Cases That Defy Logic: Implications of Medical Malpractice on Care Delivery

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Learning Objectives

1. Identify the necessary elements of a lawsuit.

2. Review strategies to avoid high risk behaviors increasing liability exposure.

3. Discuss communication and documentation practices to reduce liability exposure.
Anatomy of a Lawsuit

*Elements*

- Duty
- Breach of that duty
  - Applicable standard of care
- Causation
  - Direct
  - Proximate
- Damages

Prima Facie
Cost of Claims

Negligent Action: Commission or Omission

• Special Damages (economic)
  – Life time disability
  – Hospital expenses past / future
  – Lost and future earnings

• General Damages (non-economic)
  – Pain and suffering
  – Loss of consortium
  – Loss of companionship
  – Disfigurement

• Punitive Damages
Cost of Claims

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• Punitive Damages
Topics Du Jour

The Sympathetic Plaintiff
Wrongful Death Lawsuit
Abusing the Medical Record
Rogue Scribe
To Settle or Defend
3s a crowd! The third party claim
Electronic Risk (EMRs)
It’s not polite to point!
Crazy to make this Dx?
Deferring to the Consultant
The Sympathetic Plaintiff
The Sympathetic Plaintiff

- Sept 11, 2003
- $67 million sought
- Radiologist and Cardiologist vindicated
- $14 Million settlements paid by hospital and various medical personnel
Wrongful Death
Wrongful Death

- A 30 year old male presented to the ED, following a minor MVC. He was sent by his employer for a routine drug screen.
- He became agitated and the EP was asked to see the patient.
- Physician: “Very agitated”
- Tx: IV, Haldol (15mg), Labs, CT of the Head
• Upon CT completion, he suffered respiratory arrest, was intubated and admitted to the ICU.
• He confirmed the next day he drank water to dilute the drug screen.
• Expert: “...He states that the patient was asked to drink water to give a urine sample and then became water intoxicated. Nowhere in the medical record does it suggest that the patient was asked to drink water...”

• Expert: “...medication was given in an inappropriate route and excessive dose...”
• Expert interpretation of CT:
• “Hypoxia”
• CT was performed when saturations were 92%-99%
Outcome

• Settlement: $225,000
I cannot live with the injustice of this situation. Hopefully, my death will help to shed light on the problem of how honest [illegible] and judges are unwilling to scrutinize cases more carefully, and thus the ridiculous ones.

I have left the last letter I wrote about this case on my desk - please give it your attention.

P.S. I would like to be cremated.
Abusing the Medical Record
Stick to the Facts & Only the Facts

- 45 year old male with back pain that radiated down the left leg.
- He presented with his wife and daughter
Stick to the Facts & Only the Facts

- 45 year old male with back pain that radiated down the left leg.
- He presented with his wife and daughter

ADDENDUM: Please see the previous dictation. A complaint was made by the patient and his wife who said that I was polite, but also disrespectful. They said that while I was going over the x-rays that I used profanity in front of their 8-year-old daughter, which I do not remember at all. It is possible I used a "hell or damn" but I do not remember specifically saying that. The wife also states that I misdiagnosed the patient with muscle spasm.
Stick to the Facts & Only the Facts

- 45 year old male with back pain that radiated down the left leg.

EMERGENCY DEPARTMENT COURSE: Following history and physical exam, radiographs of the chest were obtained which revealed no acute process, per myself and [redacted], without benefit of radiology. At this point [redacted] was felt safe to be discharged home. He was given a four pack of Vicodin and a prescription for Motrin. He was told to eat a big can of suck it up and to quit his whining and then he was instructed to followup with [redacted].

DIAGNOSIS:
1. Acute cervical strain.
2. Upper respiratory infection.
3. Tobacco abuse.
Stick to the Facts & Only the Facts

- 45 year old male with back pain that radiated down the left leg.

(DIAGNOSIS:
1. Acute cervical strain.
2. Upper respiratory infection.
3. Tobacco abuse.)
Stick to the Facts & Only the Facts

- 45 year old male with back pain that radiated down the left leg.

chloroform was the only thing that really works for her.

DIAGNOSIS:
1. Acute cervical strain.
2. Upper respiratory infection.
3. Tobacco abuse.
The Rogue Scribe
The Rogue Scribe

• August 9th, 44 year old machine worker presented to the ED
• CC: Headache, Nausea, Confusion, Double vision
• PMHx: NIDDM, Hypertension, Hyperlipidemia
• PA evaluated Pts
• “Severe, sudden onset, a “pop” in his head”
• Blood work and Non Contrast CT, second CT with contrast ordered 2 hours later
  – All negative
• Physician approved evaluation but did not independently evaluate the patient
• Disposition: Discharge
• Dx: Sinusitis
• Rx: Antibiotic & an Analgesic
• No complaint specific instructions provided
• The next day
• Awoke with severe headache
  – Nausea, confusion, slurred speech and trouble walking
• Returned to the ED via ambulance
• CT: “Cerebellar Stroke”
• Transferred and required a ventriculostomy and VP shunt
• He awoke from surgery
• “Tetraplegic without bowel or bladder function or control”
• Allegations
  – CT inadequate for Cerebellar pathology
  – Admission with neurology consultation should have been performed
• Deposition testimony
• Physician reported he performed the physical examination
• Later, he admitted never examining the patient at all
• 16 months into the lawsuit the medical group released the PA’s name
• The PA was unlicensed and had failed the state licensing examination
• He was utilized as a “Scribe and Expediter”
• $2 Million settlement demand by the plaintiff
• The defense malpractice carrier declined, maintaining that the care was not negligent
Plaintiff’s Verdict

- $117 Million
- $100 Million in punitive damages
- Group 50%, PA 25%, Physician 25%
- Case filed prior to FL $500,000 cap for non-economic damages was in effect
- Appeal due to a juror not disclosing a prior felony conviction
- Prior to the appeal, the parties reached an undisclosed settlement
To Settle or Defend
To Defend or Not To ....

- 32 y/o female
- While running a marathon developed numbness in her hand, arm & leg.
- She couldn’t run straight any longer, veering to one side
- She developed an occipital headache and had one episode of emesis
- Sxs resolved, except H/A, prior to arrival at the ED
ED Course and Disposition

- Seen at 1017
- Normal neuro examination
- Normal CT
- Normal labs
- Discharged at 1317
Follow Up

• ED visit # 2
• 1812
• Unresponsive
• Friends stated she had a change in mental status at hospital number 1 secondary to medications
• She continued to worsen upon arrival at home
Follow Up

- Repeat CT: Brainstem hemorrhage?
- Transferred to tertiary referral center
- Dx: Brainstem infarct
- Severely debilitated mentally and physically
Risk Management Issues

- Allegations
- Failure to properly assess and respond to the patient’s symptoms.
- “Improper workup leading to debilitating stroke.”
Risk Management Issues

• To defend or not defend

• RN

• Mother of 5 year old boy

• Husband pulled from Marine airbase in Germany to care for his wife
Risk Management Issues

• Nurse Deposition
  – Patient could not hold the pen
  – Friend had to sign the discharge instructions
  – She could only open one eye
  – He advised the patient could not be discharged unless she could open both eyes
  – The patient manually opened her other eye
  – Patient was discharged
Conclusion

- Settled in mediation
- Separate hospital and physician settlements
- Multi-million dollar settlement
3s a Crowd! The Third Party Claim
Three’s A Crowd

• CC: “I’m Dying”
• Arrival @ 1505: 48 y/o male with an acute onset of Chest Pain at 1130 am. Tightness with radiation to the throat. Resolved while making coffee.
• Recurred at 1420, while getting out of the shower: Weak, Sweaty, Dizzy, SOB
• 103/46; 93; 18; 97.8
• 1600: 97/42
Management

- Chest Radiograph: “Left sided infiltrate”
- Labs: Cardiac Markers Normal; WBC: 16.6
- IVF, Doxycycline 100 mg IVPB
- Pending admission
- 2230: .....................
Follow up

• Not Resuscitatable
• Pronounced at 2250
CARDIOVASCULAR SYSTEM: The heart weighs 450 grams. The epicardial surface is without lesion. The coronary arteries have a normal origin and pursue a normal anatomic course and are widely patent. The myocardium is red-brown and without fibrosis, hemorrhage, or discoloration. The free wall of the right ventricle measures 0.4 cm and the left ventricle, 1.6 cm. The valves are without lesion and measure as follows - mitral, 11 cm; aortic, 10 cm, tricuspid, 13.5 cm, and pulmonic, 7.5 cm. The chambers are of normal size. Great vessels reveal minimal atherosclerosis. There is dilatation of the arch of the aorta from the root at 9 cm to tapering to 4 cm at the level of the diaphragm. There is a T shaped intimal tear located above the non-coronary cusp of the aortic valve. The longitudinal leg measures 2 cm and the transverse leg 1 1/2 cm.
Third Party Complaint

• $125,000
  – 50% Group
  – 50% Physician
Electronic Risk: EMRs
EMRs Reduce Risk?

CC: Passed out/fever

HPI: 33 year-old male, no previous medical history, c/o sudden-onset headache today.
   – He has been having fevers as high as 100.
   – He had 2 episodes of syncope today.
   – No nausea or vomiting.
   – He has had some chest congestion with cough.

MEDS: Percocet
ALL: Cephalosporins; Levaquin
SH: Smokes tobacco. Denies drugs. Occasional EtOH.
Physical Exam

GENERAL: Well-appearing male, appears to be in pain.
VS: T 98.1º, HR 81, BP 123/77, RR 14, SaO₂ 97% on RA
HEENT: NC/AT. PERRL. EOMI. Mucous membranes moist.
NECK: Supple. No meningismus or meningeal signs.
   No JVD, no LAN.
HEART: RRR, no murmurs
LUNGS: Clear to auscultation bilaterally.
ABD: Soft, nontender, nondistended. Normal active BS.
EXT: Thin, good peripheral pulses. No edema.
NEURO: Alert and oriented x3. No deficits on exam.
ED Timeline

- 11:13 Arrives by private vehicle
- 13:28 Seen by EM resident
- 13:59 Attending EM physician signs up on computerized tracking system
- 14:49 Ketorolac 30mg IV administered
- 16:24 LP completed
- 18:26 Morphine 5mg IV; Vancomycin 1gm IV administered (after LP results)
Diagnostics

- WBC 12.9, 84% neutrophils
- CT Head: Normal
- Lumbar puncture: CSF clear & colorless
  - Tube #1 - 26 WBC / 650 RBC
  - Tube #4 - 34 WBC / 41 RBC
ED Course

- 20:08 Ceftriaxone 2gm IV administered (ordered by EM attending)
  → RN calls EM physician (elsewhere in a large ED)
  → Reports patient c/o hand pruritus / flushed skin
  → Physician gives verbal order via cell phone to D/C ceftriaxone infusion

- 20:18 Benadryl 50mg IV
RN calls EM physician a 2nd time due to pt c/o SOB

→ Per RN, ‘Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms’
RN calls EM physician a 2nd time due to pt c/o SOB

→ *Per RN,* ‘Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms’

- Epinephrine 0.3mg 1:10,000 IV x2 doses
- Solumedrol 125mg IV
- Pepcid 20mg IV
ED Course

RN calls EM physician a 2nd time due to pt c/o SOB

→ *Per RN,* ‘Pt gasping, audibly wheezing, drooling, with edema of face, lips, tongue, arms’

- Epinephrine 0.3mg 1:10,000 IV x2 doses
- Solumedrol 125mg IV
- Pepcid 20mg IV

- Pt intubated with adjunct use of bougie
An additional issue:

On subsequent review, it is discovered that the same physician ordered IV ceftriaxone for a pt with a cephalosporin allergy 6 months earlier.

In a bizarre coincidence, it also happened to be the exact same patient, who had developed urticaria and mild wheezing during that previous encounter.
Due to the increase in domestic violence, we ask all patients: Are you being hurt, hit, or frightened by anyone at home or in your life? Domestic violence survey NEGATIVE risk for this elderly patient.
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SOCIAL HX: Occasional alcohol use. Nonsmoker. No drug use. A self harm assessment was performed. The patient answered "no" to the question "Have you recently felt down, depressed, or hopeless?", "Have you noticed less interest or pleasure in doing things?", "Do you have thoughts of harming or killing yourself?", "Are you here because you tried to hurt yourself?", "Have you ever tried to hurt yourself before today?" and "Have you recently had thoughts about harming or killing others?". The patient reports their
Fraud?
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

CMS AND ITS CONTRACTORS HAVE ADOPTED FEW PROGRAM INTEGRITY PRACTICES TO ADDRESS VULNERABILITIES IN EHRs

Daniel R. Levinson
Inspector General
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It’s not polite to point
It’s Not Polite to Point

• January 17th
• SE, 36 years old, G4P4
• Delivered by C-section
• 2 hours later
  – Syncope
  – Persistent hypotension
Case History

• Consultations
  – Cardiologist #1
  – Cardiologist #2

• January 19th: Cardiopulmonary arrest
Trial

- Plaintiff allegations
  - “Unrecognized bleeder: Hemorrhagic shock”
- Anesthesia: Ruled out anesthetic
- Cardiologists: Ruled out cardiac and pulmonary causes
- CT scan: An increase in intraabdominal fluid; Defendant led to believe “no change”
- DIC developed
“Geller, knowing that Weiss had left the problem unresolved, not only did not intervene in an effort to make certain that the bleeding had “stopped” but, at Weiss’ urging, put a catheter into Elias’ lung looking for evidence of an amniotic fluid embolus.

SE Died During Insertion of the Catheter!
Outcome

• Post mortem
  – Intraabdominal hemorrhage
  – AFE (Very Defensible)
• VERDICT $13,110,000
• ACTUAL $10,277,500
Crazy to make this Dx?
You’re Crazy to Make this Dx!

Don’t make primary psychiatric diagnoses in a patient with no history of psychiatric illness.
• 66 y.o. F c/o
  – Urinary retention.
  – Constipation.
  – 7 lb wt loss.
  – Generalized numbness.
• PMH
  – Sleep Disorder
  – Autoimmune Disorder.
  – Lymphocytic colitis.
  – Breast cancer
  – Hyperlipidemia.
  – Diabetes.
  – Chronic Back Pain.

Fibromyalgia?
• Physical Exam
  – BP 124/80; P 74; R 16; T 97.8; Sat 97
  – Pain Scale 0/10.
  – Suprapubic tenderness.
  – Neuro exam: none documented.
• Lab
  – U/A neg.
• Foley cath to R/O Retention
  – Nurses Note 1320h: 150cc drained on insertion.
  – EP Note: “The bladder scan shows 250cc which was drained w/o difficulty.”
  – Nurses Note 1525h: “Foley has drained 1,000ml.”
• Enema for constipation

  – Nurses Note 1320h: Pt stated “she could not feel to hold most of what was given.”

  – EP Note: “An enema was not retained by the patient, although she did have good rectal tone.”
DISCHARGE PLAN: Disposition: Discharged home in stable and satisfactory condition with instructions to follow up with her regular doctor in a few days. At this point, I don't see any significant emergencies or acute illnesses on this patient so I think it is safe to let her go ahead and go home and follow up. My guess on her is that she probably, from talking with her, has a degree of Munchhausen Syndrome because she very much seems to want to have something wrong with her, although our clinical exam does not coincide with her verbal history. In essence, her complaints also do not coincide with our observations.
• 9/1: ED Visit.


• 9/4: Admitted to other hospital.
  — Dx: Transverse Myelitis.
  — Reviewed 9/1 ED record.
• 9/1: ED Visit.
• 9/4: Admitted to other hospital.
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“I saw the Munchausen comment ... my family exploded.”
9/1: ED Visit.


9/4: Admitted to other hospital. – Dx: Transverse Myelitis.
   – Reviewed 9/1 ED record.
   “I saw the Munchausen comment… my family exploded.”

You said I was what?!
I demand that the ‘Munchausen’ comment be redacted. I have very real, serious health issues that are unusual and I do not need that following me. If this ER report cannot be corrected to reflect the errors I want it purged.

Do not bill me for anything.
Psychiatric Diagnoses without basis exposes you to serious liability!
I was not trying to find something wrong with me; I was ill. I greatly resent the mention of Munchausen Syndrome. That is a dx that is considered only after time, repeat MD, ER visits, and can affect the attitude of any following professionals. To put that in a summary is irresponsible.

If I ever decide to ‘fake’ an illness, I will choose something more glamorous than bladder/bowel retention, numb buttocks, rectum, and urethra.
Deferring to the Consultant
Relying on Bad Advice

- 53 y/o female presents with headache.
- HPI: She reported a 2 day history of headache, neck pain, nausea and vomiting
- PMHx: Sinus problems
- Exam: Diffusely tender neck
ED Course and Disposition

• CT: Declined by patient
• Analgesics
• Discharge
ED Course and Disposition

- CT: Declined by patient
- Analgesics
- Discharge

medication for her nausea. He recalls that she then asked why a CT of the head was necessary. Dr. [redacted] responded “to rule out any bad stuff.” [redacted] then indicated that she did not feel that she needed the CT of the head because she felt she had a sinus infection. Dr. [redacted] then responded, “if I miss something you will sue me,” to which she responded “I wouldn’t do that because I’m a preacher.” He recalled that [redacted] relied heavily on Dr.
Follow Up

• Visit #2
• Returned 5 days later
• Same symptoms
• LP: Tube 1 = 1330/Tube 4 = 1800 RBCs
• Consultation = Traumatic LP
  – Neurosurgeon by phone
• Dx: Traumatic tap
Follow Up

• Visit #3
• Two preceding admissions at another institution
• Primary presumed she had viral meningitis due to a previous LP
• Returned 10 days later
• Dx: Viral Meningitis
Follow Up

• Visit #4
• Patient returned 3 hours later via EMS
• Altered mental status and aphasic
• CT = SAH
• Craniotomy
• Permanent disability
Risk Management Issues

• Lack of consideration of the Dx
• Misapplication of test results!
• Phone consultation/documentation
• Check old records
Risk Management Issues

- Lack of consideration of the Dx
- Misapplication of test results
- Phone consultation/documentation
- Check old records
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Questions??

Thank you!