The following is a compilation of medical malpractice claim data from 1985 to 2010, submitted by 20 member companies of the Physician Insurers Association of America (PIAA). The PIAA is a trade association of liability insurance companies that insure more than 60% of private practicing physicians. TMLT submits claim data to the PIAA data study, but these data are reported in a codified manner. Names are not reported.

The PIAA database contains information on 256,225 claims from 28 specialties, closed between January 1, 1985 and December 31, 2010. For all claims, 29.4% were closed with indemnity payment, and the average indemnity payment was $216,842. The total indemnity paid out on behalf of all physicians in the database is $16.3 billion.¹

The following report highlights the three most prevalent medical misadventures per specialty along with the three most prevalent patient conditions associated with the misadventure. These conditions are those presented to the physician at the time of the alleged incident.

What follows is not meant to be an in-depth analysis, but a snapshot of claims by specialty. This information is designed for use as a risk management tool to inform physicians about the nationwide risk trends for their specialty.

**Anesthesiology**

Most prevalent medical misadventures and associated patient conditions

1. No medical misadventure²
   - brain damaged infant
   - pregnancy
   - back disorders including lumbago and sciatica

*continued on next page*
2. Improper performance
   • back disorders including lumbago and sciatica
   • pregnancy
   • cataracts

3. Intubation problems
   • broken tooth
   • central nervous system complications of a procedure
   • cardiac or cardiopulmonary arrest

**Cardiovascular and thoracic surgery**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • coronary atherosclerosis
   • chronic ischemic heart disease
   • aortic aneurysm

2. No medical misadventure
   • coronary atherosclerosis
   • acute myocardial infarction
   • arterial embolism and thrombosis

3. Errors in diagnosis
   • aortic aneurysm
   • acute myocardial infarction
   • malignant neoplasms of bronchus and lung

**Cardiovascular diseases (nonsurgical)**
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   • acute myocardial infarction
   • chest pain, not further defined
   • aortic aneurysm

2. No medical misadventure
   • coronary atherosclerosis
   • acute myocardial infarction
   • chest pain, not further defined

3. Improper performance
   • coronary atherosclerosis
   • acute myocardial infarction
   • malignant neoplasms of bronchus and lung

**Gastroenterology**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • benign neoplasm’s of the colon or large intestine
   • symptoms involving abdomen and pelvis
   • calculus of gallbladder or bile duct

2. Errors in diagnosis
   • malignant neoplasms of the colon and rectal region
   • symptoms involving abdomen and pelvis
   • regional enteritis, colitis

3. No medical misadventure
   • symptoms involving abdomen and pelvis
   • regional enteritis, colitis
   • hemorrhage of gastrointestinal tract

**Dermatology**
Most prevalent medical misadventures and associated patient conditions

1. No medical misadventure
   • dyschromia
   • acne
   • malignant neoplasms of the skin

2. Improper performance
   • dyschromia
   • malignant neoplasms of the skin
   • acne

3. Errors in diagnosis
   • malignant melanoma
   • malignant neoplasms of the skin
   • disorder of skin and subcutaneous tissue

**Emergency medicine**
Most prevalent medical misadventures and associated patient conditions

1. Error in diagnosis
   • acute myocardial infarction
   • appendicitis
   • symptoms involving abdomen and pelvis

2. No medical misadventure
   • symptoms involving abdomen and pelvis
   • chest pain, not further defined
   • acute myocardial infarction

3. Improper performance
   • open wound of fingers
   • symptoms involving abdomen and pelvis
   • open wound of hand

**General and family practice**
Most prevalent medical misadventures and associated patient conditions

1. Error in diagnosis
   • acute myocardial infarction
   • malignant neoplasms of the female breast
   • appendicitis
2. No medical misadventure
   • alopecia
   • no abnormal condition or no treatment encounter
   • symptoms involving abdomen and pelvis

3. Improper performance
   • calculus of gallbladder or bile duct
   • pregnancy
   • admission or office treatment for sterilization

**General surgery**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • calculus of gallbladder or bile duct
   • cholecystitis
   • inguinal hernia

2. No medical misadventure
   • symptoms involving abdomen and pelvis
   • inguinal hernia
   • calculus of gallbladder or bile duct

3. Errors in diagnosis
   • malignant neoplasms of the female breast
   • appendicitis
   • symptoms involving abdomen and pelvis

**Gynecology**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • endometriosis
   • disorders of menstruation and other abnormal bleeding from the female genital tract
   • benign neoplasms of the uterus

2. Errors in diagnosis
   • malignant neoplasms of the female breast
   • neoplasms of the female breast (unknown if malignant or benign)
   • ectopic pregnancy

3. No medical misadventure
   • benign neoplasms of the uterus
   • pregnancy
   • female infertility

**Internal medicine**
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   • malignant neoplasms of the bronchus and lungs
   • acute myocardial infarction
   • malignant neoplasms of colon and rectal region

2. No medical misadventure
   • acute myocardial infarction
   • chest pain, not further defined
   • symptoms involving abdomen and pelvis

3. Improper performance
   • symptoms involving abdomen and pelvis
   • acute myocardial infarction
   • chest pain, not further defined

**Neurology (nonsurgical)**
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   • headache
   • malignant neoplasms of the brain
   • intracranial and intraspinal abscess

2. No medical misadventure
   • back disorders including lumbago and sciatica
   • headache
   • cerebrovascular accident

3. Improper performance
   • displacement of intervertebral disc
   • back disorders including lumbago and sciatica
   • convulsions

**Neurosurgery**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • displacement of intervertebral disc
   • back disorders including lumbago and sciatica
   • disc disorder of unspecified region

2. No medical misadventure
   • displacement of intervertebral disc
   • back disorders including lumbago and sciatica
   • fracture of vertebral column

3. Errors in diagnosis
   • displacement of intervertebral disc
   • fracture of vertebral column
   • back disorders including lumbago and sciatica

**Obstetric and gynecologic surgery**
Most prevalent medical misadventures and associated patient conditions
1. Improper performance
   • pregnancy
   • admission or office treatment for sterilization
   • brain damaged infant

2. No medical misadventure
   • pregnancy
   • brain damaged infant
   • delivery of normal, single gestation

3. Errors in diagnosis
   • malignant neoplasms of the female breast
   • ectopic pregnancy
   • pregnancy

**Ophthalmology**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • cataracts
   • myopia
   • retinal detachments and defects

2. No medical misadventure
   • cataracts
   • retinal detachments and defects
   • moderate to severe visual impairment

3. Errors in diagnosis
   • retinal detachments and defects
   • glaucoma
   • other visual disturbances

**Orthopedic surgery**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • generalized or localized osteoarthrosis
   • fracture of the femur
   • disorder of the joint, not including arthritis

2. No medical misadventure
   • spondylosis and inflammatory spondylopathy
   • generalized or localized osteoarthrosis
   • disorder of the joint, not including arthritis

3. Errors in diagnosis
   • disorder of the joint, not including arthritis
   • fracture of the foot
   • fracture of the femur

**Other nonsurgical specialties** (includes podiatry, physical and rehabilitative medicine, and hospitalist)
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   • disorder of autonomic nervous system
   • displacement of intervertebral disc
   • fracture of the femur

2. No medical misadventure
   • back disorders including lumbago and sciatica
   • disorder of the joint, not including arthritis
   • displacement of intervertebral disc

3. Improper performance
   • back disorders including lumbago and sciatica
   • disorder of the joint, not including arthritis
   • bunion

**Otorhinolaryngology**
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   • sinusitis
   • desire for plastic surgery
   • deviated nasal septum

2. No medical misadventure
   • sinusitis
   • deviated nasal septum
   • diseases of the upper respiratory tract (including pharynx, larynx, and vocal cords)

3. Errors in diagnosis
   • malignant neoplasms of the larynx
   • malignant neoplasms of the pharynx and pharyngeal region
   • malignant neoplasms of the tongue

**Paraprofessional** (non-physician health care professionals)
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   • appendicitis
   • symptoms involving abdomen and pelvis
   • chest pain

2. Improper performance
   • open wound of knee, leg, or ankle
   • no abnormal condition or no treatment encounter
   • pregnancy
3. No medical misadventure ²
- injury to multiple parts of body
- chronic disease of tonsils and adenoids
- no abnormal condition or no treatment encounter

Pathology
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   - malignant neoplasms of the cervix
   - malignant neoplasms of the female breast
   - malignant melanoma

2. No medical misadventure ²
   - no abnormal condition or no treatment encounter
   - malignant neoplasms of the female breast
   - malignant neoplasms of the cervix

3. Improper performance
   - neoplasm of the breast, unknown if malignant or benign
   - female infertility
   - malignant neoplasms of the uterus

Pediatrics
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   - meningitis
   - appendicitis
   - specified nonteratogenic anomalies

2. No medical misadventure ²
   - brain damaged infant
   - routine infant or child health check
   - meningitis

3. Improper performance
   - brain damaged infant
   - circumcision
   - respiratory problems in the newborn

Plastic surgery
Most prevalent medical misadventures and associated patient conditions

1. Improper performance
   - desire for plastic surgery
   - dyschromia
   - hypertrophy of breast

2. No medical misadventure ²
   - desire for plastic surgery
   - dyschromia
   - congenital anomaly of the skin and integument

3. Failure to communicate/instruct patient
   - congenital anomaly of the skin and integument
   - desire for plastic surgery
   - benign mammary dysplasia

Psychiatry
Most prevalent medical misadventures and associated patient conditions

1. No medical misadventure ²
   - depressive disorder, not further defined
   - no abnormal condition or treatment encounter
   - neurotic disorder, not further defined

2. Medication errors
   - depressive disorder, not further defined
   - schizophrenia
   - bipolar affective disorder

3. Failure to supervise or monitor case
   - depressive disorder, not further defined
   - neurotic disorder, not further defined
   - major depressive affective disorder

Radiation therapy
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   - symptoms involving abdomen and pelvis
   - chest pain, not further defined
   - malignant neoplasms of the bronchus and lungs

2. No medical misadventure ²
   - symptoms involving abdomen and pelvis
   - injury to multiple parts of body
   - chest pain, not further defined

3. Improper performance
   - malignant neoplasms of the female breast
   - malignant neoplasms of the back, flank, or trunk (point of origin unspecified)
   - malignant neoplasms of the prostate

Radiology
Most prevalent medical misadventures and associated patient conditions

1. Errors in diagnosis
   - malignant neoplasms of the female breast
   - malignant neoplasms of the bronchus and lungs
   - neoplasm of the breast, unknown if malignant or benign

2. No medical misadventure ²
   - malignant neoplasms of the female breast
• malignant neoplasms of the bronchus and lungs
• neoplasm of the breast, unknown if malignant or benign

3. Improper performance
• malignant neoplasms of the female breast
• back disorders including lumbago and sciatica
• malignant neoplasms of the bronchus and lungs

Urologic surgery

Most prevalent medical misadventures and associated patient conditions

1. Improper performance
• calculus of kidney and ureter
• disorder of penis
• admission or office treatment for sterilization

2. No medical misadventure
• calculus of kidney and ureter
• malignant neoplasms of the prostate
• disorder of penis

3. Errors in diagnosis
• malignant neoplasms of the prostate
• disorder of male genital organs
• malignant neoplasms of the kidney

References


2. As defined by the PIAA, no medical misadventure occurs when there is no allegation of inappropriate medical conduct, but the claim has legal merit because of associated issues, such as problems with medical records, consent issues, communication between physicians, vicarious liability, product liability, etc.

New pricing for CME courses

Effective January 1, 2012, new pricing will take effect for the following TMLT CME courses.

Spring and Fall Seminars
policyholder: to remain at $25
non-policyholder: $125

Online CME (Course Insite)
policyholder: reduced to $25
non-policyholder: $100
Available at www.tmlt.org/onlineCME

Video CME
policyholder: to remain free
non-policyholders: $75
Available at www.tmlt.org/video

Video CME content will continue to be available at no cost. This fee is assessed when CME credit is applied for.

Reporter CME
policyholders: to remain free
non-policyholders: $75
Available at www.tmlt.org/reportercme

Reporter CME content will continue to be available at no cost. This fee is assessed when CME credit is applied for.

For more information, please contact the TMLT Risk Management department at risk@tmlt.org or by calling 800-580-8658.

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TrendsMD

Connecting physicians

Connect with physicians and other professionals on TMLT’s new blog, TrendsMD.

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http://www.trendsmd.com
Making a difference for patients and their families: early childhood intervention

Objectives
At the conclusion of this educational activity, the physician should be able to:

1. explain the benefits of early identification and referrals for developmental delays;
2. discuss the difference between developmental surveillance and developmental screening;
3. identify three tools used to detect developmental delays; and
4. list two referral sources.

Instructions
You have two options to obtain CME credit from this activity.

Option 1 – online
Complete Reporter CME test and evaluation forms online. After reading the article, go to www.tmlt.org/reporterCME. Click on “Earn CME” under “Making a difference for patients and their families: early childhood intervention” (2011 Volume 5). Follow the instructions to complete the test and evaluation forms. Your CME certificate will be emailed to you. Please allow up to 4 weeks for delivery of your certificate.

Option 2 – on paper
Please read the entire article and answer the CME test questions on the paper test forms on page 13. To receive credit, submit the completed test and evaluation forms to TMLT. All test questions must be completed. Please print your name and address clearly. Please allow 4 to 6 weeks from receipt of test and evaluation form for delivery of the certificate.

Questions? Please call the TMLT Risk Management Department at 800-580-8658, ext. 5919.

Estimated time to complete activity
It should take approximately 1 hour to read this article and complete the questions.

Release/review date
This activity is released on October 3, 2011, and will expire on
October 3, 2014. Please note that this CME activity does not meet TMLT’s discount criteria. Physicians completing this CME activity will not receive a premium discount.

**A mother’s story**

We never truly suspected that anything was atypical with our son’s behavior until that conference with his preschool teacher. Justin had just turned three. Ms. Vickie explained that he was not playing with the other kids. He did not reciprocate in conversation and seemed to become easily engrossed in certain activities to the exclusion of his classmates and other class activities. She gave us the phone number for the local school district’s Preschool Program for Children with Disabilities (PPCD) and encouraged us to call and have him screened.

Being a first-time mom and inexperienced in raising a boy, my first response was that Justin was just shy. I was concerned that Ms. Vickie was trying to “label” him because he was different. I did not want to contact the PPCD program because they too would assign a label that would follow Justin through school. “Schools just don’t know what to do with kids who are different,” I thought.

Justin’s 3-year well check occurred a few weeks later. His pediatrician had been treating Justin since he was 8 months old. She knew him, knew us, and we considered her as part of the family. When I shared with her Ms. Vickie’s concerns, she encouraged me to seek the PPCD screening. She told me not to worry about him being labeled and that special education services were different from what they had been when I was in school.

After that discussion and some soul searching, we decided to have Justin screened. I contacted PPCD and was immediately put at ease. The screening coordinators were kind, understanding, and genuinely interested in helping my son. Justin passed the first screening, but we were told to bring him back in 6 months for an additional screening. At the second screening, they ordered a full evaluation. Unsure of what the full evaluation would reveal, I spoke to his pediatrician again. She encouraged us to have the evaluation. Again she stressed that this would ultimately help my son.

The results from the full evaluation indicated that Justin had “symptoms associated with the autism spectrum,” but they recommended special education services for him based on a pragmatic language delay. They wanted to enroll him in the early learning environment program at his local elementary school campus. In this program they would work to strengthen his social and communication skills in preparation for kindergarten.

Another visit to the pediatrician….she again reassured me and told me that funding for special education services was scarce, and they would not be spending resources for my son unless there was a real need. She also referred us to a pediatric neurologist to obtain another opinion.

Four years later, Justin has been given the diagnosis of PDD-NOS (pervasive development disorder, not otherwise specified) by his neurologist. He takes medication for his anxiety and to help curb some of his obsessive behavior. We take him to see the neurologist three times per year. We still see his pediatrician for well checks and sick visits. Justin’s prognosis is good.

Justin receives special education services through his school based on an autism diagnosis. He receives supportive services through school, but spends most of the day in his general education third-grade classroom. He makes good grades and has several friends. He attends a social skills class once a week.

Looking back on that pivotal year in Justin’s life — which started with concern expressed by his teacher and culminated with his enrollment in a special education program — I am grateful to his astute preschool teacher, to his supportive pediatrician, and to the caring PPCD screening coordinators. I have no doubt that early intervention made a difference for my son.

**Introduction**

Developmental disabilities are prevalent and affect an estimated 17% of children under the age of 17 in the United States. Although some delays in the attainments of milestones in speech, motor, or social-adaptive development may be transient, developmental delays in early childhood are strongly associated with diagnoses such as mental retardation, cerebral palsy, speech disorders, autism, and learning disabilities later in childhood.

Others estimate that 18% of children under the age of 18 have either developmental delays or chronic physical, behavioral, or emotional conditions that place them at risk for such delays. The American Academy of Pediatrics (AAP) estimates that 12% to 16% of children have developmental or behavioral disorders.

Studies have shown that intervention before kindergarten has significant academic, social, and economic benefits. The estimated economic benefit is from $30,000 to $100,000 per child. Late identification of children with disabilities requires states, schools, and taxpayers to pay for expensive special education programs for delays that may have been resolved — or at least treated more effectively and at a lower cost — during the preschool years.

**Delays often under-detected**

Despite these benefits, developmental delays are frequently under-detected.

Parents look to their primary care physician to give them a nod if “everything is okay” with their child’s development. And while parents may not be able to specify the areas that need to be addressed, the expectations are there. Parents trust that their child’s doctor — who provides care over months or years — will be able to identify developmental strengths and weaknesses and to know when referrals are needed. The detection of developmental disorders is an integral component of well-child care.

A federal mandate requires primary care professionals who treat children and adolescents to provide early identification and
intervention for children with developmental disabilities through community-based collaborative systems. This mandate is found in Title V of the Social Security Act (42 USC Chapter 7, Subchapter V ss701-710 (1989) and is reaffirmed in the Individuals with Disabilities Education Improvement Act (IDEA) of 2004 (Pub. I. No. 108-446). 4

In 2001, the AAP published a policy statement calling for universal developmental screening of infants and young children as part of routine well-child care. The emphasis was on selecting a standardized screening tool that was practical and could be easily implemented in the office setting. 5 However, a 2003 survey found that 71% of AAP fellows used only clinical observations without a screening instrument to identify children with a developmental delay. 4 This is consistent with another estimate that one-fifth of providers used formalized screening instruments; thus significant developmental delays are frequently under-detected. 3

**Surveillance**

In 2006, the AAP issued a policy statement to refine and improve developmental screening in the primary care setting. The AAP called for:

• developmental surveillance at every well-child visit with concerns promptly addressed;
• standardized developmental screening tests to be administered regularly at the 9-, 18-, and 30-month visits; (Screening may also be administered at 24 months of age, as the 30-month visit is not reimbursable by third-party payers.) 5; and
• standardized autism-specific tool on all children at the 18-month and 24-month preventive visits. 5

“There are 5 components of developmental surveillance: eliciting and attending to the parents’ concerns about their child’s development; documenting and maintaining a developmental history; making accurate observations of the child; identifying risk and protective factors; and maintaining an accurate record of documenting the process and findings.” 4

The purpose of developmental screening is not to make a diagnosis or produce a treatment plan, but rather to identify areas in which a child’s development differs from others his/her age and who may be at risk for potential problems. 4

A statement of reaffirmation for this policy was published on February 1, 2010. 5

**Early detection**

What role does the primary care physician play in the early detection of developmental disabilities? What factors influence a physician’s decision to “wait and see” or refer? A study published in Pediatrics tested these factors using a national random sample of 800 pediatricians and 800 family physicians. A survey was sent that included three clinical vignettes describing children between 18 and 27 months of age with likely developmental delays who came for preventive care visits. 1

**“Vignette 1: gross motor delay**

Sara, an 18-month-old girl, is in for a well-child visit. Sara’s family just moved to your area. Her previous medical records are not yet available. Her mother states that Sara has always been in good health.

• Version 1 (Parental concern): . . . but she is concerned that Sara is not walking yet.
• Version 2 (No parental concern): . . . and has no concerns about her development.

Sara is pulling to a stand but not yet cruising or walking. She gets into sitting position and crawls. She says three words, and is starting to feed herself using a spoon. Sarah’s growth is normal for her age. Her physical exam is remarkable only for mild hypotonia with reflexes 1+ throughout. Based on this information, what action(s), if any, would you take at this visit?

**Results for Vignette 1: gross motor delay**

With regards to both versions of the vignettes, one third of physicians indicated they would refer the child to physical therapy strictly on the basis of the information presented, and two thirds would refer to early intervention services in the community. Approximately 60% of physicians reported that they would refer the child to a medical specialist for an additional evaluation. A total of 87% of physicians reported that they would likely provide 1 or more of the possible referrals on the basis of the information provided.

**Conclusion:** the presence of parental concern was not associated with an increased likelihood of increased referrals.

**Vignette 2: social delays and behavioral issues**

Brian, a 20-month-old boy whom you know well, is accompanied by his father and grandmother for well-child care. Brian continues in good health with normal growth. Brian’s family reports that he is walking well, and has 10 words. He can occupy himself for an hour at a time, and his grandmother comments...

• Version 1 (Avoidant): . . . He’s easy, almost too easy for a child his age. He doesn’t seem to need anything from us.
• Version 2 (Disruptive): . . . He’s easy if you let him do his own thing. But if you try to dress him or take him to the store, he has a tantrum, so I can’t take him anywhere.

And he doesn’t look at me like my other grandchildren do.’ His father believes Brian’s behavior will improve ‘when he learns to use his words to tell us what he wants, instead of just repeating them back to us.’ His physical exam is normal. Based on this information, what action(s) would you take at this visit?

**Results for Vignette 2: social delays and behavioral issues**

Half of the physicians indicated that they would refer the child for audiometry to rule out a hearing loss, half would refer to intervention services, and two thirds would refer to a medical special
ist or psychologist. Eighty-one percent reported that they would likely take 1 or more of the possible referral actions. For a child with avoidant behavior, 14% of reporting physicians made no referrals, whereas with the child with disruptive behaviors, 23% reported they were not likely to provide a referral.

**Conclusion:** The presence of avoidant behaviors compared with disruptive behaviors was significantly associated with a more intense pattern of referral to services.

**Vignette 3, Time 1: Expressive language delay in an 18-month-old**

- Version 1 (female) or Version 2 (Male): You are seeing an 18-month-old girl/boy, Alex, for a well-child visit. She/he is an established patient in your practice, in good health and growing well. She/he is walking well, drinking from a cup, and saying “mama” and “dad” (not yet specifically for each parent), and has no other words. Her/his parents are not concerned about her/his development. Based on this information, what action(s), if any, would you take at this visit?

**Results for Vignette 3, Time 1: expressive language delay in an 18-month-old**

Overall, nearly 70% of physicians indicated they would refer the child to audiometry, about 40% would refer the patient to early intervention services and 20% would refer to a medical specialist or a psychologist. Seventy-six percent of physicians reported that they would be likely to take 1 or more of the possible referral actions.

**Conclusion:** A female child with expressive language delay at 18 months of age was more likely to be referred for audiometry than a male patient.

**Vignette 3, Time 2: expressive language delay in a 27-month-old**

- Version 1 (Female) or Version 2 (Male): You are seeing an 18-month-old girl/boy, Alex, for a well-child visit. She/he is an established patient in your practice, in good health and growing well. She/he is walking well, drinking from a cup, and saying “mama” and “dad” (not yet specifically for each parent), and has no other words. Her/his parents are not concerned about her/his development. Based on this information, what action(s), if any, would you take at this visit?

**Results for Vignette 3, Time 2: expressive language delay in a 27-month-old**

Seventy percent of physicians indicated that they would likely refer the child to early intervention services; 87% reported they would refer the child to a medical specialist for additional evaluation. Overall, 94% of physicians reported that they would likely take one or more of the possible referral actions. Therefore, only 6% of physicians reported they would not likely refer to any diagnos-
opportunity to engage parents as experts on their child and recognize the provider-parent partnership. These questionnaires are available in other languages and are written at a fourth-to-fifth-grade reading level. ³

Five parent-report instruments include:

• “Parents’ Evaluation of Developmental Status (Peds), a parent-report instrument used to identify general developmental delay in the general primary care population; ²

• Ages and Stages Questionnaires (ASQ), a parent-report instrument used to identify general developmental delay in the general primary care population and/or broad high-risk population; ³

• Child Developmental Inventories (CDI), a parent-report instrument to measure social, self help, gross motor, fine motor, expressive language, language, comprehension, letters, numbers and general development; ⁶

• Language Development Survey (LDS), a parent-report instrument used to identify language delay in the general primary care population;

• Modified Checklist for Autism in Toddlers (M-CHAT), a parent-administered instrument used to screen for autism and developmental delay in the general primary care population.”


Implementation

Once the physician or practice has selected the questionnaires, how does the process get started? The following are the key steps for implementation:

• Identify a physician who will maintain the initiative as a priority.

• Involve key staff (to include front office and nursing staff) to map the workflow.

• Map the workflow, planning for when the tool will be given to parents, who will score the tool and other practice logistics. When does the scored test get filed on the medical chart or scanned into the electronic medical record?

• Consider accessing anticipatory guidance materials and educational materials on developmental delays.

• Share the process and outcome data (or appoint a designee) at regular intervals with the staff.

• Identify a key staff member to be responsible for orienting new staff in the process to prevent lapses in implementation. ³

Involving the staff and requiring accountability from the beginning will insure greater success. For practices that have consistently implemented screening instruments, responsibilities were divided among staff at multiple levels. Questionnaires might be given to the parent by the front desk staff, scored by nurses or nursing assistants, and reviewed with the family by the physician.

If a referral is needed, it might be placed by a referral coordinator. It will also be necessary to routinely evaluate and restructure the implementation system and to use this important data for quality-improvement efforts. ⁹

Staff turnover or when a new staff member is being trained can present challenges in implementing the process. Ensuring that the screening process is part of staff orientation will prevent gaps in collecting information and identifying developmental delays in your patients.

Without a separate tracking system, a practice cannot determine how many children complete their recommended referrals or are successfully referred for services. However, implementation systems for tracking referrals address a new set of tasks: tracking families’ follow-through, communication with specialists and early-intervention programs about the outcomes of completed referrals, and ensuring timely primary care follow-up. ⁹

An important aspect of record keeping is to include a copy of the completed questionnaire in the child’s medical record, especially if the results warrant a referral. Documentation is also warranted for billing purposes. ²

Referral Resources

An important step in the referral process is educating parents. A national study found that many families did not follow through with the recommended referrals because parents did not understand the reason for the referral. ¹⁰ If the results of the screening tool warrant a referral, document this discussion in the medical record.

For children under three years of age, referrals for developmental delays can be made to Early Childhood Intervention (ECI) programs. ECI is a statewide program that provides evaluations and services in the home and in community settings such as child care facilities. Services are available on a sliding fee scale and include:

- assistive technology
- audiology
- case management
- early identification screening and assessment
- diagnostic and evaluation services
- family education and counseling
- nursing services
- nutrition services
- occupational therapy
- physical therapy
- psychological services
- social work services
- specialized skills training
- speech-language therapy
- vision services

¹¹

For children over the age of three, referrals for developmental delays can be made to the child’s local school district. Referrals
are made by contacting the director of special education of your local school district. The telephone number can be found in the white pages of the phone book.  

The Internet makes it easier than ever to stay abreast of resources in your community, to access information directly, educate staff regarding key resources and guide families in accessing such information themselves.  

It is worth the pediatric primary care physician’s time to make initial contact with your local early intervention agency and public school system to seek greater contact and collaboration. An initial contact often affords the opportunity to establish follow up procedures and to improve the flow of information from schools and agencies to practitioners. It may save time in the long run in tracking down outside referrals to discuss their implication with the child’s family. 

**Conclusion**

Physicians who treat children are in a unique position to identify those patients with developmental delays. Inappropriate screening practices, high thresholds for referrals, unfamiliarity with local referral sources, lack of a tracking system, and lack of parent education can each diminish the effectiveness of the screening process. Early recognition and intervention is critical for all developmental, social and behavior problems. Developmental screening, when done early and over a length of time, has the potential to improve lifelong outcomes for the patient. 

**Sources**


Louise Walling can be reached at louise-walling@tmlt.org
CME test questions

Instructions: Using black ink, read each question, select the answer, and then clearly mark your selection. Under newly revised AMA guidelines, physicians are now required to complete and pass a test following a CME activity, in order to earn CME credit. A passing score of 70% or better earns the physician 1 CME credit. Physicians will be allowed two attempts to pass the test.

Please fax the completed test and evaluation forms to the Risk Management Department, attention Stephanie Downing 512-425-5996. You can also mail the test and evaluation forms to the TMLT Risk Management Department, attention Stephanie Downing, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide on the CME evaluation form.

This form can be completed online at www.tmit.org/reportercme.

1. The estimated economic benefit of intervention before kindergarten is from $30,000 to $100,000 per child.
   ○ a. true
   ○ b. false

2. The 2006 American Academy of Pediatrics policy statement called for:
   ○ a. developmental surveillance only after parents express concerns
   ○ b. developmental surveillance at the 9-, 18-, and 30-month visits
   ○ c. developmental surveillance at every well-child visit
   ○ d. screening tools to be administered at every well-child visit

3. A study by the American Academy of Pediatrics found that reimbursement issues were the primary obstacle to consistent screening for developmental delays.
   ○ a. true
   ○ b. false

4. Parental reports of skills and concerns about language, fine-motor, cognitive, and emotional-behavioral development are highly predictive of true problems.
   ○ a. true
   ○ b. false

5. The following issues decrease the effectiveness of a developmental screening process.
   ○ a. unfamiliarity with local referral sources
   ○ b. lack of parent education
   ○ c. lack of a tracking system
   ○ d. a and c only
   ○ e. all of the above

Statement of completion

I attest to having spent ________________ hours in this CME activity.

Physician signature ____________________________ Date ____________________________
CME evaluation form
Please complete the following regarding the article, "Making a difference for patients and their families: early childhood intervention". Please fax the completed evaluation with the CME test questions.

1. The objectives for this CME were met.  ○ Yes  ○ No

2. The material will be useful in my practice.  ○ Yes  ○ No

3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain.  ○ Yes  ○ No

4. How long did it take you to complete this learning activity?
   ○ .5 hr  ○ .75 hr  ○ 1 hr  ○ 1.25 hrs  ○ 1.5 hrs

5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice?
   ○ 1  ○ 2  ○ 3  ○ 4  ○ 5

6. What will you do differently in your medical practice after reading this article?

7. Suggestions for course improvement are:

8. Suggestions for future topics include:

Contact information
Name

Address

Phone

TMLT policyholder?  ○ Yes  ○ No

Email address (to have your certificate emailed). Please print legibly. We cannot email your certificate if we cannot read your email address. To ensure your certificate is received in your email inbox, please add TMLT to your address book or safe sender list. Otherwise, your certificate may be flagged by your e-mail provider as unsolicited mail or "spam."

Volume 5
Launched in 2005, the program awards $40,000 in scholarships annually to Texas medical students who are interested in finding creative ways to enhance patient safety. Scholarship recipients are chosen based on each student’s financial need and written essay.

In 2011, we received 81 applications from students at nine Texas medical schools. We are proud to announce the recipients of the 2011 TMLT Memorial Scholarships:

• **Duane Akwar** is a fourth-year medical student at University of Texas Medical Branch at Galveston

• **Elizabeth Rossmann Beel** is a second-year medical student at Baylor College of Medicine

• **Clay Buchanan** is a second-year medical student at Texas Tech University Health Sciences Center School of Medicine

• **Charles Willnauer** is a second-year medical student at Texas Tech University Health Sciences Center School of Medicine.

For the essay portion, applicants for the 2011 scholarship were asked to write risk management considerations for a closed claim study provided by TMLT. The case study and recipients essays are below.

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**The case study — failure to diagnose myocardial ischemia**

**Presentation**

A 45-year-old man went to the emergency department (ED) of a community hospital complaining of infrequent chest pain. He had a history of anxiety disorder, depression, high blood pressure, coronary artery disease, and a family history of heart disease. He reported smoking a pack of cigarettes a day for 20 years. The patient was seen by the on-call hospital family physician.

**Physician action**

Once in the ED, the patient reported that his chest pain had stopped. The pain had started the previous evening and was located in the middle of his chest. The family physician examined the patient and noted that his lungs were clear and his heart had a regular rate and rhythm. His blood pressure was 176/99 mm Hg and movement exacerbated the patient’s chest pain.

The physician ordered an EKG, which revealed nonspecific inverted t-waves with some premature atrial contractions. He diagnosed chest pain related to bronchitis and prescribed a dose of 1 mg of clonidine to be administered orally and 500 mg of cefprozil twice a day for 7 days. The family physician then discharged the patient.

Three days later, the patient came to the same ED complaining of severe chest pain, which had occurred intermittently for the previous three days. He was diagnosed with myocardial infarction and congestive heart failure. He was transferred to a tertiary care facility where he ultimately underwent a two-vessel bypass surgery. He was hospitalized for 16 days. At discharge, his diagnosis was triple coronary artery disease with acute myocardial infarction.

Two days later the patient was readmitted to the tertiary care facility to treat congestive heart failure. Two cardiologists saw him and consulted with a thoracic surgeon, who felt that the patient was not a candidate for another surgery and that he may eventually need a heart transplant.

**Allegations**

A lawsuit was filed against the family physician, alleging failure to perform the proper tests; failure to admit the patient for observation; failure to transfer the patient to a facility that could perform an emergency revascularization for myocardial ischemia; and failure to refer the patient to a cardiologist.

**Legal Implications**

The plaintiffs argued that the family physician deviated from the standard of care by not ordering serial twelve-lead EKGs, a serial cardiac enzyme test, or a chest x-ray. The plaintiffs were also critical that the physician did not complete a serial examination, and that he did not properly document the patient’s family history or the severity of his pain.

The defense alleged that the patient’s smoking habit could have led to his condition. They defended the physician’s exam, saying that it was thorough and did not reveal evidence of myocardial ischemia. The defense also pointed out that the physician ordered an EKG, which revealed nonspecific findings, and that he advised the patient to follow up with his family physician. The defense supported the physician’s bronchitis diagnosis, stating that it would have been a common condition for a chronic smoker.

**Disposition**

Two out of three consultants felt the physician breached the standard of care when treating this patient. Therefore, this case was settled on behalf of the family physician.

**Risk management considerations**

*b*Duane Akwar*

Among the tasks of the emergency physician is to rapidly determine the short-term risk of death and disability. The misdiagnosis of this patient was due to the physician’s failure to thoughtfully consider the possibility of ischemic cardiac pain. The outcome
could have been avoided by careful assessment of the available data, the population-wide burden of ischemic heart disease, and the potentially fatal or disabling result of myocardial infarction.

This case begins with a young male complaining of infrequent chest pain. Though considered an illness of the ‘mature,’ ischemic heart disease is often seen in 30 to 50 year olds. In fact, the courts consider failure to diagnose and treat myocardial infarction in patients under 50 years old more costly than in those older than age fifty. More than half the dollar amount paid to malpractice claimants went to those under age fifty in the Physician Insurers Association of America study in 1996. The physician should be alert to the possibility of ischemic chest pain if a ‘young’ patient has any risk factors. Though the physician must have considered ischemic heart disease (since he ordered an EKG), he did not judge it likely or ominous enough to pursue. Had the physician considered this diagnosis seriously, he should have admitted the patient for serial cardiac enzymes and, at least, a stress test. Ominous coronary disease can present in the emergency room without positive findings on chest x-ray, cardiac enzymes, or serial EKGs. Timely diagnosis might well have prevented the devastating outcome.

It might have been helpful to question the patient more thoroughly about the pain and his history. Patients may not share useful information until asked, since they are not aware of what is pertinent to the physician. A history of positional chest pain, or chest pain exacerbated by movement, can be misleading. The Lee study of 1985 showed that positional chest pain does not reliably exclude ischemic chest pain. Understanding the limitations of the history and physical exam in this setting could have led the physician to the correct diagnosis.

A good rule of thumb for physicians is to consider the broad differential diagnosis and make better, more appropriate, use of resources in order to rule out life threatening conditions. Such considerations should lead to hospital admission in a case such as this, since emergency room cardiac enzymes, EKG’s, and chest x-rays do not confirm the absence of ischemic chest pain.

In summary, to increase defensibility, the physician must be thorough in history taking, considering all related risk factors, developing an appropriate differential, use of reasonable resources in order to avoid a misdiagnosis, and understanding the limitations of history, physical and laboratory findings.

Risk management considerations
by Elizabeth Rossmann Beel

Risk management considerations in this case center around the physician’s workup of a patient with a common presenting complaint for a potential cardiac event. The plaintiff’s allegations that the physician did not adhere to standard of care by neglecting to perform serial 12-lead EKGs and cardiac enzyme tests appear to be valid given available clinical practice guidelines from the American Colleges of Cardiology and Emergency Physicians.

Prevention of many malpractice outcomes can be achieved via better physician training or guideline adherence, but putting appropriate processes and controls in the workplace can have a more global impact and can lead to better outcomes throughout the hospital. Because even the best-trained physicians can at times fail to recall the suggested steps for diagnosis, particularly in an emergent situation, algorithms and checklists offer a method for ensuring appropriate patient care at every encounter, with every physician. Though medicine is only recently embracing a system that other fields — aviation, for example — have espoused for decades, the idea of standardized patient care algorithms has been increasingly used in settings including the operating room (pre-surgical timeouts).

Similarly, a number of EDs have flowchart diagrams that help physicians work through a presenting complaint to ensure that no major diagnosis is missed -the Austin/Travis County EMS system has a Universal Patient Care protocol for chest pain on their website, and this patient’s complaint would have clearly merited a 12-lead EKG under this protocol. Because cardiac events are simultaneously a common presenting complaint, with serious medical sequelae, and are amenable to timely intervention with a drastic impact on outcomes, they are an excellent example of a disease process that lends itself well to procedural flowcharts, particularly in the emergency setting. In this situation, a clear algorithm for chest pain disseminated and widely available throughout the ED would have prevented the situation and also could have provided a potential line of defense had the physician adhered to it appropriately.

It is important to consider also the setting of this event. Though larger academic EDs may have complex electronic medical records / monitoring systems that would recognize a constellation like angina, hypertension, smoking history, and coronary artery disease and would specifically direct the attending’s attention to the need for a 12-lead EKG or other tests, a community medical center may well not have such processes in place. Though the cost burden of implementing EMR systems or similar technologi- cal advances is very high, in this case such a system could have saved both a patient from having an MI and the hospital from a large fiscal outlay on legal costs.

In this vignette, the patient’s family history, risk factors for MI (smoking, depression, inverted T-wave EKG, diagnosis of coronary artery disease), and presenting complaint clearly warrant a more substantial workup than was initially performed by the ED physician. In focusing on the larger picture for the organization of how to standardize care and defend against future lawsuits, improvements in processes and procedures can have a great deal of impact.

Risk management considerations
by Clay Buchanan

From our earliest patient exposure in medical school we are
taught that a good history will give you the diagnosis. Unfortunately, sometimes physicians latch on to what is quickest and easiest to the detriment of their patient.

The patient presented with chest pain. Chest pain is nonspecific, but a physician should always act to rule out myocardial infarction (MI). Hypertension, coronary artery disease (CAD), family history of heart disease and smoking are risk factors for MI. Additionally, the EKG showed inverted T waves which can be indicative of ischemia. This presentation cries out for more intensive questioning, testing, and intervention. The family physician neglected the history and failed to investigate. If the family physician was uncomfortable admitting the patient and/or ordering additional testing he should have made a cardiology consult at the very least.

In addition to failing to note the history and properly follow up on the cardiac issues, the family physician made the easy decision. Smoking equals bronchitis. Although not necessarily incorrect, the family physician failed to document anything that would support this diagnosis. There is no indication of wheezes, rales, sputum, dyspnea or anything else suggesting bronchitis. The failure to document anything suggestive of bronchitis increased the physician’s exposure, blinded him to the cardiac issue, and placed the patient at greater risk.

The family physician made other mistakes regarding the medication prescribed. Clearly, the patient needed hypertension management. However, clonidine was not the appropriate medication. As noted the patient had CAD, cardiac conduction disturbances, depression and a probable recent MI. Clonidine is contraindicated for each of these factors individually much less a combination of four factors. Again, the physician’s short-sighted approach left himself and the patient exposed to greater risk. The family physician would have been on safer ground prescribing a beta blocker, calcium channel blocker or angiotensin receptor blocker, but the CAD and MI should have been addressed first. Bronchitis is usually viral or caused by an irritant such as smoking. The record shows nothing to indicate the family physician did any testing to warrant use of an antibiotic. When not necessary, use of a broad-spectrum antibiotic can cause more harm than good by destroying the patient’s normal flora. In this instance the family physician should not have prescribed either clonidine or cefprozil.

As professionals, we are entrusted with our patients lives and owe them our best efforts. When history clearly indicates a possible recent MI, how can best efforts not include steps to address such a life-threatening condition? Physicians are rushed and short of time continually, but we can never short-change our patients by latching on to the easy solutions just for the sake of saving time. Saving time does not necessarily equal saving lives. A few simple steps, a few extra moments to get an adequate history, a few moments of reflection by the family physician and the patient would not have suffered as much and his outcome might have been markedly improved.

**Risk management considerations**

by Charles Willnauer

Certain chief complaints, such as “chest pain”, are a red flag within the health care community and could point to a myocardial infarction. With such a potentially life threatening diagnosis, it is better to err on the side of caution. Thus, physicians are obligated to prove the absence of a myocardial infarction rather than its presence. The breach of care in this case can be linked to one important aspect of patient care: the context of the patient history. Chest pain can be caused by a number underlying conditions, such as pain in bones or muscles of the chest, coughing during a virus induced upper respiratory tract infection, shingles, broken rib, gastroesophageal reflux disease, or even lung cancer.

The family physician was correct in ordering an EKG, but when the results proved to be inconclusive, he deviated from the standard of care by not pursuing an evidence-based diagnosis. For instance, the nonspecific inverted t-waves could be caused by numerous underlying conditions, such as pericarditis, a pulmonary embolism, central nervous system injury, effects of digitalis, or even intra-abdominal disorders. Premature atrial contractions are common, occur in healthy individuals, and can be caused by such conditions as ingestion of caffeine, nicotine, alcohol, exposure to stress, or electrolyte imbalance.

Within the context of a patient with numerous personal and family history risk factors, it becomes even more imperative to prove the absence of a myocardial infarction. The patient’s history should have overruled the nonspecific results of one EKG test. The patient should have been admitted overnight, given a serial EKG test followed by serial cardiac enzymatic tests, such as Troponin, and a chest x-ray. In the event that even these test results were inconclusive, it would then be necessary to perform a stress test before discharging the patient. Additionally, the hospital family physician should have counseled the patient to return if the pain continued or worsened since following up with his personal family physician might not be feasible in the short term. However, if such tests confirmed a myocardial infarction, then the family physician could refer the patient to a cardiologist and tertiary care center to undergo advanced treatment.

Even though the physician failed to diagnose the myocardial infarction, what may be equally concerning is the physician diagnosed bronchitis without noting any evidence such as fever, cough, or sputum production. Even if such symptoms were present, tests such as percussing the chest, pulse oximetry, or a chest x-ray were not performed or at least not noted. Additionally, the unnecessary prescription of cefprozil, a broad-spectrum antibiotic, can cause unwanted side effects.

Ultimately, medical malpractice lawsuits could be avoided if the physician used conclusive tests to rule out possibilities before finalizing the diagnosis. The results of such physical exams and vital tests need to be evaluated and documented accurately and thoroughly. The data needs to be analyzed under the context of the patient’s personal and family history. This method could help the physician avoid positively diagnosing absent conditions and negatively diagnosing present conditions.
Alleged improper performance
by Louise Walling and Laura Hale Brockway, ELS

Presentation
A 42-year-old man came to a pain management specialist on November 24 for treatment of headaches and persistent low back pain. He was also experiencing numbness down both legs and feet.

Physician action
After examining the patient, the pain management specialist diagnosed cervical facet arthropathy with resultant occipital nerve neuritis, along with anxiety and depression. He prescribed hydrocodone, tizanidine, and valdecoxib.

On December 3, the pain management specialist performed a cervical nerve block at C2 through C7 to help with the patient’s headaches. The patient reported three days of relief. On January 9, he performed cervical facet joint nerve rhizotomies of the left C2 through C7. One week later, he performed the same procedure on the right side. Sensory and motor testing performed after the rhizotomies was unremarkable.

On January 29, the patient returned to the pain management specialist with complaints of right shoulder pain. The physician felt the pain was the result of a strain to the right deltoid.

The patient next sought treatment from an orthopedic surgeon for his right shoulder pain. An MRI was interpreted as normal and the patient was given a subacromial injection that partially relieved the pain. The orthopedic surgeon ordered physical therapy.

The pain management specialist saw the patient on March 12 for hormone and saliva tests. The patient reported that he was doing his daily exercises and his motor strength was 5+ in shoulders, elbows, wrists, and fingers. The patient returned on April 12 with complaints of headache and shoulder pain. The pain management specialist ordered vitamin B and gabapentin.

The orthopedic surgeon saw the patient on April 14. He reported that his right shoulder felt 50% normal and that he was unable to perform pulling, throwing, lifting, or usual sports activities. The patient was referred to a neurologist.

On April 16, a neurologist saw the patient. At this visit, the patient reported that he had experienced severe stabbing electrical pain shooting in his right arm during the January 16 rhizotomies. The neurologist documented rapidly developing atrophy of the auxiliary nerve distribution of the right deltoid. An electromyogram and nerve conduction studies were ordered.

The neurologist concluded that the patient’s shoulder pain was consistent with a C5 nerve root injury, most likely a complication of the intraneural injection performed by the pain management specialist. He recommended a muscle stimulator.

Over the next several months, the patient’s condition slowly improved through the use of a muscle stimulator and by attending physical therapy. On February 21, the patient went to the orthopedic surgeon, who noted that the patient still had weakness in the right shoulder. The patient’s shoulder strength was rated as 4+/5, and the orthopedic surgeon recommended a follow-up appointment in six months.

Allegations
A lawsuit was filed against the pain management specialist, alleging that he failed to undertake non-invasive medical treatment before performing the rhizotomies. It was also alleged that he failed to follow current standards for denervation of a cervical facet.

Legal implications
The plaintiff’s expert stated that the pain management specialist deviated from the standard of care by failing to position the patient in a way that would decrease the risk of lesioning error. It was also this physician’s opinion that the defendant did not demonstrate which cervical facet level or levels were the most symptomatic during the patient’s initial exam.

Consultants who reviewed this case for the defense stated that the defendant’s actions were well within the standard of care. It was possible that the nerve root was damaged during the procedure, but this was a known complication.

Despite the expert support for the pain management specialist, the defense of this case was complicated by documentation issues. There were multiple addendums made to the patient’s medical record after the defendant was notified of the claim. The defendant also used “template” office and procedure notes that were virtually identical for each office visit. For example, the procedure reports for the January 9 and January 16 procedures were almost identical.

Risk management considerations
Timely and accurate documentation of the patient’s medical treatment, along with the reasons for the decisions made, greatly strengthens the defensibility of a case when complications lead to litigation. The patient’s medical records are usually the only documents the jury is allowed to evaluate during their deliberations. When it is absolutely necessary to amend the records, any addition should be labeled as an addendum, dated, and signed. While addenda may be necessary, their use should be rare.

Once a claim has been filed against a physician, it is inadvisable in almost all instances to amend the medical record. These addenda can be the subject of a targeted cross-examination in the event of a lawsuit. In addition, be cautious about writing down the details of care in a separate, private summary of events. All records and summaries of medical care written before litigation ensues may be discoverable. Once a claim has been filed, a physi-

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Failure to diagnose appendicitis

by Louise Walling and Laura Hale Brockway, ELS

Presentation
A 49-year-old man came to the emergency department (ED) on April 18 with complaints of abdominal pain. He complained of sharp, lower left abdomen pain with nausea and vomiting. The patient’s vital signs were normal, but lab studies revealed a white count of 11,400 with a normal differential and no bands.

Physician action
An emergency medicine physician examined the patient and confirmed that his pain complaints were in the left lower quadrant. He documented a physical exam that revealed no guarding or rebound tenderness. The patient’s vital signs were normal, but lab studies revealed a white blood cell count of 11,400 with a normal differential and no bands.

Abdominal x-rays revealed no sign of bowel obstruction. The physician ordered an abdominal CT scan with and without contrast. The scan was interpreted by a radiologist — the defendant in this case — as consistent with minimal sigmoid diverticulitis. “Sigmoid diverticula are noted. There appears to be mild stranding in the pericolonic fat in the area of the sigmoid colon probably indicating very mild inflammatory change. There is no abscess. There is no retroperitoneal adenopathy. There is no free fluid. Impression: probably minimal sigmoid diverticulitis.”

The patient received a prescription for antibiotics and was instructed to follow up with his family physician. He was told to return to the ED if his pain became worse.

The patient returned to the ED the next evening, complaining of increased abdominal pain and fever. Examination revealed the pain was across the patient’s lower abdomen with guarding to the left lower quadrant. The patient’s white blood cell count was 18,000.

The patient was admitted to the hospital under the care of a general surgeon. After obtaining x-rays and lab studies, the surgeon diagnosed the patient with diverticulitis with the possibility of a small rupture of one of the diverticula. A gastroenterologist was consulted, and he agreed with the surgeon’s diagnosis. The surgeon planned to treat the patient with IV antibiotics. If there was no improvement in 24 hours, he would repeat the abdominal CT scan.

Over the next four days, the patient’s condition improved. He was discharged on April 24 with a prescription for oral antibiotics and instructions to follow up with his treating physicians.

On May 2, the patient saw the surgeon. The patient had returned to work, but he was still experiencing low-grade fevers and episodes of diarrhea. A repeat CT scan of the abdomen (with and without contrast) and of the pelvis (with contrast) was ordered. The defendant radiologist reviewed this scan and reported “possible inflammatory changes near the sigmoid colon described on 4/18 are no longer apparent. Impression: Inflammatory changes adjacent to the ascending colon and cecum. No definite abscess formation.”

The radiologist called the surgeon to report that these results could represent appendicitis. The surgeon contacted the patient and advised him to come to the office; however, the patient stated he was better and that he had an appointment with the gastroenterologist the next day. The patient saw the gastroenterologist on May 3. The gastroenterologist reviewed the findings of the CT scan and advised the patient to undergo a diagnostic laparoscopy.

The surgeon admitted the patient to the hospital on May 3. However, the surgeon monitored the patient for four days, believing the patient had diverticulitis despite the results of the second CT. On May 6, the surgeon performed a diagnostic laparoscopy. He encountered significant inflammation, and the procedure was converted to an open procedure. The surgeon found a ruptured appendix and abscess. He performed an appendectomy and the patient did not experience any further complications. He was discharged on May 11.

Allegations
A lawsuit was filed against the radiologist, alleging negligence in failure to diagnose appendicitis on the April 18 CT scan.

Legal implications
According to the plaintiff’s expert, the defendant radiologist should have diagnosed appendicitis from the initial CT scan, and this failure to diagnose “misled” all the patient’s treating physicians. If the appendicitis had been diagnosed on April 18, the patient would have undergone a laparoscopic appendectomy versus an open procedure.

Radiologists who reviewed this case for the defense confirmed that appendicitis was not apparent on the April 18 CT scan. Further, the patient did not exhibit symptoms consistent with appendicitis. His pain complaints were consistently on the left side. The patient’s treating surgeon testified that even if the defendant had reported the possibility of appendicitis on April 18, the surgeon would not have taken the patient to surgery at that time.

Risk management considerations
There are rare occasions when — despite having delivered and documented good medical care — the jury interprets the care differently. It is worthwhile to note that there was a 4-day delay in surgery after the surgeon was notified of the possibility of appendicitis.

Of the physicians involved in the care of this patient, the radiologist had the least amount of patient contact. Unique risk management issues face physicians with limited patient contact. With little (if any) face-to-face time, radiologists do not have the

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appendicitis ... continued from page 19

Opportunity to develop a close physician-patient relationship. Because a close bond is not developed, a patient may be more willing to sue in the event of a less than optimal outcome.

Health care specialists in pathology and radiology are often negatively affected by hindsight when a case is filed. Pathology specimens and radiographic studies are “on the shelf” to be second guessed by experts who come armed with the knowledge of a proven diagnosis. This advantage is not given to physicians who work prospectively to make diagnoses and implement treatment plans. One radiologist described this as the “Where’s Waldo?” syndrome. Waldo is there somewhere and must be found. ¹

Disposition

This case was taken to trial and the jury found in favor of the plaintiffs. As an appeal of the case was underway, the parties agreed to a settlement.

Sources


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improper performance ... continued from page 18

A physician should be guided by the advice of his or her claims representative and defense attorney.

Chapter 165.1 of the Texas Medical Board Rules requires that the content of a medical record be “complete, contemporaneous and legible.”¹ Templates used with electronic medical records may save the physician time in documentation. However, if each patient encounter cannot be distinguished from another — except by the date and other minor changes — the records may not appear “contemporaneous.” Before a jury, those records will likely not be credible, and could portray the physician as someone who cuts corners to the detriment of the patient.

The same is true of procedure note templates. There are several pitfalls to using templates. The patient’s attorney may argue that the use of templates is unreliable.

It is easy to inadvertently fail to make needed modifications such as needle gauge size, or other similar procedural variances. Any deviation from the standard method for the procedure should be noted. Accuracy, completeness, and timeliness in medical records are key elements to the successful defense of malpractice claims. Such records demonstrate that the physician was careful and thorough in providing care to the patient.

Disposition

In light of the documentation issues, this case was settled on behalf of the pain management specialist.

Sources