

Internist Liability
Risk Management Effective
Informed Consent
Malpractice Claim
Physician Disclosure

What You May Not Have **Learned** in
Your Internal Medicine Residency

*—A guide to malpractice liability,
risk management, and patient safety*



Coordinating
Care Evaluating Insurers
Disclosure Guidelines
Electronic Medical Record

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Introduction

Virtually all physicians are aware that practicing medicine in the United States is impossible without some form of medical liability insurance. The vast majority of hospitals and other health care institutions mandate that medical staff members be insured. However, many physicians have a limited understanding of how professional liability insurance works. It is important for every practicing physician to become familiar with both the business principles underlying insurance and the types of insurance coverage available. Part I of this brochure, “Insuring the Practice of Medicine,” will introduce physicians to the principles of malpractice insurance and assist in the evaluation and selection of an effective insurance program.

While the quality of medical training in internal medicine residencies is excellent, there is often limited exposure to the variety of practice management problems that present themselves daily in medical practice. Part II of this brochure, “Medical Liability and the Internist,” will introduce new physicians to important risk management strategies designed to enhance the quality of their medical practice, promote patient safety, and minimize their liability exposure.

Part III, “Internal Medicine Malpractice Claims,” discusses five actual claims that are representative of the spectrum of liability problems encountered in internal medical practice.

I. Insuring the Practice of Medicine

1. TYPES OF INSURANCE COMPANIES

Physicians have choices when selecting a professional liability insurance company:

- **Mutual and reciprocal insurance companies** have no stockholders and are owned by their policyholders. Two thirds of practicing physicians get their coverage from physician-owned mutual or reciprocal insurance companies. These companies were formed to provide their policyholder-owners with a dependable source of insurance. They generally offer only medical malpractice insurance. Any profits that a mutual or reciprocal company makes are used to strengthen the company’s ability to pay claims or are paid back to policyholders in the form of dividends. Only a reciprocal company can return profits to policyholders by placing funds into a Subscribers Savings Account payable upon death, disability, or retirement.
- **Stock insurance companies** are public, for-profit corporations owned by their stockholders. These commercial carriers are publicly traded and provide coverage for about one third of American physicians. Stock companies offer multiple lines of insurance, and they often move in and out of the malpractice market as the business climate dictates.

If a carrier is not sufficiently capitalized, it may issue an **assessable policy**. This means that if the carrier cannot meet its financial obligations, it can require its insured physicians to make up the deficit; e.g., if the company’s claims reserves are inadequate, the current policyholders could be required to pay additional money to cover its past claim losses. A carrier that is sufficiently well

capitalized can issue a **nonassessable policy**. This frees policyholders from any obligation to pay additional money for past losses if reserves are inadequate.

2. THE ALTERNATIVE MARKET

The alternative market provides other sources of coverage that are typically exempted from certain insurance laws, such as minimum capital requirements. If you are considering nontraditional coverage through the alternative market, carefully investigate all aspects of the policy—especially the organization's provisions regarding tail coverage, its financial solvency, its regulatory requirements, and its rules regarding assessability.

- **Trusts** are a controversial alternative to insurance. In some states, trusts are not regulated by state insurance departments, nor are they protected by state guarantee funds in the event of insolvency. In order to join a trust, capital contributions are frequently required. In some trusts, only the claims actually paid during the policy period are covered. Since most trusts do not maintain reserves, trust members are retroactively assessable if the trust's assets prove insufficient to pay losses. Furthermore, some trusts stop defending and paying open claims for members who leave and go elsewhere for coverage if the members do not agree to remain assessable or do not purchase tail coverage.
- **Joint underwriting associations (JUAs)** are state-sponsored programs for physicians who have no access to other sources of professional liability insurance, typically because the standard medical malpractice insurers refuse to insure them. In some JUAs the insured doctors are assessable, and the ultimate financial obligations are unpredictable and can be significant.
- A **risk retention group (RRG)** is a group of doctors who form an insurance company that is required to follow the insurance regulations of the state in which it is domiciled. When first joining an RRG, a physician is typically required to pay a capital contribution in addition to the annual insurance premium. If an RRG is appropriately capitalized and operated, it can be a viable insurance alternative. However, due to less regulatory scrutiny, insolvencies imperiling the financial assets of the insured have occurred. Doctors considering an RRG should carefully evaluate the extent to which the state requires the high standards of solvency and management necessary to ensure that the company is able to fulfill its insurance obligations.

3. TYPES OF INSURANCE POLICIES

The most common types of coverage are claims made and occurrence, although today most professional liability insurance carriers offer only claims-made policies. Since these types of insurance provide fundamentally different protection, you should clearly understand their differences.

In a **claims-made policy**, a covered event must occur and the claim made (reported) during the policy period. Claims-made coverage can be extended back by adding **nose coverage**, in which the insurer agrees to cover claims made during the policy period based on events that occurred prior to the inception date of the policy. When a physician retires or moves to a different insurance carrier, he or she may obtain **tail coverage**. This provides insurance for a covered event that occurred during the policy period, even if the claim is not reported until later. If a physician moves from one carrier to another, the individual can choose between a tail policy with the expiring carrier and nose coverage with the new carrier.

In an **occurrence policy**, any claim arising from an event occurring in the policy period is covered, regardless of when the claim is reported or when in the future it needs to be paid. The long time between the occurrence of an adverse medical event and the time when a claim is paid (typically three to five years) makes it difficult for malpractice insurance companies to predict the ultimate costs of losses. Since today's premiums must cover future losses regardless of when they are reported, malpractice occurrence policies are seldom offered.

4. GENERAL PRINCIPLES OF INSURANCE

Most physicians are unfamiliar with the underwriting, actuarial, and reserving principles of professional liability insurance. The policy is usually filed away unread until a claim is made. Yet without this crucial document, it is virtually impossible to practice medicine in today's litigious environment. The policy is a legal contract, and it is important to read it and understand what claims are covered, the exclusions to coverage, and the endorsements that modify the policy.

A viable insurance company is a business like any other in that income (premiums) must cover expenses (losses), or the company will not be "in business" when future claims need to be paid. However, the business of an insurance company is managing risk, and in important ways an insurance company differs from other businesses. The most important difference is the need to collect an appropriate amount of premiums today to cover losses and legal defense expenses that occur three to five years into the future. By definition, these future costs are unknown at the time the insurer must price and sell the policies and are difficult to predict due to the length of time involved in resolving malpractice claims. If an insurer underestimates future costs and fails to place adequate funds in claims reserves, physicians will be left without the liability protection that they have paid for. However, their personal liability remains.

Thus, an insurance company's survival depends on its ability to determine physician risk and predict future losses, appropriately price today's premiums to cover these losses, and place adequate funds in reserves to pay losses when they are incurred. Therefore, the true value of a policy (as opposed to its premium cost) may not be apparent until years after its purchase when a claim must be defended and possibly paid.

- **Underwriting** is the risk-assessment of physicians applying for insurance coverage and their placement into subgroups sharing similar risk profiles thought to be predictive of similar future claims losses. Factors that affect risk include specialty, level of training, nature of practice, clinical setting, unusual practice profiles, and the state and county where medicine is practiced (venue). Venue assessment considers the medical-legal climate, presence or absence of tort reform, and the attitudes of both patients and juries toward doctors. Thus, high-risk specialties (neurosurgery, OB, orthopedics) pay higher premiums than low-risk specialties (dermatology, pathology, psychiatry); and a neurosurgeon in New York pays a higher premium than a neurosurgeon in California.
- **Actuaries** calculate the premium price by making specialty-specific estimates of the cost of future losses and associated expenses (legal defense and expert witness fees). Their estimates are based on the company's past experience and on predictions of future trends in claims **frequency** (the number of claims per 100 insured physicians) and **severity** (average indemnity and associated expenses paid per closed claim). The larger the physician risk pool, the more accurately losses can be predicted. The calculation for an individual physician is further refined by the loss history for the doctor's specialty in the geographic territory (venue) where he or she practices. Actuarial

models must also reflect the value of investment income. Part of the fiduciary responsibility of any insurance company is to responsibly invest premiums until the money is needed to pay future losses and expenses. The investment income collected is used to subsidize the actual cost of premiums. For this reason, insurance rates are sensitive to the state of the investment markets, especially to interest rates, since claims reserves are held in fixed income investments.

- **Surplus** is the amount by which a company's assets exceed its liabilities. It is accumulated profit that, in a mutual or reciprocal company, belongs to the policyholders. It serves as the company's capital, and it supports operations during years when unpredicted high losses have occurred. A company's surplus (capital) allows it to take on risk (write new business) and also serves as a cushion in the event that losses from that risk exceed the reserves intended to cover them. This is because surplus can make up for deficiencies in the loss reserves. *Thus, surplus serves to provide strength and to maintain fiscal integrity in the face of adverse loss experience that was not anticipated. It is the most obvious mark of a company's strength and stability—and it is closely monitored by state departments of insurance and rating agencies in order to assure policyholders that a company has sufficient assets to pay for future claims.*
- **Reserves** are the funds set aside to pay for future losses. The reserves are invested, and the interest earned becomes an additional source of income to pay for future losses. Over time, some claims settle, and the reserve estimates on open claims are modified as additional information becomes available. This necessitates a continuous re-evaluation of the adequacy of reserves. If reserves fall below a level considered adequate to pay future claims, the company is under-reserved. Money is then transferred from surplus into reserves, and premiums may have to be raised in order to rebuild surplus. On the other hand, if a mutual or reciprocal company becomes over-reserved, the "excess" dollars are transferred to surplus and taxed. If the surplus is more than adequate for the capital needs of the company, funds may be returned to policyholders in the form of a **dividend**. A reciprocal company may also place funds into a **Subscriber Savings Account** payable to the insured upon death, disability, or retirement.

The **reserves-to-surplus ratio** is an important measure of a company's reserve adequacy. It measures a company's financial ability to pay claims if reserves prove to be inadequate, since the additional reserves would have to come from the insurer's surplus. The target range of reserves-to-surplus is 2–3:1. Thus, it is important to grow surplus, since it is both the company's capital and the source of funds to bolster reserves if needed.

The percentage of premiums used to pay incurred losses is called the **loss ratio**. Losses include indemnity payments made to plaintiffs as a result of jury awards or settlements and the legal defense expenses associated with dismissal, defense in court, or settlement of claims (primarily defense attorney and expert witness fees).

The percentage of premiums used to run the company is called the **expense ratio**. These operating expenses include underwriting, claims administration, finance, marketing, and agent commissions.

The sum of the loss and expense ratios is called the **combined ratio**; this is the percentage of premiums used to operate all aspects of an insurance company (losses and expenses). A combined ratio (CR) of 100 percent is the breakeven point, i.e., losses and expenses equal the premium collected, and the profit equals investment income. If the CR exceeds 100 percent, there is an underwriting loss; and if it is less than 100 percent, there is a profit.

Historically, for most insurance companies, the CR exceeds 100 percent. How then do malpractice insurance companies stay in business? The answer is that they conservatively invest the premiums collected (primarily in treasury notes and investment-grade bonds), and the investment income generated is usually sufficient to offset the company's operating losses. If investment income is insufficient to compensate for losses, funds must be transferred from the company's surplus into its reserves.

5. EVALUATING A CARRIER

Focusing only on the price of coverage (premium) can be a serious mistake. Financial stability, not premium price, should be the first consideration when selecting a malpractice carrier. It is essential that the insurance carrier have sufficient financial resources to pay all current and future claims against policyholders. Consider the following factors:

- **Financial strength**—This is reflected in the rating it receives from an insurance industry analyst such as A.M. Best Company or Fitch Ratings. A company's financial rating is an assessment of its ability to pay future claims.
- **Management philosophy**—Carefully evaluate a carrier's management philosophy, which is reflected in its underwriting standards, claims management, commitment to promoting patient safety, and level of service it provides to its policyholders.
- **Underwriting standards**—Well-managed carriers are staffed by experienced underwriters who understand the risk assessment factors essential to properly evaluate a doctor's application for coverage. A financially sound carrier exercises underwriting discipline by not insuring doctors whose practice profiles or claims histories suggest a high risk for future indefensible claims. Such claims could imperil the assets of the company and, in the case of a doctor-owned company, the security of its insured physicians.
- **Claims management**—Claims should be reviewed promptly by experienced claims specialists. Policyholders should be vigorously defended against nonmeritorious claims. In instances where there is negligence, the company should attempt to settle claims quickly and fairly with the physician's consent. Where permitted, a guaranteed consent-to-settle provision should be included in the policy. Such a provision requires that the carrier must obtain the physician's written consent in order to settle any claim. This gives the physician control over how claims are settled.
- **Patient safety/risk management**—Patient safety programs, including loss prevention and traditional risk management assessments and interventions, should be an integral part of the services provided by a medical liability insurer. The company should conduct expert claims reviews in each specialty to uncover recurrent problems of medical error, system failure, and patient injury. It should also provide its policyholders with ongoing, proactive patient safety programs and information designed to enhance the safety of their medical practices, reduce the risk of patient injury, and decrease their exposure to a claim resulting from an adverse outcome.
- **Organizational structure**—It is important to learn if the carrier is organized as a mutual company, a reciprocal company, a stock company, or a trust.

6. QUESTIONS TO ASK WHEN SELECTING A CARRIER

- What kind of carrier is it? (Is it a stock company, a mutual or reciprocal carrier, or an alternative market carrier?)
- If it's a mutual or reciprocal carrier, is there a dividend policy in place? If it's a reciprocal carrier, is a Subscriber Savings Account offered?
- How long has the carrier written medical malpractice insurance?
- Does the carrier offer policy deductibles? Does it offer discounts for physicians with favorable claims histories or to those who participate in patient safety activities?
- Is the carrier endorsed or sponsored by national specialty societies or medical associations, and does it offer program discounts for membership?
- Does the carrier have a certificate of nonassessability that protects policyholders from unlimited personal liability for losses incurred by the carrier's past claims?
- What payment plan options does the carrier offer?
- If I take family leave, disability leave, leave for military service, or a sabbatical, will the carrier charge me while I'm not practicing?
- Will I have easy access to the carrier's medical director and its policyholder services?
- Does the carrier have its own patient safety department? What types of patient safety/risk management services are offered?
- If I have a claim, will it be reviewed by a consultant in my specialty?
- Can the carrier settle a claim without my consent?
- Will the carrier cover my locum tenens and ancillary personnel?
- What does the policy cover beyond traditional malpractice insurance? Will it cover actions and reviews by Medicare, Medicaid, medical licensing boards, credentialing agencies, and professional review organizations?
- Will I be reimbursed for lost income if I have to go to court? What kinds of services are provided as part of my defense?
- How do the carrier's insurance industry ratings compare with those of its competitors? How sound are the carrier's reserves and surplus?
- Does the carrier actively support national medical-legal tort reform?
- If I move my practice to another state, can I carry my coverage with me?
- What are my extended reporting (tail) coverage options if I retire or decide to move to a practice covered by another carrier?
- Do physicians serve on the carrier's board of directors?

II. Medical Liability and the Internist

Malpractice is defined as medical care that falls below accepted medical standards and causes patient injury. Most medical malpractice actions are based on laws governing professional negligence. Thus, the cause of action is usually the alleged failure of the defendant-physician to meet the standard of care and to exercise the reasonable degree of skill, learning, and care ordinarily possessed by other doctors in the same medical specialty in the community. Whereas in the past the term *community* meant the local community, it is now presumed that all doctors keep up with the latest developments in their field, and *community* is now generally interpreted as the “specialty community.” Thus, the standards are now those of the specialty without regard to geographic location. In practical terms, what this means is that if you are practicing in a small community, you can be held to the “standard of care” of a university medical center.

The sequence of events that often leads to a malpractice claim includes:

- Unanticipated medical event, complication, or outcome
- Physician nondisclosure of the event
- Communication breakdown
- Doctor-patient relationship compromised
- Patient anger
- Lawyer—claim

The following patient safety/risk management strategies may prevent patient injury, ameliorate anger, and interrupt this cascade of events:

1. INFORMED CONSENT

Simply stated, *informed consent* means that adult patients who are capable of rational communication must be provided with sufficient information about the risks, benefits, and alternatives associated with a proposed treatment or procedure in order to make a decision and expressly give permission. In most states, physicians have an affirmative duty to disclose such information. This means that you must not wait for questions from your patients; you must volunteer the information. However, questions should be encouraged.

The informed consent for a treatment or procedure is not just a signed document; it is a process of managing the patient’s expectations. Patients who are informed about the purpose, benefits, risks, alternatives, and expected outcome are less apt to have unrealistic expectations. The informed-consent discussion implicitly shifts the responsibility for decision making from the physician alone to a mutual responsibility of both the physician and patient that strengthens the physician-patient relationship.

When properly conducted, the process of obtaining informed consent can help establish a therapeutic alliance and launch or reinforce a positive doctor-patient relationship. If an unfavorable outcome occurs, that relationship can be crucial to maintaining patient trust. By focusing on how you say something as well as on what you say, you can transform a preoperative routine into an effective claims prevention mechanism.

To allay anxiety, you may seek to reassure your patients. In doing so, however, be wary of creating unwarranted expectations or implying a guarantee. Consider the different implications of these two statements:

- “Don’t worry about a thing. I’ve taken care of hundreds of cases like yours. You’ll do just fine.”
- “Barring any unforeseen problems, I see no reason why you shouldn’t do very well. I’ll certainly do everything I can to help you.”

The therapeutic objective of informed consent should be to replace some of the patient’s anxiety with a sense of control resulting from the patient’s participation in the decision making process. To be certain the patient understands your explanation, ask the patient to repeat back what you said. This strengthens the alliance between you and the patient, and instead of seeing each other as potential adversaries in the event of an unfavorable outcome, you are drawn closer by sharing acceptance of the uncertainty inherent in clinical practice.

Effective Informed-Consent Documents

While informed consent will not absolve you from responsibility if there is negligence, a well drafted informed-consent document is proof that you tried to give the patient sufficient information to make an intelligent decision. This document, supported by a handwritten note in the patient’s medical record, is often the key to a successful malpractice defense when the issue of consent to treatment arises.

The documentation (dictated or handwritten) usually does not need to be a laundry list of every possible complication. There is always the risk that in a long list the very complication that occurred is not listed. However, always follow your state’s statutory requirements governing informed consent; some states, such as Texas, actually require a “laundry list” of risks to be disclosed for certain procedures.

Written and audiovisual materials for the patient to take home are a useful supplement to the informed-consent discussion. These are helpful because many patients cannot remember or explain to their family what they were told by their doctor.

If the patient is unable to communicate rationally, as in many emergency cases, there is a legally implied consent to treat. The implied consent in an emergency is assumed only for the duration of that emergency. However, if at all possible, it is safer to obtain the consent of the patient’s closest relative.

The treatment of minors carries the responsibility of obtaining consent from the parents or legal guardians. An exception in most states is the “emancipated” minor (those who are pregnant, married, serving in the military, or legally free and financially independent). However, in an emergency, you must not delay in treating a minor or an incompetent person if such a delay might adversely affect the outcome of the case. In such circumstances, anything less than prompt attention and treatment will increase your exposure to liability.

Informed Refusal

Doctors must also warn patients of the consequences of failing to heed medical advice by refusing treatment or diagnostic tests. It is essential to carefully document such refusals and their consequences in the medical record and to note that the patient understood those consequences. If a claim is filed and such a refusal is not written in the medical record, it never happened!

2. IMPROVING PHYSICIAN COMMUNICATION SKILLS

Physician-patient communication (“bedside manner”) is not only important in the healing process, but it is also one of the most important factors in determining whether or not an unanticipated event results in filing a malpractice claim. Patients expect their doctors to “care,” meaning that how a physician communicates a bad outcome or complication is crucial. Many patients who sue are more angry than injured. If your patient likes you, he or she is less apt to sue you—and patients like doctors who demonstrate a personal interest by listening, explaining, and talking to them.

An arrogant physician who is abrupt, abrasive, or impatient and who avoids explaining an unexpected event with empathy and compassion is at high risk for a lawsuit. A “deny and defend” mentality often drives the patient to an attorney. It is not uncommon for an insurance company to settle an otherwise medically defensible claim because of concern that an arrogant doctor will make a bad witness and “turn off” a jury.

Don’t make promises you can’t or don’t intend to keep, i.e., telling a patient that you’ll return a phone call or see him or her during rounds at a specific time or meet with family members post-op to explain the surgical outcome. Failure to keep promises leads to disappointment, frustration, and anger. And anger leads to a claim.

3. PHYSICIAN DISCLOSURE OF UNEXPECTED EVENTS OR BAD OUTCOMES

Disclosure (“I’m Sorry”) programs encourage physicians to disclose unanticipated adverse events or adverse outcomes. Adverse events are defined as patient injury resulting from medical error or systems failure. An adverse outcome is a result that differs from the anticipated result of a treatment or procedure and results in harm to the patient. The ethical rationale for disclosure is that the patient and his or her family have a right to know what happened—simply put, it’s “the right thing to do.”

Patients usually know when they have been injured as a consequence of an adverse outcome. When no one explains what happened, they assume a mistake is being concealed—and become angry. Anger drives many malpractice claims. Disclosure takes the “edge” off anger and is essential to maintaining the physician-patient relationship.

Adverse outcome disclosure requires an open, honest communication that includes full disclosure of the unanticipated event coupled with a genuine expression of concern that may include an apology—if appropriate. It is important to meet with the patient/family as soon as possible after the adverse outcome occurred. Since the cause of the event may not be immediately apparent, only the known medical facts are reviewed. It’s OK to say “I don’t know.” Later, when the investigation is complete (including a root cause analysis of the sentinel event), a final disclosure meeting is held.

The basic components of disclosure include:

- Physician disclosure of the event to the patient and family, explaining what happened, and responding to questions.
- Physician acceptance of overall responsibility for the patient’s care.
- Empathizing with the patient, genuinely expressing concern and regret, and saying “I’m sorry this happened.” However, it isn’t appropriate to say “I’m sorry I did this” unless a clear-

cut error has occurred that could have been prevented—and the person making the apology was responsible for the error.

- Discussing the future consequences of the injury (hospitalization, medications, surgery, disability, etc.).
- Explaining what is being done to prevent this from happening again to another patient.

Some programs provide limited patient compensation for additional medical expenses that are not covered by insurance *and* for time lost beyond what would have been the expected recovery period. Events that involve a patient demand, an attorney, a summons and complaint, or state medical board involvement are excluded. National Practitioner Data Bank reporting isn't necessary since there is no patient claim or demand for monetary compensation. It is important to become familiar with applicable state disclosure laws and institutional disclosure policies.

4. MEDICAL RECORD DOCUMENTATION

Medical malpractice claims can be won or lost based on the quality and content of the medical record. It is essential that the medical record accurately documents everything a doctor does with regard to evaluating, managing, and treating a patient—and it is particularly important to document the rationale for critical decision making. If there is poor written documentation or if the medical record is vague, incomplete, or altered, the defense of a claim will be compromised, and the claim frequently results in settlement or loss. Furthermore, since claims are often filed years after an event occurred, physicians may not remember the case in sufficient detail without a detailed medical record to review.

All entries should be legible and in ink. Each entry should be made with the same pen to avoid any suspicion that information was subsequently added. Illegible entries, contradictions, factual errors, and especially the appearance of altered records are repetitive problems. If the medical record is or appears to be altered, a jury will conclude that the doctor was attempting to conceal an error. On the other hand, any inaccurate information left in the medical record can also result in liability. If such an entry or an error is discovered, draw a single line through the entry/error, then initial and date it. Do not write over the entry to make it illegible, attempt to erase it, or use whiteout. Never squeeze words into a line or leave blank spaces between entries; draw diagonal lines through the blank spaces.

Late entries, especially if they augment sparse notes and are written in the margin of the page, can raise questions of retroactive tampering with the record. It is preferable to make a late entry in an empty space on the notes page, indicate the date and time, explain why it was entered late, and is therefore out of sequence, and cross-walk it to the appropriate place in the record using asterisks or arrows. Never add anything to the medical record unless you write a separately dated and signed note. Similarly, late dictation of a history and physical or progress note can raise questions. And if you become aware that a malpractice claim may be filed, do not add a lengthy late entry justifying a treatment, diagnostic conclusion, or adverse outcome because it may appear self-serving, and a jury may doubt that such detail can be recalled accurately.

Experts on document examination can detect virtually any alteration of or addition to the medical record—and deliberately altering a medical record is illegal and can lead to criminal charges, disciplinary action, loss of license, and fines.

5. THE ELECTRONIC MEDICAL RECORD

The *Personal Health Record* (PHR) is owned and controlled by the patient and used by the patient or his or her caregiver. It contains basic health care information such as lists of medications, medical conditions, allergies, immunizations, past surgical procedures, and other information related to care provided by *all* physicians or hospitals. This is the information currently collected on a clipboard when the patient has an office appointment, is admitted to a hospital, or is seen in an emergency department.

The *Electronic Medical Record* (EMR) is owned, controlled, and used by the physician or hospital that provides care to the patient. It contains detailed information about the care provided, but only for the care delivered by a single provider and only during the period that the patient was in his or her care. It is easily readable, provides clear documentation, has automatic alerts for allergies and drug interactions, provides medication lists, charts lab and radiology results, provides current medical guidelines for preventive care and chronic-disease management, and allows timely remote access. It provides a better presentation of data for clinical decision-making.

About one third of physicians use an EMR and more than half are primary care physicians. A review of 363 malpractice claims from The Doctors Company revealed that system errors contributed to 30 percent. Thirty-two percent of these were medication-related errors, 27 percent were communication errors, and 13 percent were medical record errors. Medication errors involved monitoring (one third were failures to properly monitor Coumadin), wrong dosage, inappropriate medication, failure to consider side effects, drug-to-drug interactions, and errors related to medication reconciliation. The EMR can reduce these errors through medication alerts/warnings/reminders, by facilitating communication among providers, by providing computerized physician order entry (CPOE) to eliminate errors resulting from legibility issues and multiple hand-offs, and by improving medical record documentation.

However, physicians may have difficulty keeping up with all the medical information coming to their EMR from outside sources. Primary care physicians should make every effort to review new information in the system at each patient visit.

Potential malpractice risks may result from physicians' increased access to data originating outside of their own practices. Physicians may think they can read online reports from other providers and not file them in their own EMR or that they can simply ignore online data (such as lab results). However, audit trails will show that electronic messages were sent and/or opened, and a plaintiff's attorney can prove that a physician had access to information but failed to review or utilize it. Failing to review medical information and then initiating an incorrect treatment or prescription would constitute a violation of the standard of care.

Community medication histories, available to physicians who prescribe electronically, also pose a liability challenge. For example, you may discover that another physician has prescribed a medication that interacts with a drug you've prescribed to a patient. Obviously, acting on that discovery could prevent an adverse drug event—and failure to act could result in patient injury.

The *Electronic Health Record* (EHR) combines the EMR with the PHR. The PHR communicates electronically with the EMR from any physician or hospital providing care, thereby creating a comprehensive record. With an EHR, *all* physicians would know *all* medications, tests, procedures, and diagnoses for a given patient. The EHR would have a profound impact on medical record accuracy and would reduce medication errors.

6. ASSURING FOLLOW-UP OF LABORATORY TESTS AND IMAGING STUDIES

It is important to create a suspense file or computerized “follow-up” list for all ordered laboratory tests, imaging studies, diagnostic procedures, and consultations—both to assure that they were completed and that the physician reviewed the reports. Sometimes requested tests are not performed due to failure of office or hospital personnel to order them or because of patient noncompliance. For example, a delay in diagnosis of prostate cancer may be indefensible if a screening PSA was ordered but not performed because the test request was never received by the laboratory or was incorrectly requisitioned by office staff. Furthermore, if the test was performed and an elevated PSA result was charted without physician review, it may constitute negligence. Physicians must be certain there is a process by which laboratory, imaging, and consultants’ reports are never filed *unless* the report has been dated and initialed by the doctor as proof that it was reviewed.

7. COORDINATING MEDICAL CARE

Failure to coordinate care between the specialists to whom a patient is referred can create medical problems for the patient and a malpractice claim for the doctor—when no one appears to be clearly in charge of overall patient management. Likewise, failing to follow up on ordered diagnostic studies (such as EKG, CT scan, and mammogram) or a requested consultation from a specialist (pre-op cardiology evaluation) is a recipe for disaster if a patient is injured as a consequence. This is most apt to happen when a decision is made to monitor a patient’s symptoms or disease progression, and the patient is lost to follow-up—a risk that exists under managed care, where patients change health plans (and doctors) frequently. Document the course of action you plan to follow or the reason for deferring active intervention and create a suspense file to assure that you don’t lose track of the patient. Create a process whereby if a patient fails to keep an appointment, this is documented in the medical record with a notation about recommended follow-up.

Additional risk management and patient safety resources, including general and specialty-specific articles, alerts, and informed-consent forms, are available on The Doctors Company’s patient safety Web site at www.thedoctors.com/patientsafety.

III. Internal Medicine

Malpractice Claims

CLAIM 1. Despite all attempts at maintaining a professional demeanor, there will be those patients who bring out our emotional sides—and medicine is one of the few professions for which the admission “I’m only human” is rarely an acceptable excuse.

A 62-year-old woman, whose physician was a member of a large internal medicine group, phoned their exchange on a Friday night complaining of several hours of unrelenting chest pain. The insured internist was on call for that group. She told the patient to go immediately to the emergency room for evaluation. A cardiologist was consulted when EKG changes were suspicious for myocardial infarction. Nitroglycerine therapy was effective in relieving the pain, and arrangements were made for cardiac catheterization.

The patient was admitted to the ICU under the care of the insured internist. When the cardiologist who was to perform the angiography arrived at the hospital, he discovered that the patient’s INR was elevated due to chronic Coumadin therapy for her prosthetic heart valve. He decided that the risk of bleeding was too high, and as the patient remained stable, he elected to allow the clotting studies to normalize before proceeding. The patient became upset with the insured when told that the catheterization would not be done at that time, accusing the internist of calling the wrong cardiologist or of postponing the procedure only because it was a weekend. The internist spent an hour with the patient and her husband trying to explain the medical rationale but finally left the room stating, “There is nothing more I can do now.”

How Could the Internist Have Helped This Situation?

In retrospect, there was already a problem developing in terms of the trust and rapport between the patient and the insured. Some possibilities to help this situation might have included a group meeting between the patient, husband, cardiologist, and internist or an attempt to contact the patient’s own internist, with whom she had had a long-term relationship. Alternatively, there could have been an attempt to get another cardiologist to render a second opinion.

On Saturday, the insured was off duty, but there was a communication problem in signing the patient out to the on-call internist, and the patient was not seen by anyone for the medical group on that day. The cardiologist came to see the patient in the evening, writing a note in the chart that the INR still remained too high for an invasive procedure. The patient was apparently sleeping at the time and was not awakened.

By Sunday afternoon, the patient was demanding to know why she hadn’t seen “one single physician in two whole days.” The insured was again on call and, when phoned by the ICU nurse, came immediately into the hospital. She found a note in the patient’s chart written by the cardiologist that morning, stating that if the INR result was near normal, the patient should be started on heparin to prevent her valve from clotting while awaiting the cardiac catheterization. The catheterization had been scheduled for Monday morning.

The patient and her husband were both very hostile toward the insured as soon as she entered the room. She tried to explain that the labs had been followed closely and that there was now a need for heparin. The patient’s husband told her he thought all of the doctors on the case were “idiots” and that he was not going to allow his wife to take heparin since they had been repeatedly told that

she was already over-anticoagulated. The patient also insisted she was going to refuse the drug. A heated discussion lasting several minutes ensued as the insured raised her own voice in an attempt to be heard over the husband. Finally, wagging her finger at the patient, she explained, “If you refuse this drug, your valve could clot, and you would die. It’s suicide, but I can’t do anything to stop you.”

A patient has a right to refuse medical therapy, and the physician has a responsibility to make it an informed refusal, wherever possible, so that a patient understands the risks of making a decision against medical advice. Although not articulated in an eloquent manner, reviewers felt that the internist had attempted to inform the patient of the risks of refusing treatment.

While the insured was at the nursing desk writing a progress note in the chart, an alarm sounded in the patient’s room. The woman had gone into ventricular fibrillation. A code was run, but the patient was pronounced dead 45 minutes later. The patient’s husband began screaming at the insured, “You killed her. You did this!”

Could the Internist Be Held Responsible for This Death?

An autopsy revealed a myocardial infarction with ventricular wall rupture and 70 to 80 percent narrowing of each coronary artery. Defense expert cardiologists opined that myocardial rupture most commonly occurs four to seven days after an MI and that it was not caused by the heated argument between the patient and the internist or by the delay in coronary catheterization.

It was felt by the plaintiff’s experts that the delay in cardiac catheterization was below the standard of care. The main concerns regarding the insured centered around the patient’s not being seen in the hospital the day before the arrest and the confrontation that had occurred immediately prior to it. While it could be argued that neither of these facts altered the ultimate outcome of this case, it was not clear how they would make the insured appear before a jury.

Most damaging was the testimony of the ICU nurse who was in the room at the time of the discussion between the insured and the patient. She stated she called her supervisor because she thought that the internist’s behavior had been inappropriate. The nurse was told to document the entire conversation, which she had, after the patient’s death. She recalled the insured as being hurried and arrogant, failing to completely explain the function of the heparin to the patient and her husband. “She just didn’t show them any respect.” The nurse claimed she had heard the internist call the patient and her husband “fools” before leaving the room.

The nursing supervisor who arrived in the ICU immediately after the code had also been irritated by the insured’s demeanor. She stated in deposition that she had questioned the internist as to why she had become so upset with the woman and her husband. The internist’s response was that she was having a really bad day. The nursing supervisor pointed out that it was not nearly as bad a day as the patient was having. “It would have been nice if she had apologized, but I don’t think she ever did.” After the deposition of the nurse, the insured agreed to settle the case rather than take it to trial.

What Else Can We Learn from This Case?

The internist became angry when speaking with the patient. Communication skills, especially in an unpleasant situation, do not come naturally. Health care providers must realize that angry patients often sue and that skills for dealing with anger can be learned.

A competent adult patient has the right to refuse medical treatment. It is the physician’s responsibility to inform the patient of all the treatment options, including no treatment, so that if the patient refuses treatment, it is then considered to be an informed refusal.

CLAIM 2. The relationship between physician and patient is often viewed as a collaboration—with physicians offering advice on treatment and testing options, and patients assuming ultimate control of their own health care decisions. A gray area remains, however, in the care of patients who are noncompliant or slow in fulfilling their roles in this process. What is the physician's responsibility when a patient does not follow directions?

A 52-year-old woman was followed by an internist for minor complaints over a several-year period. On one visit, the patient complained of hemorrhoids. She subsequently complained of diarrhea, abdominal pain, and flatulence. A proctoscopic exam was performed, revealing only hemorrhoids. She was placed on a lactose-free diet with some improvement in her symptoms. On each of the next four visits, the patient was given hemoccult kits to take home, but despite multiple explanations by the insured regarding their importance, she failed to return them by mail as advised.

Three years later, the patient presented to the insured physician with complaints of rectal bleeding noted on toilet paper and when straining. The insured performed a rectal exam, which was normal except for several large hemorrhoids. A sigmoidoscopy was performed to 60 cm, revealing only thrombosed hemorrhoids. Again, the patient was given a hemoccult sample kit, which was not returned.

One year later, on a routine office visit, the internist palpated a mass on rectal examination. The mass was 5 cm in diameter and extended to 5 cm from the anal verge. Biopsy confirmed adenocarcinoma. The patient alleged a delay in the diagnosis of cancer.

Did the Internist's Care of This Patient Meet Prevailing Standards?

A defense expert felt that the insured met the prevailing standard of care. He stated that giving the patient hemoccult tests and doing a flexible sigmoidoscopy when she complained of rectal blood were consistent with current screening guidelines. The insured stated that he had office procedures in place for follow-up of missed appointments and rescheduling, but did not feel it was his responsibility to follow up with patients who failed to return their occult blood screening tests.

When asked what he would have done had the patient returned the test, the insured stated that if it were negative, he would have done another proctoscopic exam, followed by a lower GI series. If the hemoccult screen were positive for blood, he would have referred the patient to a gastroenterologist for colonoscopy.

The plaintiff's expert criticized the insured for failing to test for occult blood himself when the patient was in the office, failing to follow up with the patient when she did not return the tests, failing to order a CBC to check for anemia, failing to give the patient instructions for follow-up examination or for any recurrence of the bleeding, and failing to suggest the possibility of referral for evaluation by a gastroenterologist. Another expert felt that the insured deviated from the standard of care by not ordering a barium enema in addition to the flexible sigmoidoscopy and by not referring the patient for colonoscopy when she complained of bright red blood by rectum.

Was the Delay in Diagnosing This Cancer Significant?

The patient underwent abdominoperineal resection, and the pathologist's evaluation revealed an adenocarcinoma with 20 positive lymph nodes and a metastasis to the mesentery. Following surgery, the patient received adjuvant radiation. Liver metastases were subsequently diagnosed,

and she expired one year after surgery. Her family continued litigation, arguing that a several-year delay in the diagnosis of rectal cancer had cost the woman her chance for survival.

Defense experts stated this was an extremely aggressive cancer that might not have been detectable even six months before it was diagnosed. The insured was adamant that he had visualized the entire area where the cancer was ultimately diagnosed only one year earlier, and a lesion was not present.

The plaintiff's expert oncologist argued that this tumor was likely present for a minimum of two to three years before metastasizing. He stated that colorectal cancers evolve from polyps and that the polyp would have predated the patient's demise by five to seven years. He felt that had the diagnosis been made during the period when the insured was following the patient, she would have had a higher chance of survival.

Should This Case Be Tried?

All the experts agreed that, had the insured more aggressively followed up with the patient regarding return of the hemoccult slides, it is possible the diagnosis of rectal cancer would have been made earlier, improving the percentages of survival. This was felt to be a critical issue because this patient was followed by the insured for such a prolonged period of time, during which she complained of increasingly severe rectal problems. The blood she passed rectally could have been related to the hemorrhoids. Of more concern, however, would have been the presence of occult blood within the stool, which could only have been detected with the hemoccult test. Based on these concerns, the insured consented to settle this case.

CLAIM 3. Patients often present with complex problems that take time, attention, and high-technology procedures to sort out. Sometimes a patient's quality of life issues are not at the forefront, but as this claim involving pain management illustrates, they may be no less important in our overall care.

An 88-year-old woman was brought to a hospital emergency room complaining of severe back pain. It was recommended she be admitted for evaluation and treatment. Since the patient's regular physician did not have privileges at that hospital, the insured internist was asked to consult and provide inpatient care. The patient and her daughter gave a history of new onset back pain, a 70-pack-year smoking history, and a recent significant weight loss that was suggestive of malignancy as the cause of the back pain.

The woman was placed on intravenous (IV) fluids, oxygen, and bronchodilators with Demerol 25 mg IV for pain and Compazine for nausea and vomiting. Her admission chest x-ray was abnormal as was a CT scan of her lung, so a pulmonologist was asked to consult on the case. He performed a fiber optic bronchoscopy, which was suggestive of a submucosal tumor, but the brushings and biopsies were negative.

This was discussed with the woman and her daughter. Both refused further workup for the clinically suspected metastatic disease and requested that the patient be discharged home to her daughter's care with arrangements for hospice assistance. She was discharged with a prescription for Vicodin.

Was Any Part of the Insured Physician's Care Negligent?

The refusal of the patient and her daughter to consider further diagnostic studies was well documented and would constitute informed refusal. The concern centered on the patient's complaints of pain. At discharge, the patient's daughter had been concerned about the ability of Vicodin to control the severe pain. The insured added a Fentanyl patch 75 mcg and informed the daughter he

could not order anything stronger. When the visiting nurses found the patient's pain not well controlled, her original primary care physician was contacted. This physician doubled the Fentanyl patch dose and added an oral morphine solution. The patient died four days later. The family sued the insured internist and the hospital, claiming inadequate pain management and elder abuse.

Is This Malpractice?

A review of the in-hospital chart showed the nurses consistently recorded the patient's pain score as eight to 10 on a scale with 10 being the worst pain. Although the physician did make subjective comments about the patient's level of pain, he had not referred to the pain scale itself. The patient's daughter was deposed and testified that her mother had been in excruciating pain. She added that each evening she would inquire of the nurses if more medication could be given, and Demerol would be given IV.

The plaintiff's expert internists alleged the patient had a very strong clinical diagnosis of metastatic bone cancer, which should have allowed her the greatest level of pain relief. They felt the Demerol dose was inadequate and found the Vicodin prescription inappropriate in light of the patient's difficulty swallowing pills and the fact that she had been on Vicodin at home prior to hospitalization, and it had failed to control her pain. A pain specialist stated that Demerol given PRN is inadequate for chronic pain, and that these patients need some analgesia ordered around the clock, combined with additional medication ordered for breakthrough pain. Other pain medication options, including methadone, Oxycodone, morphine, or Dilaudid, were suggested. It was also noted that the patient had not had a bowel movement documented during the entire hospital stay, and the insured had taken no steps to evaluate or treat for constipation in the setting of the continued narcotic usage.

Defense experts countered that the insured had met the standard of care. The patient had chronic obstructive airway disease, which would affect the selection of pain medication. A pain specialist stated in deposition that for patients with lung disease, IV morphine by infusion is not always a good choice. He pointed out that although the IV Demerol could have been given up to eight times a day, the patient received it only three times—indicating the nurses did not feel the pain was that constant or severe. They argued that the treatment of this patient's pain fell into the realm of medical judgment.

Should This Case Be Tried?

The plaintiffs argued that the insured physician knew his patient was a senior citizen suffering from intractable pain, but failed to respond to the patient's increasing pain during the hospitalization and did not provide adequate pain medication upon discharge home. The insured was adamant he had not deviated from the standard of care, and had often successfully treated patients with severe pain and terminal diseases; therefore, this case was taken to trial. The jury deliberated for four days before returning a near policy limit verdict in favor of the plaintiff on the issue of elder abuse. They deadlocked on the issues of malice and intentional infliction of emotional distress, which could have triggered punitive damages. The physician's insurer was astonished at the verdict, as this case was thought to be defensible. Physicians called upon to manage severe pain in the elderly might find this doctor's experience eye opening.

CLAIM 4. Many malpractice claims involve failures to diagnose disease. When a patient dies, it can be difficult for a jury to accept that a competent physician could have missed the correct diagnosis.

A 43-year-old obese woman with a history of asthma was followed by the insured internist for more than 10 years. During this time, she had multiple episodes of thrombophlebitis following an initial episode of deep venous thrombosis and pulmonary embolism, which had been treated with intravenous heparin and then oral warfarin. Her multiple episodes of leg and joint pain were attributed to phlebitis and arthritis and were treated with nonsteroidal anti-inflammatory drugs (NSAIDs) or short courses of warfarin when the anti-inflammatories failed to relieve the symptoms.

The patient presented to the insured's office on a Monday morning complaining of right leg pain, which had lasted the entire weekend. Although it was similar to her previous episodes, this time the pain was not relieved by rest or leg elevation and was constantly present from her ankle to her buttocks. The patient had developed shortness of breath walking from the parking lot to the internist's office. Physical examination revealed no leg swelling, but the patient had mild tenderness over the greater trochanter with decreased hip flexion when compared to the other side. The insured suspected recurrent trochanteric bursitis, phlebitis, and asthmatic exacerbation. He recommended bed rest, Feldene, and local heat application. He instructed the patient to call the office in several days for follow up.

Was This an Appropriate Evaluation and Treatment of the Woman's Symptoms?

Two days after the office visit, the patient died of a massive pulmonary embolism. The defense expert opined that there were no physical or objective findings that would have led the insured to a diagnosis of deep venous thrombosis (DVT). He argued that the clot that had given rise to the pulmonary embolism had likely not formed at the time of the office visit. The plaintiff's expert countered that the insured should definitely have ordered a venogram or the less invasive alternatives of an ultrasound or Doppler to rule out a DVT—especially given the change in her symptoms. He pointed out that with bursitis, pain usually comes on with walking and is relieved by rest. In contrast, thrombophlebitis pain is constant, consistent with the pain the patient was describing in the insured's office. The shortness of breath the patient described may have been a result of smaller emboli to her lungs. The plaintiff's expert felt that the woman should previously have been placed on lifelong anticoagulation because of her chronic and repetitive episodes of phlebitis following a documented pulmonary embolus.

Can This Claim Be Defended?

This case was peer reviewed and a panel of internists agreed that it would be difficult to defend the insured's care. Panel members opined that the insured should have been thinking about the possibility of a DVT in an obese patient with a history of venous disease and should have considered appropriate diagnostic and therapeutic interventions. It was felt that the only way to defend the case would be to argue that the patient's complaints during the office visit were not medically related to the pulmonary embolus that developed 48 hours later.

The panel felt the plaintiffs would likely argue that the symptoms were clearly related and were, in fact, a warning sign missed by the insured. This would probably be more convincing to a jury, especially in light of the fact that the internist had on at least two previous occasions prescribed anticoagulation therapy for this patient's venous problems. When the woman presented to the office complaining of leg pain, a jury would likely expect a physician to have done more to investigate her complaints. The insured stated that the patient did not want a venogram because the procedure had been quite uncomfortable when one was performed before, but it appeared that the noninvasive diagnostic alternatives had not been offered to her as an option.

Economists calculated that the patient's death resulted in a \$600,000 economic loss to her family. In addition, she left her husband to raise three children, one of whom was handicapped. This would have been a highly sympathetic factor had it gone before a jury. There was a real possibility a verdict could have exceeded the policy limit, so it was decided to settle this case.

The failure to diagnose DVT and/or PE and the failure to initiate appropriate anticoagulant prophylaxis in high-risk patients is a relatively common cause of malpractice claims. The symptoms of deep venous thrombosis and pulmonary embolism can be insidious. Assuming the worst and ruling out this potentially life-threatening condition is one way to reduce liability. Certainly not all patients with leg pain require diagnostic procedures to rule out DVTs, but with at-risk patients, the reasons for choosing an alternative diagnosis should be thought out and documented in the medical record.

CLAIM 5. Many historic medical studies were performed primarily on male subjects—often with the assumption that findings could then be generalized to the entire population. Gender differences in clinical presentation are now well described and are important for clinicians to be familiar with.

A 51-year-old woman received medical care and treatment from her internist over a 15-year period. She was noted to have high blood pressure, chest pain associated with gastroesophageal reflux disease, and mild obesity. On multiple office visits, she listed complaints of occasional fatigue and mild back and chest pains. The patient was advised to lose weight and was placed on a diuretic. Her blood pressure remained elevated with systolic pressures of 140–170 mm Hg and diastolic pressures ranging from 95–110. A beta-blocker was added as an antihypertensive. Electrocardiograms were obtained approximately every three years and were read as normal. The patient was last seen in the insured's office for a blood pressure check. She had no complaints at the time. Her pressure was 156/98, and a routine EKG performed in the office was computer-read as "possible left ventricular hypertrophy."

Does This Patient Require Additional Intervention?

The insured felt that no further testing was warranted. The woman was given a return appointment in three months for blood pressure evaluation. The insured received a phone call from the coroner two months after the last office visit stating that this patient had died suddenly at home. The cause of death was acute myocardial infarction, with extensive atherosclerotic cardiovascular disease noted at autopsy. The patient's family filed suit alleging failure to diagnose and treat cardiac disease.

Did the Internist Deviate from the Standard of Care?

One expert who reviewed this case felt that with a history of chest pain and any abnormalities in the EKG, even in the face of a diagnosis of gastric reflux, the patient should have been referred to a cardiologist for further evaluation. He also stated that the blood pressure should have been better controlled and rechecked sooner after the last elevated readings. Another defense expert opined that the insured met the standard of care because none of the EKGs demonstrated evidence of ischemia, and the patient had minimal risk factors for coronary artery disease. A cardiologist agreed that the insured had acted appropriately since the patient was a nonsmoker, was only moderately overweight, and had reasonably controlled blood pressure.

The plaintiff's expert described three areas where he believed the insured deviated from the standard of care. The first was in simply following the chronically high blood pressures for years without any documentation of new interventions. The second was the failure to follow up on one laboratory test showing elevated cholesterol and failing to educate the patient about the associations between elevated cholesterol, diet, and heart disease. Finally, it was alleged that the last few EKGs on this patient demonstrated left ventricular hypertrophy likely caused by the hypertension. This patient had listed shortness of breath, which may have been a symptom of left ventricular dysfunction, on a check-off sheet on at least two office visits. There was never any documentation of a differential diagnosis for this complaint. This expert felt that the patient should have been referred to a cardiologist for specific tests of her cardiac function.

The plaintiff's expert cardiologist testified that the abnormal EKG warranted either a treadmill test or a cardiology referral. He felt that all of this patient's EKGs had subtle abnormalities with nonspecific ST-T wave changes suggestive of left ventricular hypertrophy or ischemic heart disease. This cardiologist argued that with appropriate follow-up and testing, the underlying atherosclerotic disease would have been diagnosed and then treated with angioplasty, possibly followed by stent placement or coronary artery bypass grafting.

All experts agreed that coronary disease in women may present atypically with complaints of shortness of breath and fatigue rather than with classic substernal chest pressure.

Should This Case Be Tried?

One defense expert cardiologist was supportive of the insured and willing to testify on his behalf, but other experts felt that the patient should have been sent for cardiology consultation in light of the EKG changes. The persistently elevated blood pressure readings were also an area of concern. The insured consented to settle this claim, but the plaintiff's settlement demand remained near policy limits. The decision was made, in conjunction with the insured, to proceed to trial. The jury deliberated for one hour before rendering a defense verdict in favor of the physician.

According to the American Heart Association, heart disease is the number-one killer of women in the United States. Cardiovascular disease, including strokes, causes more female deaths than the next six causes combined. Suggested contributing factors to the high death rate include the fact that both clinicians and patients often attribute chest pain in women to noncardiac causes such as gastroesophageal reflux. Women have a greater tendency to describe atypical chest pains or to complain of abdominal pain, difficulty breathing, nausea, or unexplained fatigue.

In conclusion, while many claims can be prevented through vigilant patient care, rigorous documentation, and adherence to proven risk management and patient safety strategies, it is a fact of medical practice that "claims happen"—and if this occurs, be assured that your malpractice carrier will be there to defend and protect you.

