MANAGEMENT

Medication refill requests from patients must be managed with great care. Inappropriate approvals of medication refills without "guardrails" (protocols) could result in significant patient harm.

In many practices, refills may be reviewed and approved only by a physician or APP. Some practices allow refills to be filled by other clinical staff with written protocols, while others allow a clinical team member to do the initial screening and forward approved refills to the physician for final sign-off before sending to the pharmacy. Ultimately, physicians must decide what they are comfortable delegating.

State regulations should also be considered. Certain states, such as California, have specific laws regarding the MA's role in refill management.[8] Texas law does not address the role of MAs in refill management, but does require that physicians designate and retain a list of the personnel who are allowed to transmit refills to pharmacies.[9]

If you allow MAs or any staff member in your practice to play a role in refill management, proceed with caution and develop appropriate protocols. Protocols to guide refill management may include the following.

- **A limited list of medications that may be refilled by MAs or another staff member.** Be conservative when determining which medications are appropriate for this list.
- **A list of the types of medications that may NOT be refilled by MAs or another staff member.** These might include controlled substances, antibiotics, and other medications that have significant risks or contraindications.
- **A list of mandatory questions to ask patients.** These questions should be determined by the physician. A patient answering "yes" to any of these questions would necessitate review by the physician before any further action is taken. Example questions may include:
  - Are you taking any other prescribed or over-the-counter medications or supplements that are not on the list we went over?
  - Do you have any issues or questions about the medication you're requesting?
  - Is there a possibility you are pregnant? (if applicable to medication)
  - Are you requesting a change of dosage?
- **Additional parameters determined by the physician(s)**, such as:
  - number of refills allowed;

- whether the patient has had appropriate lab testing within the required timeframe;
- whether the refill is within an acceptable timeline from last appointment; and
- whether a scheduled follow-up appointment is required to process the refill request.

Err on the side of caution. Allowing staff members to manage portions of the refill process should be done only after careful consideration. If questions arise or a staff member is uncertain about a refill request, they should be trained/instructed to consult a physician.

COMMUNICATION AND TEAM ENGAGEMENT

Physicians, as leaders of the team, must encourage staff to communicate any concerns or questions openly and without fear. Communication failure has been identified in multiple studies as a significant contributor to patient injury and medical liability. The Joint Commission identifies "communication error among the most common attributable causes of sentinel events." [10] Open and clear communication may be the most critical factor when working as a part of a health care team.

- As discussed above, develop written, acknowledged protocols that are readily available to all for review when needed. Regularly assess these protocols as a team. If questions or issues arise, meet to review together in a group discussion. While emailing and messaging has become a primary communication method, in-person meetings may achieve goals more promptly and with clarity for all.
- When possible, engage MAs in making decisions regarding protocols and processes that they will be expected to perform. For example, if MAs manage the process for tracking and following lab or other diagnostic orders, review your EMR system's capabilities together to determine how best to use them. Once processes have been developed, check in with the team after a week or two to see how well the process is working. If issues need to be addressed, ask for their ideas to help resolve them. People are much more likely to follow a protocol or process if they have been engaged and involved in its development.
- Hold regular, scheduled staff meetings to discuss any issues affecting the practice or your patients. Ask that staff share their questions, concerns, or ideas in these meetings. If concerned about time, ask for agenda items before the meeting.
- Reiterate to your team that you want to hear from them, and that open communication will not be punished. It is preferable to know if your staff needs additional training or has questions about a process before issues arise.
- Give MAs ongoing, constructive feedback. Do not ignore problems that are identified; address any issues promptly.

IN SUMMARY

The medical assistants you work with every day are a vital part of the patient care team. Working closely with them to establish good protocols and communication enhances both the safety of your patients and your practice. By prioritizing the development of workflows and protocols and encouraging effective communication and team engagement, physicians can support MAs and other staff to work within their professional boundaries.
Taking these steps enhances patient safety and leads to high-functioning care teams. A proactive approach toward working with your MAs and clinical team helps to minimize risk of liability and fosters a culture of accountability and continuous quality improvement.

CASE STUDY: FAILURE TO SEE PATIENT FOR FOLLOW UP

Presentation

A 51-year-old man came to the emergency department (ED) of a regional medical center at 2:55 p.m. on Thursday. The patient had been seen at his employer's health clinic for mild chest pain, right arm pain, left arm pain, and thigh pain. Before that visit, the patient had played one hour of tennis. His employer's clinic called his family physician who instructed the patient to go to the ED immediately.

In the ED, the patient said that he took no medications, had no prior surgeries, and had borderline high blood pressure. He played tennis daily for exercise, did not smoke, but drank beer.

Physician action
According to the ED triage nurse, the patient reported chest tightness since 10 a.m. and joint discomfort. The discomfort worsened with activity. His initial vital signs were blood pressure, 151/101 mm Hg; pulse, 106 bpm; respirations, 22. He was placed on a monitor and pulse oximeter and was noted to be in no acute distress.

An emergency medicine (EM) physician examined the patient at 3:25 p.m. He noted the patient was in mild distress but was otherwise asymptomatic. When specifically questioned by the physician, the patient refused to use the term "chest tightness" for what he experienced, instead calling it a "chest sensation." He told the physician his symptoms had started the day before, and that he had a physical one month earlier.

The EM physician completed a thorough physical exam, and the results were normal. He ordered a monitor, chest x-ray, pulse oximeter, oxygen, IV access, and lab work including CBC, UA, Chem7, cardiac enzymes, and PT/PTT. He ordered two baby aspirin to be given. The physician's recollection is that the patient's chest "sensation" did not occur during the exam.

The patient's lab results and chest x-ray were within normal limits. An EKG revealed a normal sinus rhythm with nonspecific T-wave changes laterally. Because the patient did not have chest pain during the ED visit and his symptoms started more than 24 hours earlier with no enzyme elevation, the physician did not recommend admission.

At 5:15 p.m., the EM physician called the patient's family physician to schedule a follow-up appointment. Though the details of this conversation were not documented, an appointment was scheduled for 11:30 a.m. Friday, the next day.

The patient was discharged at 5:30 p.m. He was instructed to follow up with his family physician, resume a normal diet, and take ibuprofen 3 times a day. He was further advised to rest, and report to the ED if persistent or worsening symptoms arose.

The patient did not keep the Friday follow-up appointment. He died Saturday, two days after the ED visit, while playing basketball with his son. The autopsy report listed the cause of death as "a cardiac arrhythmia due to myocardial ischemia due to severe coronary atherosclerosis (heart attack)."

Allegations
Lawsuits were filed against both the EM physician and the family physician. The plaintiffs alleged that the EM physician was negligent for not immediately admitting the patient to the hospital. Allegations against the family physician involved the scheduling and management of the patient's follow-up appointment.

Legal implications
In reviewing this case for the plaintiffs, an emergency medicine expert stated the patient should have been admitted for serial EKGs and cardiac enzymes to rule out acute coronary syndrome. A prompt stress test should also have been scheduled. The plaintiff's emergency medicine expert indicated that had the patient been admitted, he would still be alive.

To the defense experts who reviewed this case — including two cardiologists and three emergency medicine physicians — the main weakness of the case was that the physician did not admit the patient or order repeat EKGs or cardiac enzyme tests.

The EM physician stated that there were four pieces of information the patient did not share: history of playing tennis when the pain started; history of high cholesterol; history of having been seen at his employer's health clinic that day; and history of a prior cardiac work up by a cardiologist. The physician stated had he known that the patient's pain started when he was playing tennis, he would have admitted him as an urgent, but stable patient.

For the focus of this article, discussion of what happened at the family physician's practice is most relevant. Conflicting testimony was given by the family physician and the patient's wife about the rescheduled appointment.

The patient's wife testified that when her husband called the family physician's office on Friday to confirm the appointment, a staff member told him that the physician was booked all day and could not see him. The appointment was rescheduled for Monday.

Upon reviewing the details of this case, a consultant reviewer felt the standard of care was not met because the patient's follow-up appointment was rescheduled by the physician's office staff. The reviewer stated that if the patient had been seen as scheduled on Friday morning, treatment, referral, or advice could have been rendered that would have prevented his death.

The family physician's MA testified that when the patient called, he stated he was feeling better and did not want to come in that day. She told him that was fine and to come in on Monday, and in the meantime to follow the doctor's instructions from the hospital. The MA did not check with the physician before telling the patient it was all right to come in on Monday.

This conversation was documented in the medical record as "feels better and wants to wait until next week." However, the MA admitted that she made this entry on Monday after the office had learned that the patient died. The entry was dated Friday.

Patient accountability was an issue in this case. In his discharge instructions, the EM physician told the patient to "rest." The patient's wife acknowledged that the patient knew he should not play sports, but did not follow those instructions. The patient was playing basketball when he collapsed and died.

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

Risk management considerations
As discussed, establishing policies and procedures that outline appropriate staff communications with patients are recommended. Doing so may prevent staff from exceeding their authority and rendering advice or making decisions without the physician's knowledge.

Cancellation of and rescheduling appointments can be a challenging area to manage, but the addition of a few questions for staff to ask patients may be helpful. For example, asking if a patient has been recently discharged from a hospital visit might reveal information requiring a higher level of attention and escalation to a physician.

In this case, due to the late documentation (after the patient's death), it was unclear whether the patient was told the practice was too busy for him to be seen, or whether he initiated the rescheduling of his appointment.

Protocols for documentation in the medical record apply to the entire health care team. Phone calls function as a key component of health care, and any communications regarding patient care should be documented in the record promptly. In this case, there were two instances of missing or late documentation: the conversation between the emergency and family physician and the phone call between the patient and MA that was not documented contemporaneously.

In addition, the late entry — after the patient's death — by the MA was not identified as such and cast doubt upon the credibility of the entry. Any late entry to a medical record should be clearly identified and dated as such, with the signature of the staff member making the addendum. Any addendum should include the date and time of the actual encounter referenced, and the reason for the addendum.

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CLOSED
CLAIM
STUDY

FAILURE TO PROPERLY PERFORM GYNECOMASTIA LIPOSUCTION

by Laura Hale Brockway, ELS, Vice President, Marketing

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

A 42-year-old man came to a weight loss and aesthetic clinic to be treated for night sweats and fatigue. Family Physician A, who owned the clinic, attributed the patient's symptoms to his use of testosterone and marijuana. The patient was employed as a coach and fitness instructor.

The patient returned two months later to discuss bilateral gynecomastia liposuction. He reported a history of excess fat in his breasts since puberty. Family Physician A — who had received training in liposuction and autologous fat transfer — would perform the procedure. Tumescent local anesthesia was to be used, as the patient could not afford to have the procedure performed in the OR.

PHYSICIAN ACTION

On the day of the procedure (April 6), Family Physician A went through an extensive informed consent process with the patient. Family Physician A explained what would take place during the procedure, and that the post-procedure instructions were important to follow. He also addressed the complications of bruising, bleeding, and contour irregularities. The patient confirmed his understanding of these risks and signed the consent forms. He also signed a form consenting to a video recording of the procedure. Preoperative photos were taken and added to the patient's medical record.

The procedure began at noon. According to the operative note, this was a difficult case due to glandular tissue that was fibrosed and strongly attached to the skin. According to Family Physician A, this was the first time he encountered this much glandular tissue during a gynecomastia procedure. He documented that as he was bluntly dissecting the upper pole of the glandular tissue, his scissors cut through the skin in two places where there was minimal subcutaneous fat.

The patient was shown the area where the cuts occurred. According to the medical records, the patient told Family Physician A not to worry, and that he would tattoo over his chest area. Because blood loss was minimal and hemostasis was achieved, Family Physician A did not place a drain.

Before discharge, Family Physician A told the patient to contact him if he saw any signs of skin necrosis or infection. He also told the patient that it was very important for him to take a break from exercising for two weeks. The patient agreed to this and was discharged at 1:50 p.m.

The next day, Family Physician A called the patient and learned that he had been to the gym. The patient came to the office and the records noted that the left breast looked larger than the right breast, though there were no signs of infection. Antibiotic ointment was applied, and the patient's chest was re-bandaged. Family Physician A recommended lymphatic drainage massage. He again advised the patient to avoid exercise and heavy lifting.

Two days later (April 9), Family Physician A travelled out of town for a family emergency. He scheduled the patient for an office visit before he left town, but the patient did not return for the appointment.

The patient was next seen on April 10. Family Physician A's medical assistant performed a lymphatic massage and confirmed there were no signs of infection. Family Physician A received a text from the patient on April 12 about the development of bilateral bruising. He told the patient he could see the clinic's physician assistant (PA) or a plastic surgeon.

On April 18, the patient texted Family Physician A that his left breast was swollen. The patient was treated by the clinic's PA at this visit. The patient's left side was draining blood. The PA attempted to drain the hematoma, but the hematoma was too hard. The patient was referred to Plastic Surgeon A.

Plastic Surgeon A saw the patient on April 19 and documented that he had a hematoma on the left breast greater than the right and that it was draining through the incision. Plastic Surgeon A performed an exploration, incision irrigation,

debridement, and evacuation of the leaking hematoma in the OR on April 20. The indications for the procedure were the patient's increased level of activity, no drain, and bilateral hematomas.

The patient healed well after the second procedure, with no recurrent hematoma, no seroma, and no collection of fluid. Ten months after the second procedure, Plastic Surgeon A noted that the patient had one persistent area of lipodystrophy along the inframammary fold on the left chest wall. The patient did not want further surgery.

ALLEGATIONS

A lawsuit was filed against Family Physician A, alleging that he was not qualified to perform gynecomastia liposuction and should have referred the patient to a plastic surgeon. It was further alleged that Family Physician A failed to place a drain, which led to the hematomas, open wound, pain, and additional procedure.

LEGAL IMPLICATIONS

In her medical records, Plastic Surgeon A stated that Family Physician A performed an overly aggressive mastectomy. Other plastic surgeons who reviewed this case expressed similar opinions. While stating that the surgery was well documented and that the informed consent process was thorough, they questioned the Family Physician's training and ability to perform gynecomastia liposuction.

Causation was also an issue in this case, as both reviewers stated that the patient was very active following the first procedure and this may have caused the bilateral hematomas.

Two other factors affected the defense of this case. Family Physician A recorded the procedure in order to create a "before and after" video to post on social media. The consent form signed by the patient for the video recording specified that his identity would not be shown. The patient's face was visible at the end of the video. If the video had been posted on social media, it would have violated the terms of consent. Another difficulty for the defense involved Family Physician A's use of a general liposuction consent form that did not specify excision of the gynecomastia tissue.

DISPOSITION

This case was settled on behalf of Family Physician A.

RISK MANAGEMENT CONSIDERATIONS

When performing elective cosmetic procedures, physicians face unique legal risks. The following risk management considerations highlight key areas of focus in this case.

Scope of practice and appropriate referral

It is good risk management practice for physicians to carefully assess whether a planned procedure falls within their formal training, skill set, or scope of practice. Even with additional training, complex procedures — such as gynecomastia involving significant glandular excision — may require referral.

Informed consent and procedure-specific forms

Ensure that consent documents match the actual planned procedure. Documents should detail all expected components of the planned surgery (e.g., liposuction and glandular excision for gynecomastia). Risks specific to the procedure should be clearly explained and documented.

Postoperative instructions and patient adherence

When patients do not adhere to postoperative advice, document all counseling and efforts to reinforce instructions,

as non-compliance can contribute to complications and defense challenges. Consider implementing a standardized, written postoperative instruction sheet that patients sign to confirm understanding.

Photography, video, and social media

Obtain detailed, written documentation of informed consent when recording or photographing patients. Take additional steps to confirm that no identifying features (e.g., face) are visible. When using clinical photos or videos for promotional or educational purposes, ensure patient privacy and confidentiality are protected. Obtain written consent for the specific planned use (social media, website, etc.) of any photographs or videos.

CLOSED
CLAIM
STUDY

COMPLICATIONS FROM SPINAL FUSION PROCEDURE

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

A 50-year-old man came to see a pain management physician (PM Physician A) on March 1, 2022. The patient's history included hypertension, knee replacement, and knee and back pain. He had a BMI of 47 (Class III or extreme obesity).

The patient reported lower left side pain that radiated to the left hip with pressure on his lower back. A week earlier, the patient had a caudal epidural steroid injection (CESI) at L4-L5 that failed to relieve his pain.

He also recently completed a prescribed program of chiropractic care for six weeks and had an MRI two months earlier.

The MRI findings revealed "congenital lumbar spinal stenosis with superimposed acquired central canal stenosis at L2/L3, L3/L4, and L4/L5 with cauda equina crowding and exiting nerve root anatomic impingement. There is a 3mm annular bulge at L2/L3 and again at L3/L4. Bilateral L5 nerve root anatomic impingement was found and moderate acquired central canal stenosis at L1/L2 with 3mm annular bulge and bilateral L1 nerve root anatomic impingement."

PHYSICIAN ACTION

PM Physician A examined the patient and documented decreased sensation on the lower left thigh, knee, medial leg, lateral leg, and dorsum of the foot. Straight leg raising test was positive at degrees. The patient was noted as "ambulating independently with normal gait."

The physician's impression was lumbar spondylolistheses, degeneration of lumbar intervertebral disc, and spinal stenosis of the lumbar region. PM Physician A scheduled the patient for spinal fusion surgery on March 16. Fusion would be at the patient's L4-L5, using a minimally invasive, interspinous-interlaminal fusion device to stabilize and create space in the spine.

On March 15, a pre-surgical x-ray of a lateral view of the patient's lumbar spine did not show any evidence of acute fractures. Results of a new MRI showed severe, multi-level intervertebral disc disease at L1-L2 and L3-L4. Anterolisthesis was found at L4-L5.

The next day, PM Physician A took the patient to surgery at Hospital A. He obtained informed consent from the patient and documented the patient's history and physical exam. He also noted that the patient's previous epidural steroid injections indicated that the source of the pain originated from a nerve root compression and degeneration involving the L3-L4 segment.

PM Physician A used fluoroscopic guidance for the procedure. The L4-L5 segment was identified on lateral view as the spinous processes of the adjacent segments. During the procedure, PM Physician A attempted to place a guide pin between the spinous processes at the L4-L5 segment. However, the interspace was too tight, and the guide pin would not pass through to the contralateral side. The procedure was aborted.

The patient was discharged the next day on March 18, with prescriptions for acetaminophen 300mg for low back pain with no refills, cephalexin 500mg, and tizanidine 4mg.

The patient was rescheduled for posterolateral fusion and fixation at L4-L5 with allograft bone graft implants on March 23. The patient reported to Hospital A for surgery as scheduled and PM Physician A performed the procedure.

The operative note did not note patient positioning prior to the procedure, only indicating that it was appropriate. No complications were noted, and vitals remained stable. The physician also noted the patient was able to transfer himself to the OR stretcher on his own and was transported to the recovery room in stable condition.

While in the post-anesthesia care unit, the patient began having severe diarrhea. The nurses notified PM Physician A. He did not come to evaluate the patient, as he did not feel the diarrhea was related to the surgery. He recommended

anti-diarrhea medication for the patient.

The patient was discharged, but his condition deteriorated when he arrived home. His daughter called EMS. When they arrived, they found the patient in respiratory distress with gastrointestinal bleeding. The patient was transported to Hospital B but was comatose on arrival and in hemorrhagic shock. The patient was admitted to the ICU, intubated, and given vasopressors and multiple transfusions.

Imaging revealed a small retroperitoneal hemorrhage. An esophagogastroduodenoscopy with embolization of the gastroduodenal artery was performed. The patient was in multi-organ system failure and his condition in steep decline. The patient died the next day.

ALLEGATIONS

A lawsuit was filed against PM Physician A and Hospital A. The allegations included:

- failure to have the proper training, experience, and skill necessary to perform a complex spinal surgery;
- failure to properly position the patient during surgery;
- unnecessary and improper surgical technique;
- failure to address postop complications; and
- improper and unsafe postoperative discharge of patient.

LEGAL IMPLICATIONS

Consultants for the plaintiff and defense criticized PM Physician A for acting outside the scope of his specialty (pain management) in performing complex spinal surgeries. The procedures in this case are typically performed by orthopedic spine surgeons or neurosurgeons. PM Physician A's training in this procedure was from a four-day training session.

Hospital A was also alleged to be negligent for not verifying PM Physician A's board certification and specialized training (fellowship or advanced certification) before allowing him to perform this surgery.

A defense neurosurgery expert stated that PM Physician A erroneously documented and coded the procedures as an L4-L5 fusion with fixation but there was no fixation. This expert believed that the surgery resulted in an L4 transverse process fracture and a retroperitoneal bleed. The expert further stated that PM Physician A violated the retroperitoneal space and this led to the patient's death.

Both plaintiff and defense consultants stated that the patient was not safely positioned for spinal surgery in a way that would protect his abdominal organs and circulation. There was no documentation that the patient was adequately monitored, or that his position was adjusted to avoid compression of and damage to his organs, circulation, and tissues.

There was little to no documentation on the patient's positioning. Members of the surgical team testified that padding was used to position the patient, but there was finger pointing among the team about who was responsible for monitoring the patient's position and his post-surgical care.

There was also minimal documentation about the patient's history or pre-operative condition. There was no documentation of the patient's potential risks and contraindications. Extreme obesity and inability to lie prone for the duration of the procedure are established contraindications for these types of procedures. There was no documentation of whether risks and contraindications were discussed with the patient or his family before surgery. The results from the patient's preoperative MRI were also not found in the patient record.

DISPOSITION

The case was settled on behalf of PM Physician A. The hospital also settled with the plaintiff.

RISK MANAGEMENT CONSIDERATIONS

As the general U.S. population ages, the need for more intensive pain care is on the rise. To meet demand, many physicians in pain management and anesthesiology have expanded their skillsets to include interventional pain procedures and surgeries.

It is the position of the American Academy of Pain Medicine that "interventional pain procedures, and surgeries, be performed by a physician with sufficient training and expertise for the performance of any given procedure, as are the standards in other interventional and surgical subspecialties in medicine."[1]

To learn more about the requirements for expanding clinical skills or performing new procedures, please check with your state medical board or specialty society.

In this case, PM Physician A's documentation was either minimal or absent. Complete, accurate, and contemporaneous documentation is a physician's first, best defense in the event of a claim. Poor or sloppy documentation may lead a jury, plaintiff's attorney, or another physician to think the documenting health care professional is negligent or uncaring toward the patient. Thorough patient records help physicians maintain a better continuity of care between providers and reduce questions of liability in the event of a claim.

SOURCES

1. American Academy of Pain Medicine. AAPM Statement on Scope of Practice in Pain Medicine. Approved by the AAPM Executive Committee on September 6, 2017. Available at https://painmed.org/aapm-statement-on-scope-of-practice-in-pain-medicine/.
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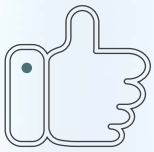

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