By Michele Luckie
Senior risk management representative

Presentation
A 5-year-old boy was scheduled for an MRI of the brain with and without contrast due to recurrent cholesteatoma.

The patient’s history included ear infections and middle ear problems that led to the diagnosis of cholesteatoma and subsequent surgery to remove the growth. Following the surgery, the patient was noted to have partial hearing loss in the right ear. A second surgery was performed to repair a small eardrum perforation and remove some recurrent cholesteatoma. He was referred to an inner ear specialist for an evaluation of the remaining cholesteatoma. The inner ear specialist determined that the ossicles would have to be removed in order to remove the growth. He requested an MRI to evaluate the area of the residual cholesteatoma.

Physician action
The MRI was performed and the radiologist’s report stated: “Patient with previous resection of congenital cholesteatoma, right ear. Abnormal signal in the posterior superior mastoid air cells which appear mildly atretic and probable involvement of the attic. There is some enhancement consistent with post-operative granulation tissue/fibrosis but not all of this enhances. Approximately 1cm area suspicious for residual/recurrent cholesteatoma at this site. I am unable to well visualize the right cochlea on this MRI. Mild right mastoid atresta also noted.” This was the radiologist’s only involvement in the treatment of the patient.

The inner ear specialist performed a typanomastoidectomy to remove the remaining cholesteatoma, and a second surgery was successful in reconstructing the ossicles.

Approximately one year later, the patient began experiencing recurrent headaches. A CT scan of the brain was performed, and the results were reported as normal. The patient continued to have ear infections over the next few years.

At the age of 12, the patient was seen by a psychiatrist for evaluation of depression and angry behavior. He also saw an optometrist due to sharp stabbing pains on the right side of his head. He was referred to a neurologist for evaluation of possible migraine headaches. The neurologist’s records indicate the patient was 4’7” and weighed 80 pounds, and that his growth and development milestones were all abnormal. The patient’s mother was concerned that his behavioral problems were attributable to the headaches. She requested an MRI. The MRI revealed a suspected Rathke’s cleft cyst in the pituitary sella. The radiologist compared this film with the patient’s previous MRI and noted that the cyst had increased in size. A CT scan confirmed that the mass was expanding the sella.

The patient underwent a bone age study that established his bone age to be approximately 2.5 years younger than his chronological age. He was referred to an endocrinologist for assessment of possible pituitary disease. The patient’s height and weight were noted to be in the 5th percentile during this visit. It was noted that seven years earlier he was in the 75th percentile for his age. The endocrinologist stated that the pressure from the cyst on the pituitary was affecting its function. He diagnosed the patient with growth hormone deficiency and mild hypothyroidism.

A pediatric neurosurgeon performed a transphenoidal resection of the sellar lesion. The pathology report confirmed that the lesion was a Rathke’s cleft cyst.

This closed claim study is based on an actual malpractice claim from TMLT. The 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. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

continued on page 2
ing the surgery, the endocrinologist requested a growth hormone stimulation test. The results were abnormal, and it was felt that the patient’s irregular pituitary function was most likely permanent. It was further documented that while the patient had done well on growth hormones, he still had not gone through puberty.

Another bone study was performed when the patient was 14 years old, resulting in a bone age of 11 years. The patient was also diagnosed with hypogonadism at that time and placed on testosterone.

**Allegations**

A lawsuit was filed against the radiologist who read the patient’s first MRI. The plaintiffs alleged that he failed to diagnose the Rathke’s cleft cyst on the initial MRI. Additional allegations included failure to order follow-up studies for the mass located near the pituitary gland and failure to notify the patient’s health care providers about the presence of the mass. It was further alleged that this failure to diagnose the cyst prevented serial radiographic monitoring and earlier surgery, which in all likelihood would have prevented permanent damage to the pituitary gland.

**Legal implications**

The plaintiffs were able to locate expert testimony to support their allegations. Several radiologists reviewed this case for the defense. They were all shown the patient’s initial MRI, and they all identified the Rathke’s cleft cyst. The reviewers stated that the defendant most likely concentrated his review on the internal auditory canals because he had been asked by the treating physician to rule out cholesteatoma. One of these reviewers stated that the presence of the cyst was an incidental finding that was mistakenly missed, but the defendant did not breach the standard of care.

Neurology and endocrinology consultants who reviewed this case felt that earlier diagnosis of the cyst would have led to serial MRIs and hormone stimulation testing to determine when or if surgical intervention was necessary.

**Disposition**

Although the defense consultants were mostly supportive of the defendant’s actions, there was some concern about the radiologist’s failure to detect the Rathke’s cleft cyst. It was also felt that a jury would be very sympathetic to the patient due to his future infertility problems as well as the possibility that he may never go through puberty. With these issues in mind, the case was settled on behalf of the radiologist.

**Risk management considerations**

The interpretation of diagnostic imaging studies is based upon relevant clinical information, a working diagnosis, and/or pertinent clinical signs and symptoms the patient is exhibiting. This information should be provided to the radiologist in order to enhance the clinical relevance of the report and promote optimal patient care. The radiologist in this case was given a specific clinical question to answer: rule out a cholesteatoma. While he addressed that issue appropriately, he did not report the existence of a Rathke’s cleft cyst.

American College of Radiology practice guidelines state that a differential diagnosis should be given when possible, and that follow up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate. The variety and complexity of human conditions make it impossible to always reach the appropriate diagnosis. However, from a risk management viewpoint, it is better to provide all the findings to the referring physician—incidental or not—and allow that physician to determine the course of treatment based on that information.

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TMLT continues fight to maintain medical liability reform
by Dana Leidig, ABC

On September 13, 2003, the citizens of Texas voted on Proposition 12 which determined whether the Texas Legislature should have the right to set caps on non-economic damages in medical liability cases. This legislation passed and along with House Bill 4, dramatically reformed the medical liability system in the state. In February 2008, the Texas Medical Association (TMA) along with John McKeever, MD, filed suit in Travis County in response to a liability lawsuit filed against Dr. McKeever in Nueces County claiming the $250,000 non-economic damage cap is unconstitutional. The appeal process for constitutional challenges to the 2003 tort reforms allows that, regardless of the county of origin of the plaintiff’s constitutional challenge, the defendant physician may file a suit in Travis County to address the issue. This case was heard in Travis County and a declaratory judgment action determined the cap to be constitutional.

This was not the only constitutional challenge mounted in 2008, though none have yet proved successful. These early challenges may be harbingers of a bigger, more organized storm to come when the Texas Legislature convenes in January 2009. There may be a strong effort by opponents of medical liability reform to weaken important aspects of this legislation. In order to keep the 2003 reforms that have helped cut both non-meritorious claim frequency and medical liability premiums in half and brought approximately 7,000 new physicians to Texas, it is essential that the strong coalition that achieved these landmark reforms six years ago remain active and vocal.

Grassroots efforts work

In the fall of 2001, TMLT and the TMA, the Texas Hospital Association, many county medical societies and specialty societies, physician groups, and other stakeholders joined together to form the Texas Alliance for Patient Access (TAPA). TAPA was dedicated to solving the problems of declining access to health care in Texas by analyzing medical liability laws and proposing changes that could reform the medical liability system. At that time, TAPA members worked tirelessly throughout the state to educate physicians about the issues. TMLT executives were part of the team, traveling from Brownsville to El Paso, Dallas to Houston to Texarkana to make presentations to physicians working in these locales. In conjunction with TAPA, TMLT executives were also part of the team making presentations to the Texas House Insurance Committee to help legislators understand the critical nature of the issues. As physicians became more informed, the battle heated up. In April 2002, physicians attired in their white coats participated in an organized demonstration in the Rio Grande Valley and later in a white coat march on the state capitol to draw public attention to medical liability issues.

Achievements we cannot afford to lose

According to the Pacific Research Institute’s Tort Liability Index: 2008 Report, “the states that have the best overall tort rules on the books, and that will be heading in the right direction if the rules are fully implemented, are Colorado, Texas, Ohio, Georgia, Indiana, Florida, and Michigan.” 

It is vital to keep the Texas medical liability reforms intact and unchanged in order to control costs and encourage competition in the medical liability insurance industry. In the years following medical liability reform, the number of medical liability insurance carriers grew from 4 to 30, providing physicians greater choice and encouraging responsible rate setting among carriers.

What reforms mean for physicians

After five years, the positive effects of medical liability reform for both physicians and patients are clear: lower medical liability rates, decreased claims frequency and fewer non-meritorious lawsuits, more physicians moving to Texas, expansion of health care services, and greater access to health care for patients.

TMLT was the first medical liability carrier to lower rates for Texas policyholders. Subsequently, other medical liability insurance carriers followed with rate reductions. TMLT has decreased rates six times since medical liability reform was enacted, including a 4.7% average rate reduction effective January 1, 2009 setting the trends for other carriers. The cumulative premium savings by TMLT policyholders will exceed $275 million since January 2004. TMLT was also able to return savings to its policyholders through dividends. Since the first dividend was declared in 2005, TMLT policyholders have saved approximately $105 million with dividend credits off renewal premiums.

Claims frequency at TMLT—including mass litigation—has declined from 22.82% in 2002 to 9.46% in 2007. The number of cases taken to trial has also declined from 76 in 2002 to 49 in 2007. The percentage of claims closed without indemnity has increased from 86.89% in 2002 to 89.42% in 2007. Bob Fields, president and CEO of TMLT, stated in the 2007 annual report that in 2007 there were fewer frivolous and non-meritorious claims to defend.

These good results must be guarded carefully however. They are largely the result of the $250,000 cap on non-economic damages. According to TAPA, “any change to the non-economic damage cap will increase cost and frequency of suits and would reduce access to care.”

More physicians are available for Texans in their communities. According to an article published by the TMA, “The Texas Medical Board licensed a record 3,621 new doctors this fiscal year; 9 percent more than last year’s previous record of 3,324. Texas has licensed 14,499 new physicians post-reform.” This includes specialties such

continued on page 4
as neurosurgery, orthopedic surgery, trauma surgery, emergency medicine, obstetrics, and pediatric subspecialties whose numbers in Texas were declining before tort reform. TMA’s article also states that many physicians are now confident in offering services to patients considered high risk. “Many physicians report adding new in-office procedures and testing, nursing home coverage, and after-hours services. Others say they are now providing more charity care, participating in volunteer programs, and accepting more Medicaid and Medicare patients because of the liability reforms.”

On-call for tort reform

As the legislative session opens in January 2009, physicians must again be prepared to defend medical liability reforms. The importance of keeping these reforms intact cannot be overemphasized. Your local county medical or specialty society can provide you with information as the legislative year progresses, or visit www.texmed.org for current news on the issues. The TMA web site also is a good resource for materials suitable for making presentations to physician groups. The TAPA web site, www.tapa.info, will have legislative updates as well as a library of news articles from around the state. Stay informed. Write letters to your state senator and representative expressing your concerns and encourage your colleagues to do the same. Lawmakers need to be reminded how much medical liability reform has meant to physicians and their medical practices, and to patients who have greatly improved access to health care.

Sources


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