Case #1

Clinical History

- 74 yr old woman
- Progressive right hip pain

- PMH - mild HTN
- Meds - Norvasc, Motrin
- No alcohol or tobacco

- Moderately active, limited by pain
- Married, retired school teacher

- Hip films - severe degenerative changes
- Because of pain - elected to have THR

Case #1

June 2, 2006

- Informed consent obtained in the surgeon's office
- Proposed procedure - Right Total Hip Replacement
- Indication - Severe arthritis and intractable pain
- Risks - Blood loss requiring transfusion, infection, nerve damage, failed/misaligned prosthesis, DVT/blood clots in the leg which may travel to the lungs, and death
- Alternatives - continued medical treatment
- No notation that the patient voiced an understanding of the procedure or the risks

Case #1

June 8, 2006

- Seen by anesthesiologist
- Pt signed a separate informed consent for general anesthesia
- Risks - vocal cord injury, tooth damage, stroke, nerve damage, heart attack and death

Case #1

- Pt instructed to take an aspirin 1 day pre-op as DVT prophylaxis
- 6/15/2006 - Right Total Hip Replacement
- Uneventful, immediate post op course without incident
- Daily aspirin continued post-op
- Rx TED hose, Pt documented as wearing

Case #1

June 18, 2006 – SOB

- Pulse - 156 Irreg Irreg
- BP 96/60
- RR 28
- O2 sat 86% on Face Mask
- ECG - AF, right axis deviation (both new)

Case #1

- Rx - Heparin bolus, heparin drip
- Tx to SICU
- Chest CT scan - Multiple pulmonary emboli.
- Pulmonary consult - Agreed with treatment plan
- Following 12 hours - Two episodes of SBP into 70s for 3 to 5 minutes

Case #1

June 19, 2006

- + Cardiac enzymes
- Sinus rhythm 110
- PTT - therapeutic

- Cardiology consult – MI secondary to PE and hypotension

- 1 PM - Right arm weakness
- Neurology consult - Stroke secondary to hypotension

Case #1

June 20, 2006

- Pulse 104, regular
- BP 112/74
- Hip - clean and dry

- Head MRI - Probable infarct, left motor cortex
- Cartotid Doppler – Mod stenosis bilaterally

Case #1

June 27, 2006

- PT INR - 3.0 on Coumadin
- Slight weakness right arm/hand, reduced fine motor skills
- Discharged to rehab

Case #1

July 10, 2006

- Ambulating without pain
- Neuro - Slightly improved
- Echo - EF 40%, anterior hypokinesis
- PT/INR - 2.8 on Coumadin
- Discharged home

Case #1

October 2006

- Ambulating without pain
- Mild SOB with exertion
- Neuro – Unchanged

Case #1

February 2007

Lawsuit against orthopaedist, cardiologist and neurologist

- Failure to initiate proper DVT prophylaxis
- Improper Blood Pressure and fluid management after the occurrence of the pulmonary emboli
- Improper management of the Myocardial Infarction
- Improper management of stroke
- Inadequate Informed Consent for the procedure

Case #1

Plaintiff's expert witness (orthopaedic surgeon)

- Informed consent invalid because no verification of patient understanding
- More effective anticoagulation with LMWH or coumadin warranted
- Aspirin alone was below the standard of care.
- Cardiologist mismanaged MI, pt should have undergone immediate angioplasty
- No testimony was offered against the neurologist.

Case #1

- Defendant orthopaedic surgeon
- Testified that he specifically discussed the high risk of DVT/PE with the patient
- Pt appeared to understand
- Cardiologist
- Testified that angioplasty not warranted

Case #1

Disposition

- Settled prior to trial on behalf of the orthopaedic surgeon for $400,000
- Cardiologist and neurologist dismissed

Case #1

Informed Consent

- Nature of the Procedure
- Proposed Benefits
- Material Risks (bleeding, infection, worsening of the underlying condition, damage to surrounding structures, risk of anesthesia and death)
- Viable alternatives

Case #2

Clinical History

- November 10, 2006
- 55 yr old man seen ER
- Urinary frequency, left flank pain x 2 days
- No PMH
- Meds - Advil
- Creatinine 1.2
- Urine + blood
- IVP - 7 mm radio-opaque stone, left proximal ureter

Case #2

- Urologist - spontaneous passage unlikely
- Options discussed
- Patient elects retrieval via ureteroscopy
- Informed consent - Numerous risks, risk of ureter damage and loss of kidney

Case #2

11/10/2006 (PM)

- Ureteroscopy and removal of the stone
- Integrity of ureter interrupted
- Percutaneous nephrostomy tube

11/12/2006

- Creatinine 0.8
- Discharged home
- Reconstruction of ureter discussed with patient

Case #2

November 17, 2006

- Flank pain
- Temp 101
- No drainage from nephrostomy tube

- Presents to different ER, seen by second urologist
- Call to the first urologist's office – No information given
- HIPAA authorization faxed – Records to be picked up by patient

- Admitted to second hospital by second urologist
- Unable to replace nephrostomy tube
- Sepsis – BC + E Coli

Case #2

November 18, 2006 (Hospital Day 2)

- Nephrostomy tube replaced in OR
- Post op - Minimal urine flow, kidney non-functioning
- Rx - Antibiotics per ID consult

November 25, 2006

- Continued fever
- Kidney non-functioning
- CT scan - Multiple abscesses, left kidney

November 26, 2006

- Left nephrectomy

November 30, 2006

- Afebrile
- Discharged home

Case #2

Lawsuit against first urologist and ID physician

- Improper performance of the stone retrieval
- Failure to properly place and monitor the nephrostomy tube
- Failure to prescribe appropriate antibiotic prophylaxis
- Failure to properly treat the E Coli sepsis
- Failure to obtain informed consent

The second urologist was not named in the lawsuit.

Case #2

- Prior to trial, the ID doctor sent a letter to plaintiff's expert witness threatening to report him to the state board of medicine if he twisted the truth in any way.
- The plaintiff attorney brought the letter to the attention of judge.
- The defense attorney denied any knowledge of the letter.
- The judge admonished the parties to refrain from any improper contact with witnesses.

Case #2

- The case went to trial.
- The plaintiff's expert, a highly regarded urologist, was critical of the care which had been rendered.
- He stated that the physicians should have better managed the sequence of procedures and that the patient's kidney should have been saved.
- The jury returned a verdict against the urologist for $220,000.
- No liability was found against the ID physician.

Case #2

Two months after the case ended, the ID physicians filed a *pro se* lawsuit against the plaintiff attorney alleging:

- Legal Malpractice
- Abuse of the legal process
- Filing of a frivolous and non-meritorious lawsuit

The lawsuit was dismissed after the defense filed several preliminary objections

Case #2

- 55% of people who sued said that they were prompted to do so by a critical remark by another healthcare provider regarding the care that they had received.
- 70% of the time, the person who said it was a consultant who saw the patient after a bad event occurred.

(Beckman HD, Markakis KM, Suchman AL, Frankel RM. The Doctor-Patient Relationship and Malpractice. Arch Intern Med. 1994;154:1365-1370.)

Case #2

- Witness tampering is a felony
- Legal Malpractice – only against your own attorney
- Malicious Use of Process – must show malice, not just greed
- Filing a Frivolous and Non-Meritorious Lawsuit – not a viable cause of action

Case #3

Clinical History

- 53 year old white man
- Presents to internist c/o back pain, several weeks duration
- Lower thoracic area
- No h/o trauma or associated symptoms
- No sig PMH
- 1 pack of cigs/day X 30 years

Case #3

- Afebrile, BP 142/84
- No pain at rest
- Moderate pain with movement of torso
- Heart sounds -WNL
- Chest - Clear to auscultation
- Moderate paraspinal tenderness, R > L
- Abd - Unremarkable
- No motor or sensory deficit
- DTR – 1/4

- Diagnosis of “back spasms”
- Ordered CXR, spine films - “Back pain, h/o smoking, r/o pathology”

Case #3

Films obtained that same day showed:

- Moderate degenerative changes in thoracic and lumbar spine
- 4 cm Right hilar mass, suspicious for malignancy

The radiologist immediately called internist's office and left message with medical assistant

In the dictated report, under "Impression," the first line read:

- "Hilar mass, suspicious for malignancy, recommend further evaluation."

The report contained documentation that the internist's office had been called

A copy of the report was subsequently sent to the internist

Case #3

- Pt seen in internist's office 10 days later
- Pain decreased with meds
- Internist documented that spine films showed "No sig dz"
- There was no comment in the chart as to the chest x ray
- Pt prescribed PT
- Tylox switched to Motrin
- The patient did not return

Case #3

- Two months later, the patient suffered a seizure at work and was taken to the ER
- Head CT - brain metastasis
- Subsequently diagnosed with small cell cancer of the lung
- Underwent radiation and chemotherapy
- After an initial response, the patient relapsed and died 5 months after the initial diagnosis

Case #3

Six months later, a lawsuit was filed against the internist and the radiologist alleging:

- Failure of the radiologist to properly communicate the results of the Chest X-ray to the internist
- Failure of the internist to properly act on the results of the Chest X-ray
- Delay in diagnosis of the lung cancer

Case #3

- During discovery, the patient's chart at the internist's office was found to contain a copy of the Chest X-ray report, which had been initialed by the internist.
- At his deposition, the plaintiff's expert witness testified that the radiologist should have confirmed that the internist planned to evaluate the lung mass.
- He also testified that the internist violated the standard of care when he failed to act on the Chest X-ray report.
- He stated that no competent physician would miss such a serious finding and that mistakes like this were outside the standard of care.

Case #3

- At his deposition, the internist testified that he had been in practice for 26 years, was board certified, had previously been the chair of the hospital quality improvement committee, and had never before been sued.
- He had no history of mental or psychiatric illness.
- His only medication was for high blood pressure.
- He stated that drank alcohol several times a year at social gatherings and that he did not use illegal drugs.
- He testified that he had no explanation for how he missed the X-ray report.

Case #3

Disposition

- The case was settled prior to trial on behalf of the internist for $520,000.
- The radiologist settled for an undisclosed sum of money.

Case #3

Managing Diagnostic Tests

- Ordering Physician
  - Provide clinical information when the test is ordered
- Interpreting Physician
  - Issue an accurate interpretation
  - Display significant findings in prominent manner
  - Call with unexpected, emergent or serious findings
- Ordering Physician
  - Process in place for reviewing results

Case #3

Medical Errors/Mistakes & Medical Malpractice

- Malpractice involves medical care that falls below the standard of care
- The standard of care is not a standard of perfection and it must allow for mistakes

Case #3

The question in a malpractice case is not whether the physician made a mistake, but whether he used ordinary care. A position that no mistake can be made when ordinary care is used would render a human being infallible. Even in the exercise of utmost care, people can and do make mistakes. Even leaving a sponge in a patient does not negate the physician's defense that he used ordinary care.

Oklahoma Supreme Court (Boyanton v Reif, 798 P2d 603 (1990))

Case #3

- “Doctor, is it your understanding that this jurisdiction requires physicians to deliver a standard of care or a standard of perfection?”
- “OK. Do you agree that the standard of care doesn’t require perfection, that it’s not the same as a standard of perfection?”
- “As long as a physician used ordinary care, any mistake would be permissible.”
- “Do you believe that the internist made a mistake even though he used ordinary care?”

Exercising ordinary care is the same thing as delivering the standard of care.