By Barbara Rose, Senior Risk Management Representative

The following 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 physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Presentation
A 45-year-old male with a history of type II diabetes presented to the defendant physician with complaints of pain in the right great toe. Physical exam revealed the toe to be red and swollen and the symptoms were attributed to either cellulitis or gouty arthritis.

Physician action
Indocin and Prednisone were prescribed and refilled nine days later without the patient being seen in follow up. Four days after the medications were refilled, the patient returned to see the physician with a temperature of 103 degrees and an overtly infected and semi-necrotic right foot. He was sent to the emergency room and admitted. The day after admission the patient was taken to surgery. Incision and drainage with excision of necrotic tissue and bone was done followed by partial amputation of the first and second toes.

Four days postoperatively, due to continued demarcation of his foot and nonviable tissue, the patient underwent revisional surgery that included trans-metatarsal amputation. Three days later the patient was discharged with a diagnosis of amputation secondary to a diabetic infection identified as staphylococcus aureus. Antibiotics were continued as well as medications to control his diabetes. He was scheduled for hyperbaric oxygen therapy.

Allegation
The plaintiff filed suit against the internal medicine physician with allegations that he was negligent by incorrectly diagnosing gout rather than a serious staph infection; in prescribing corticosteroids when they were contraindicated; and in his failure to closely monitor the patient’s condition.

Legal implications and disposition
Failure to diagnose is the most cited allegation in claims against primary care physicians. All the consultants reviewing this claim stated that, due to the plaintiff’s diabetes, an infection should have been the first suspected problem. They all agreed that Prednisone should not have been prescribed unless gout was definitively diagnosed and an infectious process ruled out. The consultants also felt the defendant acted below the standard of care when he made no attempt to obtain joint fluid for a cell count, crystal exam, or culture and sensitivity.

Review of the defendant’s medical record identified several weaknesses in documentation. These included an illegible office record, undocumented phone calls, and antibiotic pharmaceutical samples reportedly given to the patient but not entered in the record. The patient disputed the physician’s statement that he was given antibiotics. It was also discovered that the defendant added entries to the record after the suit had been filed. This claim was settled during mediation for $139,000.

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A weak medical record may present a challenge that cannot be overcome in the defense of a physician. Illegible writing continues to be a common weakness in medical records and may make it impossible to accurately determine all aspects of a patient’s condition and care. The documentation can be subject to broad interpretation of what was written, and may lay the foundation to disparage quality of patient care. Some physicians admit being unable to read their own writing and a plaintiff’s attorney may use this as a means to question standard of care. All entries in a medical record need to be legible.

Documenting all phone calls and prescription refills is a required element of a comprehensive medical record. All patient encounters whether in person, by phone or email, need to be included in the record. “If not documented, it did not happen,” may still be heard if one attempts to rely on memory that invariably differs between the plaintiff and defendant.

The failure to document pharmaceutical medication samples creates an incomplete record. Giving medication samples to a patient is to be documented with the same elements as a new prescription or refill. Include the name, dosage, route of administration, frequency, duration, number prescribed, and patient education regarding side effects and potential adverse interactions.

Making additions to a record after a notice of claim may place a physician in a compromised position. Complete and accurate entries at the time of the encounter may prevent the alteration of a medical record. An addendum or late entry in a medical record may be allowed if done in a timely manner and clearly identified. The date and time, a reference to the date and time of the actual encounter, reason for the late entry, the added information and signature of the author are elements to be included. After the fact entries are to be avoided as they may be viewed as alterations and compromise the defense of a malpractice suit.

Risk management considerations

One physician’s claim story

Editor’s note: this article was written by TMLT policyholder John McKenzie, MD. Thank you for sharing your experience Dr. McKenzie.

I have been a rural family practitioner in Texas for 19 years. My first malpractice suit was filed last year. The action of my patient surprised me, but given the climate in the state, it should not have come as a surprise. I was fortunate to win a relatively quick summary judgment in my favor in one year.

The allegation was the failure to diagnose colon cancer in a patient with multiple medical problems. He had described rectal bleeding since 1965, and had a colonoscopy revealing polyps on his initial visit in my practice eight years ago. This patient refused follow up colonoscopies to monitor the polyps. Part of the allegations suggested I was negligent in not doing a rectal screening exam during his visits for coronary artery disease and hypertension. In my practice different types of visits are scheduled based on patient complaints and time required. Though made aware of the importance of a comprehensive physical exam on many occasions, this patient only scheduled problem visits. My weakness in the medical record was not documenting the patient’s refusal to have further colonoscopy and the advice to schedule a screening exam. It was a revelation to me that physicians can be sued not only for missing a breast lump but also for the failure to document the exam as offered to the patient and recommending a mammogram.

In preparing my case, I learned a lot about the process and how lawyers think. If a claim goes to trial, the jury decides guilt or innocence. There is no gray zone. The plaintiff will have an expert cite a standard of care as if it should always be followed for every patient. There is no mention of the difficulty getting noncompliant patients to watch their diet, stop smoking, take their medicines as directed, and show up for office visits concerning current problems, much less schedule and keep a preventative annual checkup. The plaintiff’s attorney is reviewing the record to determine if screening is offered and documented, particularly by primary care physicians.

Newly learned awareness of these risks and possible litigation led to a number of changes in my documentation. I developed a one-page handout that discusses the reasons for screening exams along with a list of my recommendations and how to schedule age/risk appropriate tests, vaccines, etc. This is posted in the reception area and all exam rooms. I also make sure that all adult patients receive a copy and document in the progress note: “comprehensive physical exam (CPE) recommendation sheet given.” On the left side of my records, I keep a problem list/flow sheet that includes the date, problem and patient education which I complete while with the patient. This provides a “snapshot” of the patient with their past medical and social history, family history, and serves as an easy access for evaluation and management (E & M) documentation. The bottom of the sheet is used for tracking preventative care in recommended time frames. Included are Pap smears, mammograms, PSA, colonoscopy, pneumovax, etc. This form remains on the top of that side of the record, and allows for easy review during every visit of the patient’s screening status and risk factors such as family cancer or cardiac disease history. Before a screening exam, the patient is asked to complete a questionnaire that includes past medical history, family history, medications, allergies, a review of systems, etc. In my practice one comprehensive physical is scheduled in the morning and one in the afternoon.

No physician wants to be notified of a medical malpractice claim. However, as with most new experiences in life, we ultimately learn something. Everything must be documented in the medical record to provide an accurate chronology of the patient/physician relationship. If not documented, the allegation will be the action did not happen and the record will not aid in the physician’s defense. I have also learned to document any patient’s refusal to follow appropriate recommendations. If the refusal has grave consequences, have the patient read and sign an informed refusal for the medical record.

Proactive risk management should be a part of every physician’s practice and the time to implement is when the career in medicine is started. Don’t wait for the experience of a lawsuit to develop the systems that will both compliment the quality of patient care and diminish liability exposure.
What liability risks lurk in your office?

By Jane Holeman, Vice President, Risk Management

In the volatile Texas medical liability environment, it is more important than ever for physicians to be aware of potential risks in their medical practices. Determining risk exposure improves patient safety and outcomes. Additionally, it protects physicians from claims of medical negligence and improves defensibility if a claim or lawsuit occurs. Whether you are a solo practitioner in a rural area or a member of a large physician group, the TMLT risk management staff can assist you in improving your practice.

The practice review

The practice review is a comprehensive risk evaluation offered free to all TMLT policyholders, and available to both office-based and hospital-based practices in all specialties. This on-site, direct interface with physicians and office personnel enables risk management staff to address specific risk exposures in the following areas:

- medical records
- informed consent
- peer review and QI
- physician/patient relationships
- procedures for follow-up
- medication administration
- patient complaints
- release of medical records
- surgical procedures
- diagnostic procedures
- procedures for exams/treatments
- procedures for office emergencies
- biohazardous management
- medical equipment safety
- HIV protocols
- infection control
- general office procedures
- patient visits
- staffing
- telephone protocols
- appointments
- fees, billing and collections
- electronic medicine.

During the review the risk management representative will:

- examine the office for physical safety concerns;
- review the practice’s policies and procedures;
- evaluate medical record documentation;
- provide resources on how to reduce risks in the office;
- discuss outcomes with the physician(s) during an exit interview;
- follow up with a confidential, written summary.

Participation in a practice review helps raise physician awareness of the medical practice issues and legal pitfalls in their practice, and also offers the opportunity for a premium discount. Following completion of the review and compliance with any recommendations, physicians are eligible for a 3 percent discount and 2 hours of continuing medical education (CME). The discount continues through the expiration of the current policy plus an additional two full policy periods.

Positive feedback from physicians is indicative of the value and benefit of this service. “These are areas of my practice I never considered . . . very informative and helpful. We are all enthused about initiating practice changes,” said Mark Wentworth, MD, a family physician.

The process

The process begins with a request from a physician. A risk management representative contacts the office to schedule a time for the review that will accommodate physician, office staff and patient schedules. The review takes approximately four to five hours (longer for large groups) and can be completed without interrupting patient appointments. A specialty-specific questionnaire is mailed to the office to be completed prior to the review. Generally, the representative arrives mid-morning and begins by reviewing the questionnaire with the physician and/or office administrator. This gives both parties an opportunity to ask questions and address specific concerns related to their particular setting.

With assistance from the office staff, the representative will complete a walk-through tour of the facility. If there are multiple sites it may be necessary to visit each site depending on the specialty, procedures performed, rotation of medical staff through various sites or other unique situations. The office tour includes front and back office areas, patient exam rooms, as well as procedure rooms, laboratory and x-ray areas. The tour provides an opportunity to observe and evaluate areas of particular risk to patient safety, as well as regulatory and statutory compliance.

Office policies and procedures will also be reviewed. Telephone communications with patients, refills of prescription medications and procedures for follow-up are critical areas that lend themselves to standardization.

As failure to diagnose is the most frequent allegation in claims against primary care physicians, the representative spends a significant amount of time reviewing and discussing procedures for follow-up related to diagnostic testing, missed appointments, and patient compliance. For example, the representative will discuss with the physician and office personnel what procedure is routinely followed for reviewing diagnostic tests upon receipt in the office as well as communicating results to the patient.

“The discussion was most helpful because it raised my awareness on how I can improve my current method of documentation. Some suggestions were also made on tracking results and triaging ‘no shows,’” said Marissa Largoza, MD, an ob/gyn.

A medical record review for documentation strengths and weaknesses will be conducted during the review. In the event of a claim or lawsuit, documentation is the backbone of the physician’s defense. In many situations, even when there has been no medical negligence, it is difficult to take a continued on page 4
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case to trial secondary to poor documentation.

The record review focuses on complete, thorough documentation of each patient encounter, including but not limited to documentation of allergies, history and physical, clinical decision-making, telephone encounters with patients and appropriate follow-up on outside referrals, consultations, and diagnostic testing. The representative will emphasize areas where specific documentation will help protect the physician in the event of litigation. For example, physicians and staff often discuss in detail the risks and benefits of certain procedures or medications. All too often, these discussions and instructions are not documented in the medical record. According to Texas statute, obtaining informed consent is a non-delegable responsibility of the physician. However, office personnel may assist the physician in this process by obtaining patients’ signatures on printed consent forms and reinforcing the information given to the patient by the physician. It is recommended that the physician include a note in the patient record indicating that the associated risks, benefits and alternatives were discussed with the patient and any family members, as well as the patient’s understanding and agreement to proceed with the treatment plan.

“The entire experience was very positive and helpful. I know it will help my practice become more efficient and increase my awareness of improved risk management,” said Jim Colvin Jr., MD, an ob/gyn.

The follow up

Upon completion of the on-site visit, the representative will discuss with the physician and appropriate office personnel any areas of concern, and make recommendations for implementing changes to the medical practice. Relevant resources and materials will be provided to assist in implementation. A formal written report will be mailed to the physician requesting written responses to the recommendations within 30 days. Upon receipt of the responses, the physician is eligible for the risk management discount. Qualified risk management staff are available to provide ongoing assistance in identifying risk exposures and relevant solutions.

In conjunction with the practice review, physicians may be eligible for an additional 2.5 percent discount for use of electronic medical records and/or electronic prescribing. Eligibility for this discount is contingent upon documented use of a program for a minimum of one year. The program must also meet specific risk management criteria. Much of medicine is routine, requiring compulsive attention to details and protocols. Computers are well suited to enhance medical decision-making. An electronic medical record or electronic prescribing system has the potential to greatly enhance quality of care, providing a safer environment for patients.

“Exactly what I was looking for . . . excellent recommendations,” said Jeffery B. Gibberman, MD, a physical medicine and rehabilitation specialist.

To schedule your practice review, please contact the Risk Management Department at 800-580-8658, ext. 5912 or visit the TMLT web site at www.tmlt.org.