



CASE REVIEW

A Review of Case Studies for MLMIC-Insured Physicians & Facilities

Summer 2016

Treating friends and relatives as patients can lead to malpractice litigation. Unfortunately, sometimes such relationships result in poor or inadequate medical documentation and disastrous results for the patient. To the shock of many physicians, friends and relatives do not hesitate to sue, despite what previously was a close relationship. The potential ramifications of treating family members and close friends are demonstrated in the two cases presented in this issue of Case Review.

CASE STUDY # 1

Delay in Diagnosis of a Nasal Cavity Chondrosarcoma

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In October 2005, a 19-year-old college student presented to the insured, an ear, nose and throat (ENT) physician, with complaints of sinus congestion, nasal blockage, and epistaxis for 3 days. The physician knew the patient's family because they both attended the same religious services. The insured ENT considered this to be an informal visit and did not submit a bill to the patient's insurer. He examined the patient's ears and found the examination to be within normal limits. However, the left nasal septum was deviated on the right and the anterior turbinate was hypertrophic. He gave the patient a prescription for a CT scan of the sinuses. He also recommended that the patient be seen promptly by a neurology consultant, but neither referred the patient to a specific con-

sultant nor made an appointment with a neurologist.

The CT scan was apparently performed in November 2005. However, the insured ENT never received an official reading or written report from the radiologist. Further, he failed to contact the radiologist to obtain a copy of the report. Rather, the patient gave the insured ENT a disc which contained the images of the CT scan. The ENT reviewed the CD and advised the patient that he had chronic sinusitis. He then mailed the CD directly back to the patient. He did not document his diagnosis of chronic sinusitis in the medical record, nor did he document that he sent the CD back to the plaintiff after reviewing it. His record contained only the brief note from the initial patient visit.

In January 2007, the insured ENT received a written request for the CT report from a subsequent treating ENT physician. The subsequent treating ENT included with his request a copy of his own consultation and follow up notes regarding this patient. The insured ENT responded that he had never received a final report of the CT scan and that the patient had the CD of the CT scan.

In May 2007, a third ENT physician saw the patient. He ordered a new CT scan which revealed a very large expansile lesion in the midline, pushing into the anterior cranial fossa as well as pushing into both orbits and anteriorly toward the ethmoid sinuses. There was a significant

continued on page 2



Case #1 *continued*

amount of expansion and erosion of the base of the skull. The lesion did not appear to be wildly invasive, but rather expansive in nature. This physician reviewed the 2005 CT scan and confirmed that this lesion was in fact present on that first scan but at that time was not yet near the orbits.

The patient was advised to promptly undergo a cranial facial resection and did so. An endoscopic resection of a sinonasal

physician. He claimed that the insured was responsible for a 19-month delay in diagnosis. He claimed damages for pain and suffering arising from three transnasal surgeries and a bilateral craniotomy to remove the tumor. However, after he commenced the lawsuit, the patient's condition continued to deteriorate. Later in May 2008, the patient experienced headaches and visual disturbances. He underwent surgery for recurrence of the tumor. An endoscopic resection of a tumor involving the paranasal sinuses and skull base was performed without complication using image guidance. The pathologist made a diagnosis of a chondrosarcoma. In August 2008, the patient was diagnosed with bilateral optic neuropathy. His correctable vision was 20/30 in the right eye and 20/40 in the left eye.

In May 2010, the patient was re-evaluated by a neuro-ophthalmologist due to double vision. The patient was hospitalized from February 2011 through March 2011 for a cerebrospinal fluid leak and secondary meningitis. By May 2011, the double vision had subsided without additional therapy because it apparently was due to an inflammatory process. The patient's mental status, cranial nerve, and motor coordination testing remained normal. However, the patient was orthophoric. His vision was 20/100 in the right eye and 10/400 in the left eye. He had temporal loss in his right eye and poor fixation. The patient had a worsening of his bilateral optic neuropathy.

The insured ENT was shocked that the son of his acquaintances would sue him for only one appointment for which the patient was not even billed. However, the expert ENT reviewers for MLMIC were very critical of his treatment of this patient. They focused their criticism on his failure not only to document his review of the results of the November 2005 CT scan but also his failure to pursue a copy of the final CT

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and skull base neoplasm was performed, using intraoperative image guidance. The probe confirmed that the tumor had been removed at the level of the anterior cranial fossa dura, the clivus and the cavernous sinus laterally. The patient's visual acuity improved to 20/40.

Although an MRA of his brain was normal, an MRI revealed residual disease. In October 2007, the patient was admitted for treatment of what was initially believed to be a recurrent chordoma. He again underwent an endoscopic resection with image guidance. He was discharged the same day and had an uncomplicated postoperative course.

In May 2008, the patient commenced a lawsuit against only the insured ENT

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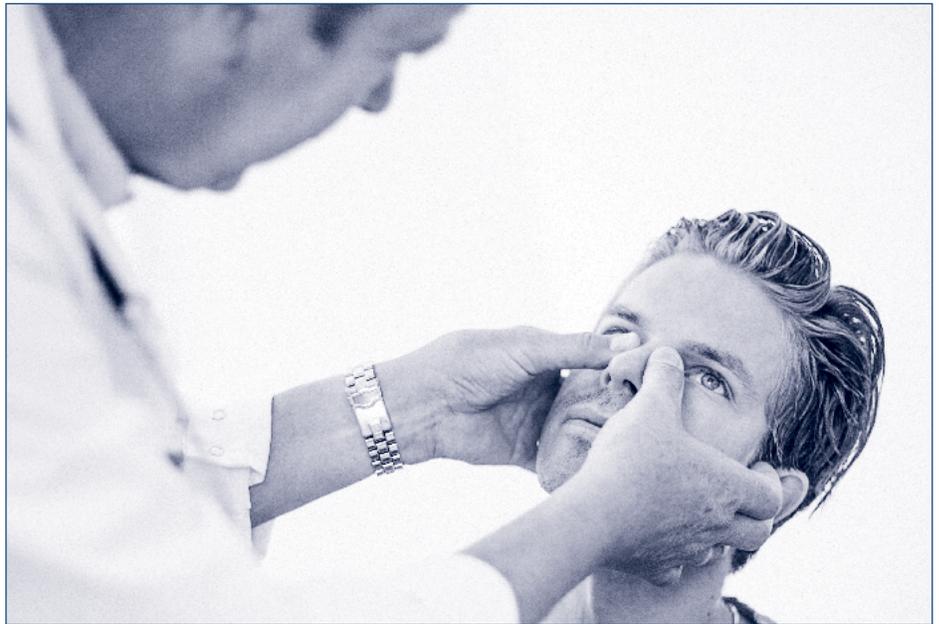
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report from the radiologist. By failing to do so, he completely missed the sphenoid lesion causing the patient's symptoms.

The experts also criticized his failure to confirm that the patient promptly underwent the recommended CT scan and evaluation by a neurologist.

Finally, the lack of documentation in the medical record of his alleged communication with the patient after the initial visit also weakened the defense of this lawsuit.

As a result of these serious deficiencies, the case was settled on behalf of the insured ENT for \$1,250,000.



CASE STUDY # 2

Failure to Refer Patient for Cardiology Consultation Resulting in Myocardial Infarction and Death

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A 55-year-old married contractor and volunteer firefighter with two children was initially seen by the defendant family physician on April 24, 2002. The physician's children and those of the patient were friends and on the same sports teams. The physician had also treated the patient's wife and siblings. Additionally, the patient had performed work for the physician.

The family physician documented the patient's past medical history

of hypertension, a weight of 208 lbs., and a B/P of 142/102. His physical examination revealed a clear chest and regular heart rate. Lopressor and enalapril were prescribed and a six week return appointment given.

The patient was treated by this physician from June 3, 2002 to September 12, 2007. During this time period, the patient continued to be noncompliant with both his medications and his low salt/low cholesterol diet, despite his cardiac risk

factors. Laboratory studies from July 26, 2006 and September 12, 2007 were remarkable for very elevated cholesterol and triglyceride levels. Despite this, the physician did not prescribe lipid-lowering medication nor did he perform an EKG or refer the patient to a cardiologist for evaluation.

Concurrently, the patient was also examined by the fire department physician for the "clearance physi-

continued on page 4

als.” On July 26, 2006, this physician did perform an EKG which revealed “NSST changes” [non-specific ST changes]. The patient was advised to schedule a stress test “with his PCP.” However, he did not do so. Further, it was unclear whether the July 2006 EKG report was ever sent to and reviewed by the family physician. Despite knowing of the concurrent care, the physician relied solely on the patient to comply and to provide him with records or information from the fire department physician.

The patient was next seen by the family physician on March 14, 2008. His weight had increased to 214 lbs. His B/P was 130/80. The patient was advised to adhere to a low sodium and low cholesterol diet.

On June 26, 2008, the patient was seen by the fire department physician, who performed an EKG. The EKG was interpreted as “borderline abnormal.” He was advised to have a stress test. His cholesterol and triglycerides levels were elevated. He was advised to follow-up with his family physician. However, he again failed to comply with this advice. Nor did his family physician obtain records from the fire department physician despite being well aware that he too treated the patient.

On April 29, 2009, the patient returned to the family physician for a check-up. Due to his complaints of erectile dysfunction, the family physician discontinued the ACE inhibitors, placed him on Benicar, and recommended that he return

to the office in 4-5 months. At that time, he also recommended that the patient undergo a complete physical examination. However, he did not put the patient on cholesterol and triglyceride lowering medications because the patient was resistant to taking them.

On July 29, 2009, the patient presented to the emergency room with complaints of being light-headed. Importantly, he denied chest pain or shortness of breath. His EKG identified non-specific ST abnormalities. He was discharged with instructions to rest and follow-up with both his family physician and a cardiologist. The patient called the family physician and advised him of both the hospital visit and the test results. The physician referred him to a cardiologist to undergo a stress test. However, later that same evening, the patient was brought by ambulance to the hospital complaining of severe chest pain and shortness of breath. While being monitored, he suffered a cardiac arrest and expired on July 30, 2009. He left a wife and two teenage sons.

The patient’s estate commenced a lawsuit against both the family physician and the emergency department physician. The allegations against the family physician included negligent failure to obtain routine cardiac workups, the failure to prescribe medications to lower the patient’s markedly elevated cholesterol and triglycerides, and the failure to address an abnormal EKG

performed by the fire department physician.

The case was reviewed by experts for MLMIC. They opined that the family physician should have performed complete annual physical examinations, including periodic EKGs and laboratory tests to evaluate his lipids. Further, he should have promptly admitted the patient to the hospital when he was called on July 29, 2009. Instead, over the years, he had relied on the fact that the patient informed him that the fire department physician would be obtaining EKGs. However, the family physician had continuously failed to obtain any records from either the fire department physician or even the patient’s prior treating physician.

When questioned by defense counsel, the family physician admitted that he should have been more diligent in addressing the patient’s potential cardiac issues. He stated that he had failed to do so because the patient was not only a family friend, but had performed building repairs for him. Ironically, the plaintiff’s attorney was a friend of both the plaintiff and the defendant family physician. Further, all of their children were friends as well.

The litigation was settled on behalf of the family physician for \$1,050,000. The codefendant emergency room physician settled with the estate at a later date.

A LEGAL & RISK MANAGEMENT PERSPECTIVE

Treating Relatives & Friends

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The two previous cases epitomize what can go wrong when treating a friend, relative, or even an acquaintance. In both cases, the documentation was not only insufficient, but at times did not exist. The failure to obtain the final report of a test that was ordered, and the failure to follow up and use a tickler system resulted in serious delays in diagnosis which were both devastating and life threatening.

Physicians must carefully consider the particular circumstances presented before deciding to treat a family member, close friend, or even an acquaintance. The AMA has issued an ethical opinion¹ which discourages the treatment of immediate family members. The basis for this opinion is the concern about your ability to be objective when an urgent or emergent situation arises. If such a situation does arise, your professional response to it might not be the same as it would otherwise. If the patient is injured as a result of your treatment, failure to make a diagnosis, or follow up on test results, even relatives may not hesitate to sue you. In short, the quality of care provided to friends, acquaintances, and relatives must be at least equivalent to the care provided to all other patients.

Unfortunately, the records of relatives or friends are often poorly



documented, if documented at all. Frequently, no record is made or retained. The failure to maintain a medical record for a patient is professional misconduct.² If an injured relative or friend makes a complaint to OPMC, this could result in a misconduct investigation and even disciplinary action. Always document your care in an accurate, detailed, and timely manner.

You must always perform a thorough history and examination. It is important to listen carefully and respond to the patient's concerns and questions, just as you would with

any patient. The patient's needs and wishes must be both identified and respected. From the patient's perspective, he/she may not be open or comfortable, or may even be embarrassed, discussing certain information with you that could potentially be crucial to diagnosis and treatment. You may fail to ask crucial questions while taking a history. The patient may feel pressured or unable to question you about a proposed treatment or symptom. Taking a complete history and performing a thorough physical examination requires that you ask all of the same questions and

1. AMA Code of Medical Ethics E-8.19.

2. New York State Education Law § 6530 (32).

continued on page 6

perform the same examination that you would for a patient who is not a relative or friend.

You should always discuss the treatment plan and costs in depth to avoid surprises. Even when you have not billed them for your care, relatives and friends who are

Not charging a friend or relative for an office visit has no effect on your responsibility to follow up with the patient if he/she fails to obtain recommended tests or consultations.

injured often do not hesitate to sue. They may believe you won't view the litigation as a personal attack because you have insurance for medical malpractice.

The patient must give informed consent for invasive procedures. Always perform a thorough informed consent discussion of the risks, benefits, and alternatives to treatment, including not undergoing treatment, and the risks of the alternatives. Documentation of the consent discussion and the use of consent forms are important.

When appropriate, make referrals to specialists or consultants. If the patient's condition is potentially serious, you should actually make the appointment with the specialist or consultant. Follow up of all tests and referrals to consultants must be as aggressive as with any other patient.

Not charging a friend or relative for an office visit has no effect on your responsibility to follow up with the patient if he/she fails to obtain recommended tests or consultations.

You should use a tickler system to track whether the tests have been performed or the consultations obtained. If the patient has not complied, you must make a telephone call to that patient. If there is no response, you must send a letter to urge the patient to comply with your recommended treatment plan.

If the patient cannot afford to pay for testing or consultations, you must not hesitate to explain the risks of noncompliance to the patient. Referrals and discussions about the need to be compliant, and the risks of noncompliance, must be well documented. As with all patients who are noncompliant, you may need to discharge the patient to mitigate the possibility of liability, regardless of the relationship.

Your care must always remain reasonable, appropriate, and consistent with the standard of care that you provide to all of your patients. If the patient at any time indicates he/she feels pressured by you regarding the choice of treatment, or he/she pressures you to perform procedures which are beyond your skills, competency, and expertise, you should respectfully decline to continue to treat that patient. When this occurs, promptly refer the patient to the local medical society or his/her insurance carrier to obtain the name of a competent professional or specialist. You must not succumb to patient pressure to provide treatment and care beyond your skills and training.

In summary, if you decide to provide treatment to friends or relatives, you must be careful to treat them exactly as you would all of your patients. Do not fear to upset a patient who is a friend or relative by adhering to the standard of care you must provide. Your failure to do so may come back to haunt you in the future.

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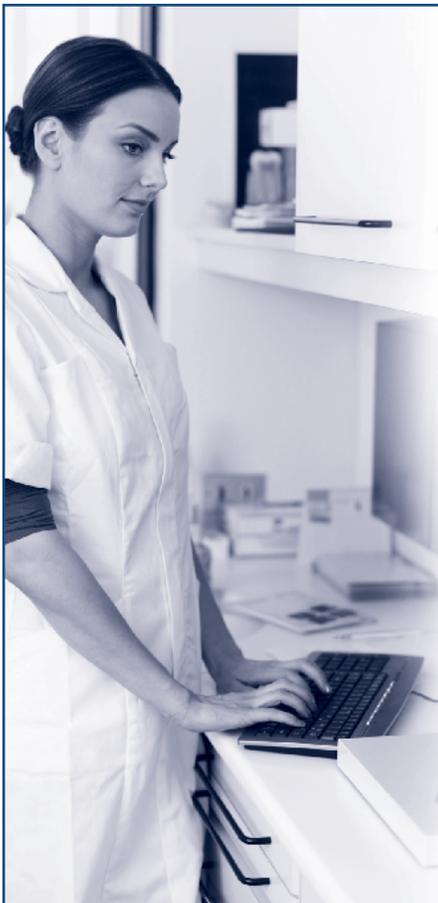


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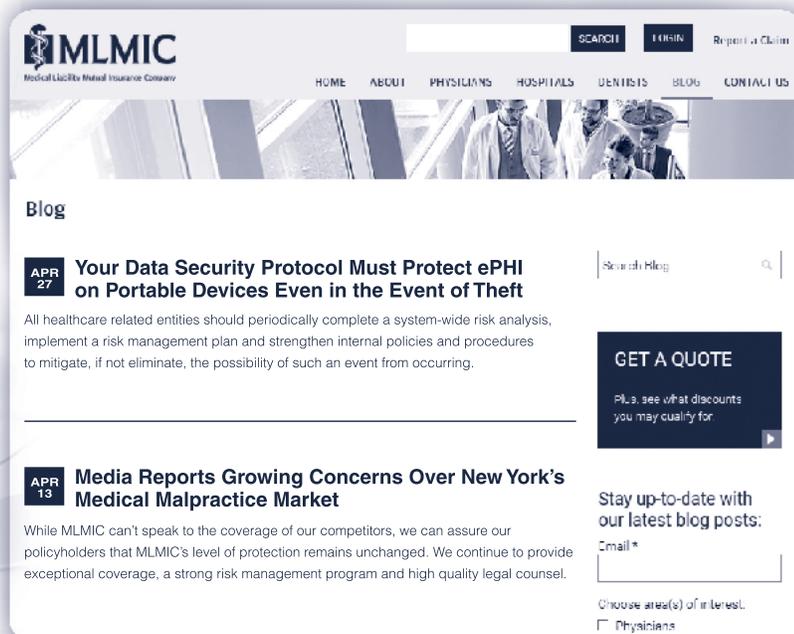
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