

the Reporter

DEATH/FAILURE TO TREAT DIABETES FAMILY PRACTICE CLOSED CLAIM STUDY

by Stacey Agnew, 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.

Clinical presentation

A 28-year-old male presented to his family physician for elevated blood pressure. The patient was scheduled for blood work (SMA-C, CBC, TSH) the following business day. The patient never returned for the blood work. One year later, the patient came back to the physician complaining of blurred vision, weakness, fatigue, weight loss, polydipsia, and polyuria.

Physician action

When the patient returned with the above complaints, his blood pressure was 148/90 and heart rate 110. Urinalysis showed glucose of 1000, Ketone levels 160, specific gravity of 1.005, pH of 5.0. The physician obtained a Chem 21, CBC, and TSH.

The physician saw the patient three days later and discussed the results of the lab tests, including a glucose of 680, sodium of 129, chloride of 87, cholesterol of 600, and triglycerides of 4300. The CBC revealed Hgb of 15.2,

Hct of 38.8, and WBC of 4,100 with a normal differential. Thyroid panel was normal. The physician recommended hospitalization, however the patient refused stating he did not want to be hooked up to machines and poked by needles. The patient also indicated he could not afford medication and requested sample medications. The physician had samples of Amaryl, which he gave to the patient and instructed him to take one half tablet per day and follow-up in two weeks. He placed the patient on a sugar free diet.

Two days later the patient was found dead in his home. Autopsy reports indicate the cause of death as diabetic ketoacidosis.

Allegations

The plaintiff alleges that the physician violated the standard of care in that:

- Lab values were not obtained in a stat fashion.
- The physician failed to admit the patient to the hospital. Instead, the patient was sent home on a sugar free diet.
- Lab values were not monitored and/or the significance was not understood.
- Amaryl was prescribed, which is contraindicated in a patient with these lab findings.

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Disposition

It was felt the treatment was below the standard of care. Consultants were critical of the decision not to hospitalize a patient with such an extremely elevated glucose level and possible ketoacidosis. The patient should have been immediately hospitalized and treated. The physician should have been more aggressive in explaining the risks of not being hospitalized to the patient. All consultants were critical of the use of Amaryl in treating a patient with ketoacidosis.

This case was settled on behalf of the physician for six figures.

Risk management considerations

The first time the patient presented to the office, the physician recommended lab work. The patient never returned to have the lab drawn. There was no attempt to contact the patient and there was no entry in the medical record indicating the patient failed to keep the appointment. It is recommended that protocols for follow-up on cancellations and no-shows be developed. This may assist in identifying patients whose conditions require a visit. By doing so, your patients are reminded that it is important to follow through with scheduled appointments. Documenting these phone calls or letters also demonstrates your efforts to contact patients should a problem subsequently occur.

As family practitioners refer large numbers of patients for diagnostic testing and referrals, it is critical to have a system in place to ensure patients do not fall through the cracks. In this particular case, it is alleged that once the patient did return to the physician one year later and had lab work done, the results were not maintained in a stat fashion. For patients who are referred for laboratory tests, diagnostic studies, or consultations, a tracking system is recommended to ensure the patient is seen and results are received in a timely manner. A "diary" system to determine if a patient is seen and that results are received is recommended. Additionally, physicians may decide to schedule test and consultant appointments for the patient, requesting the office be advised if the patient does not keep the appointment so the record can be documented.

In this case, the physician alleges that the patient refused hospitalization. Additionally, the patient did not want a prescription for medication, but would agree to take available sample medication. The physician should document noncompliance or refusal of medical treatment in the medical record. It is further recommended that a staff person, such as a nurse, witness the

Sample Informed Refusal
Your Letterhead

In order to diagnose/treat my condition a _____ was
(Test/Procedure)

ordered for me on _____ . The reasons for ordering this test/procedure
(date)

have been carefully explained to me. I understand the potential benefits are _____
_____ and
the alternatives include _____

In addition, Dr. _____ has informed me of the risks involved in not having a
_____ performed. These risks include _____
(Test/Procedure)

After careful consideration of the benefits and risks concerning the above I am refusing
_____. My reason(s) for refusing is : _____
(Test/Procedure)

Signed this _____ day of _____ by:

Patient Signature

Witness Signature

Sample informed refusal form

discussion and entry. Patient acknowledgement and understanding should be documented as well. Patients refusing medical treatment should be asked to sign an informed refusal. (Please see sample.) Historically, plaintiffs have been successful in claims alleging they were not adequately informed regarding the benefits of a proposed treatment. They often state they would not have refused had they been educated and informed regarding the benefits of treatment and the risk in refusing such treatment.

RISK hot topics MANAGEMENT

The medical liability crisis in Texas

Last year TMLT participated in the TMA Medical Liability Data Study. The three largest carriers in Texas, Medical Protective, API and TMLT, submitted data to TMA. An exhaustive study was conducted on claims data identifying alarming information about claims frequency and severity. Carrier's rates became insufficient, resulting in under-pricing of \$138 million during 1996-1999. (Please see figure 1.) Claims payout trends indicated the necessity for premium rate increases. While there have been no further studies, the Texas Department of Insurance is in the process of mandating a statewide study.

TDI data indicate that medical liability carriers doing business in Texas collectively lost \$103 million in 1999. With \$280 million in indemnity paid, \$98 million in legal expenses, over \$16 million in commissions and brokerage fees and \$8 million in taxes and license fees, they experienced a net loss of 30 percent on \$299 million in written premium. (Please see figure 2.) Indications are that 2001 will be worse. TDI data include physicians, nurses and hospitals, but TMLT is not included in this data since it is a trust and not a regulated carrier.

Companies experiencing these losses include Frontier, Lawrenceville, Medical Protective, Phico, St. Paul and Western. They are reacting by raising rates, restricting who they will cover and where they will offer coverage, as well as reducing limits and leaving the state.

TMLT protects more than 10,000 physicians, which is 40 percent of available TMA members. Claims frequency at TMLT has reached 25 percent. This is unheard of in the medical malpractice industry and the highest ever recorded by the Trust. We are now mired in a complicated medical liability crisis.

Liability reform is necessary to combat this crisis. In 2000, TMLT received 3,022 claims for a policyholder base of 10,000 physicians. Faced with increases in claim activity, malpractice carriers across the state are raising rates substantially. Rate increases may challenge the ability of physicians to continue to practice medicine.

Lawsuit abuse threatens the delivery of health care as physicians either quit or refuse to enter high-risk specialties or practice in high-risk areas.

Figure 1

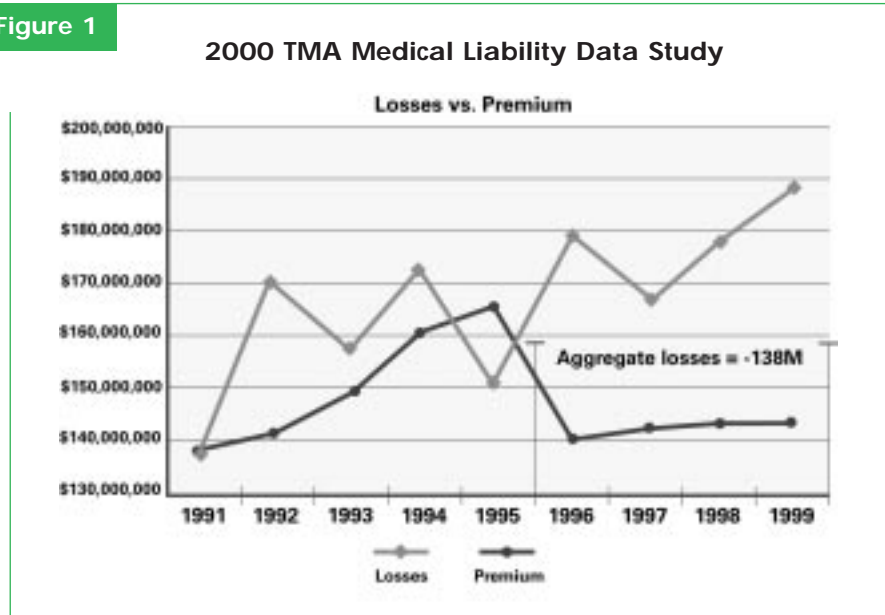
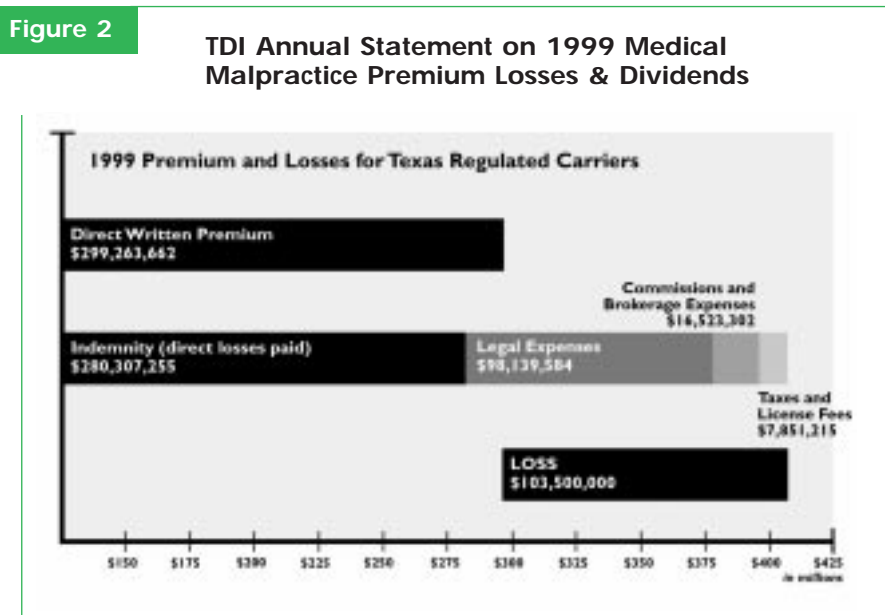


Figure 2



TMLT is working to help build momentum for tort reform at the grassroots level. TMLT and TMA are forming a consortium of interested parties to help battle the well organized and financed plaintiff's bar. We need the help of other insurance companies, organized medicine, hospitals, physicians and nursing homes. We also need the help of lobbying and

tort reform associations like Citizens Against Lawsuit Abuse, the Texas Civil Justice League, Texans for Lawsuit Reform and the American Tort Reform Association.

If you would like to be a part of this effort, you may contact us through our web site by emailing Theo van Eeten by calling TMLT, 800-580-8658, extension 5938.

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