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

This case involves a 37-year-old woman with a history of congenital problems affecting both hips and requiring multiple prior surgeries. Twenty years before the defendant’s surgery, the patient had undergone acetabular osteotomy requiring extensive dissection. The patient did relatively well but gradually developed osteoarthritis.

Physician action

The defendant physician performed reconstruction of the acetabulum with autogenous bone graft and left total hip arthroplasty. The patient did well postoperatively until four months later when some protrusion of the acetabular component and slight migration of the prosthesis was noted. The plaintiff reported at that visit that she had fallen on her left leg.

Two months later, x-rays showed more protrusion and the patient was advised to have a revision or reconstruction of her left hip arthroplasty. This was done a month later. A postoperative appointment two weeks later revealed a neuritis or neuropathy of the femoral nerve. Two months later, the defendant physician planned to refer the patient for a neurology consultation. Two days after this appointment, the plaintiff fell and sustained ruptured quadriceps and patella tendons which required a surgical repair three days after the fall. This surgery was done by the defendant.

Five weeks after the repair of the patella tendon, the patient presented with a stiff hip and limited range of motion. An EMG revealed the femoral nerve to be involved with no nerve conduction present. Three weeks later some improvement was noted and x-ray showed an excellent result of the total hip revision. A month later, the patient was noted to be doing well with the tendon repair and the neuritis was “pretty well gone.”

Four months later, a femoral nerve paresis or paralysis of those muscles involved from the femoral nerve was present but slowly improving. The patient was referred for a neurological consultation and started physical therapy. Two months later, a neurosurgeon performed exploratory surgery of the femoral nerve and was unable to obtain access to the area where he suspected a femoral nerve injury. The nerve appeared to be stuck on the bottom of the pelvic bone and was compressed. The inferior hook of the acetabular cup was noted to be adjacent to the femoral nerve with more severe scarring than anticipated. Eleven days later, the reconstruction looked good but there was no femoral nerve function.
Three days later, this same surgeon performed another procedure to repair the femoral nerve with the assistance of the defendant physician. A sural nerve graft was performed. It was this surgeon’s opinion that the defendant injured the femoral nerve during the placement of the hip prosthesis. The patient was referred to a specialist who placed two pulse generators and four muscle electrodes in an attempt to maintain some function of the quadriceps muscle while the nerve graft repair was regenerating. The patient subsequently developed an infection and hematomas and required hospitalization. The patient was seen a year later by the physician who did the nerve graft and appeared to have regained some quadriceps function and early stages of nerve recovery. The patient’s final outcome was still unclear. She may require a brace for the rest of her life, but with continued improvement, may need nothing for support.

Allegations

• Failure to utilize proper surgical technique in two procedures and take the necessary precautions to protect the femoral nerve.
• Use of a cup which was too small and excessive bone grafting to support the cup in the first surgery which led to failure of the hip replacement.
• Vicarious liability against the defendant’s Professional Association.

Legal principle

Negligence is defined as the failure to use ordinary care, that is, failure to do that which a physician of ordinary prudence would have done under the same or similar circumstances or doing that which a physician of ordinary prudence would not have done under the same or similar circumstances.

Consultant physicians for TMLT indicate the defendant offered a reasonable surgical procedure to establish an improved left hip joint in both function and pain control. When complications arose, they were recognized and neurological and neurosurgical consultations requested in a timely manner. Femoral nerve injury was one of the known risks of the hip replacement revision. The expert for the plaintiff opined, in retrospect, that the defendant did not take sufficient precautions to protect the femoral nerve with the anterior-lateral approach. This physician expressed the belief that the defendant placed the wrong sized acetabular component which then migrated and necessitated the second surgery.

One of the plaintiff’s subsequent physicians advised that one does not normally see a severed femoral nerve after this procedure and described this outcome as very close to a breach of the standard of care. This physician also hypothesized that perhaps the nerve was penetrated by a drill, screw, or tap used in the hip surgery and can occur without negligence on the part of the surgeon. Other potential causes of nerve injury are a cautery, retractor, and compression from scar tissue.

Disposition

This case proceeded to trial and the jury returned a verdict for the plaintiff with an award of $3.4 million. Before hearing the verdict, both parties reached a compromise agreement for approximately forty per cent of the jury award. The claim was closed on behalf of the defendant and his Professional Association with this agreement. A mother of two young children with a permanent disability did evoke sympathy from a jury resulting in a significant award for the plaintiff. The statements of a subsequent treating physician suggesting a breach of the standard of care diminished the chances of a successful defense verdict.

Risk management considerations

The defendant physician strongly felt, and TMLT consultants agreed, that negligence did not occur in the procedure or postoperative care of this plaintiff. The suggestion by another treating physician that the femoral nerve should have been protected in the procedure, even when it was not in the operative field, created doubt in the minds of the jurors. The odds must be weighed for a successful defense verdict versus the sympathy factor seen in jury decisions.

The one weakness identified in the record keeping was the lack of completeness in the informed consent for the revision of the arthroplasty. It does not include the potential risks of nerve injury. Physicians have the ultimate responsibility to educate the patient preoperatively and to discuss the benefits, risks, and alternatives relevant to the procedure planned. Though others may assist with the consent forms, witness the patient’s signature, and reinforce instructions, the physician performing the procedure is required by Texas law to inform the patient, answer questions, address concerns, and document patient understanding and the desire to proceed. The informed consent process should be documented in the office record as well as the facility record where the procedure is performed.

Documentation of the informed consent discussion in the office may include the following:

Advised patient of the need for __________________ due to __________________. Discussed risks, benefits, and alternatives. Patient reviewed educational materials/instructions and states he/she understands and wishes to proceed. It is my judgment that the patient understands the treatment plan.
Anger is a common element noted in closed claim studies. The patient who is angry, whatever the reason, is more likely to seek retribution through the court system. The anger is usually a result of frustration fed from the inability to communicate effectively with the physician or his/her staff. Many patients will tell an attorney they are seeking information and answers from the physician. Thus, special emphasis must be given to communication issues, especially when patients experience complications of care or unexpected results. All patients experiencing less than perfect outcomes do not sue their physician. What makes the difference? Ongoing open communication and a caring attitude with the patient and family members may prevent a lawsuit.

A primary component of effective communication is the informed consent process which is more than pieces of paper. The proposed treatment is to be discussed by the physician with patients and their families, where appropriate. Use the simplest language possible during patient education and consent. For example, describe an “open reduction” as “an operation to put broken bones back together.” This discussion should include:

- The reasons for treatment;
- The risks involved;
- Any alternatives to treatment currently available;
- The risks of not performing the proposed treatment;
- Possible serious outcomes, e.g., paralysis, death, etc.

Upon completion of the informed consent process, document in the medical record that it occurred, the patient expressed understanding, questions were answered, and he/she wishes to proceed with the procedure/treatment. Prior to the procedure, the patient will be asked to complete and sign the informed consent document. This document is witnessed and includes the signature of the physician or an agent such as a nurse acting as witness.

When the informed consent process is followed, legal actions that include an allegation of failure to obtain informed consent are often defensible. Both the process and its documentation enhance the defensibility of such claims. A truly informed patient has acknowledged the risks and complications that may occur. In the event of an unanticipated outcome, disappointment will be shared with patient and physician.

The informed consent process will also focus on ensuring the patient and physician agree on what constitutes realistic expectations of the treatment plan. Physicians are cautioned against making broad statements regarding their success rates and avoid promises of unrealistic results.

**System Problems**

In spite of ongoing efforts at correction, wrong site procedures continue to occur in orthopaedics and all areas of surgical practice. Although one would think this is completely preventable, there is apparently no fail-safe remedy in the hospital surgery suite or the outpatient surgery center. What system(s) are in place where you operate? Do patients mark the site? Are you actively involved? How many checks regarding right patient, right site, right procedure are in place?

If the system fails and negligence occurs, is the facility and its physicians prepared? Are the policies for patient safety and disclosure of an adverse outcome understood and followed by all involved?

**Problems in the Defense of Claims**

The successful defense of a claim can be undermined by inadequate or altered documentation and criticism from other treating physicians. The medical record is the principal tool in defending a claim of medical negligence. In all cases, it needs to include documentation of actual events as care progresses and reflect the physician’s ongoing assessment of problems and plans for addressing each problem. Clearly documenting the thought process is important because “juries are often unwilling to fault physicians for a true scientific error if it is properly documented, especially since there is often more than one “right way” to address a given problem.”

Medical records must be legible, typed, or transcribed, and the content produced contemporaneously. Avoid comments that may be offensive to those who subsequently review a record, e.g., jurors.

Records altered after the fact provide perfect ammunition for a claim to be settled in favor of the plaintiff. Irrespective of the quality of care provided to the patient, an altered record often renders a case indefensible, as juries will be inclined to discredit a physician who alters a medical record. Exercise caution if changes to the record are needed. Amendments should be written as an addendum. It should include the current date and note the reason that information is being added. Avoid erasures and white-outs in the record. Notes added in the margins or in blank lines to clarify earlier entries are contraindicated in any medical record.

Claims of malpractice may arise as a result of criticism, whether direct or implied, if expressed by subsequent treating physicians. All physicians are advised to exercise caution in the criticism of earlier care until complete data have been reviewed including the patient’s entire medical record, imaging and laboratory studies. When possible, discuss the patient’s care with the previous treating physician(s) in order to clarify all elements of treatment and the reasons leading to those decisions.

A physician who criticizes the care of a prior physician in the medical record or in conversation may be named as a co-defendant in any ensuing legal action. Though not negligent, if named in a lawsuit, the process is stressful and requires time and significant legal expense to resolve.

**Sources**

1. Fountain, Steven S. et al, Committee on Professional Liability, AAOS, Managing Orthopaedic Malpractice Risk, 1996.
Three insurance industry trade groups came together 2/11/2003 to set the record straight on the causes of the current medical malpractice crisis. The Physician Insurers Association of America (PIAA), the Insurance Information Institute (III), and the Alliance of American Insurers (AAI) presented statistical evidence that clearly places responsibility for the current medical liability and health care accessibility crisis on the shoulders of a dysfunctional tort system and its out-of-control costs. A series of exhibits showed the escalation of jury awards and settlements, the strength of medical malpractice insurers’ investment portfolios, and the rising costs to the health care system of the vast numbers of meritless malpractice cases that are filed every year. Stated Larry Smarr, PIAA President, “We realize that this is an emotional issue for many, including those for whom the services of doctors are increasingly unavailable. If the facts can get as much air time as the myths and soundbytes, I am confident we will find an effective solution to this national problem.” In addition, the group presented strong statistical support for caps on non-economic damages, showing the lower premiums paid by doctors in states with strong tort reforms already in place. For example, in California, Kansas, and Colorado, caps on non-economic damages and other tort reform measures have resulted in a more stable and predictable insurance market, which has translated to lower premiums for physicians in those states.

Mr. Smarr also presented similar evidence at a Senate hearing on the medical liability crisis later in the afternoon. There he testified that from 1992 to 2001, the average claim payment amount has risen at a compound annual growth rate of 6.9 percent as compared to 2.6 percent for the CPIU.

A complete transcript of this press conference is available at www.thepiaa.org.