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CASE REVIEW

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

Summer 2018

In addition to their obvious negative effect on the medical care rendered, lack of communication and poor communication between healthcare practitioners remain top contributing factors when examining the various causes of loss experienced by MLMIC policyholders. The following are two such cases.

CASE STUDY #1

The Importance of Protocols for Dealing with Noncompliant Patients

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A MLMIC-insured internist first saw the 41-year-old male patient in mid-June. At that visit, he complained of occasional fatigue. The internist also heard a slight heart murmur. The patient advised the physician that he was taking lithium prescribed by a psychiatrist, who was not a MLMIC policyholder. However, he not only refused to discuss the specifics of his psychiatric condition, but also refused to provide the internist with the name of his psychiatrist. Laboratory test results revealed an elevated cholesterol of 234 and a creatinine of 1.5. The physician documented that he spoke to the patient via telephone and advised him that he wanted him to return every three months to follow the hypercholesterolemia.

The patient returned three months later complaining of occasional slight chest discomfort, shortness of breath, and abdominal pain in the right upper quadrant. An abdominal sonogram revealed slight hepatomegaly. An EKG revealed a grade 1/6 mitral valve murmur, but was otherwise within normal limits. Upon physical examination, the patient's blood pressure was 130/80 and his lungs were clear. Abdominal and neurological examinations were within normal limits. His liver function tests were also within normal limits. However, his cholesterol was now 243.

The patient failed to return to the physician in three months. Instead, he returned seven months later. At this visit, he had no complaints. The internist documented the patient's history of elevated cholesterol and the fact that he was still taking lithium and Tegretol. His blood pressure was 120/70 and he was in normal sinus rhythm. His lungs were clear and his abdominal examination was within normal limits. His cholesterol, however, was now 253 and his creatinine was 1.6. While the physician recognized that the creatinine was elevated, he attributed it to dehydration. He told the patient to return in three months.

Instead, the patient returned to his office ten months later complaining of a cough and congestion. The internist diagnosed bronchitis and heard occasional rhonchi. The patient's blood pressure was 130/78. His abdominal and neurological examinations were normal. Due to his illness, the patient refused to undergo blood tests. The physician prescribed Biaxin 500 mg #20 and Robitussin AC and told the patient

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Case #1 *continued*

to contact him if the bronchitis did not improve and he would order a chest x-ray.

Fourteen months later, which was almost three years from his first visit, the patient again came to the physician complaining of occasional shortness of breath. He denied smoking or drinking alcohol. His blood pressure was 120/80, his heart was in normal sinus rhythm with a grade 1/6 murmur, and his lungs were clear. The remainder of the physical examination was within normal limits. He also complained of occasional burning upon urination for the past three days. A urinalysis revealed white blood cells. His creatinine was now 1.8 and the urine protein was 30. The remainder of the blood work was within normal limits. The physician prescribed Cipro twice a day and planned to perform an echocardiogram and EKG at the patient's next visit.

The internist, however, did not ask about the patient's intake of lithium. He continued to assume that the patient's prescribing psychiatrist was also monitoring the patient's creatinine levels. Yet, despite the rising creatinine values, he never advised the patient of the risks of lithium or his need to consult with the psychiatrist because of the increase in his creatinine level. He assumed that the patient would continue to refuse to allow him to contact his psychiatrist.

Sixteen months later, the patient again returned complaining of shortness of breath and a cough. His history of mild mitral regurgitation was noted. His blood pressure was 130/78 and his heart was in normal sinus rhythm with a grade 1/6 murmur. His lungs were clear. Examination of his abdomen and extremities were within normal limits and he was neurologically intact. An echo color flow Doppler revealed that the left atrium of his heart was mildly dilated and the left ventricle was slightly enlarged. His creatinine was now 2.57 and his BUN was 42. He was given the name of a nephrologist and told to obtain an immediate nephrology consultation. The patient never again returned to the internist.

The patient was seen by a nephrologist several days later. The nephrologist sent a letter to the internist documenting that the patient had bipolar disorder with a long history of lithium use. The nephrologist promptly contacted the patient's psychiatrist to immediately discontinue the lithium. One month later, the patient underwent a kidney biopsy which revealed chronic tubulointerstitial disease, accompanied by focal segmental glomerulosclerosis and hyalinosis. These findings were consistent with lithium toxicity.

The patient commenced a lawsuit against the MLMIC-insured internist alleging that he failed to properly and timely diagnose and treat the patient's rising creatinine levels. He also alleged that the internist failed to repeat the elevated tests or refer him to a nephrologist much earlier for consultation. Finally, he also alleged that the internist failed to regularly monitor his lithium levels. He also sued his psychiatrist, who was not a MLMIC policyholder. Unfortunately, at the time the lawsuit was commenced, the patient had been placed on the waiting list for a kidney transplant.

At his deposition, the internist testified that when he saw that the patient's creatinine level was 1.8, he promptly called the patient to tell him to return in three months to repeat the creatinine test. However, this call was not documented. Further, despite the fact that the patient did not return in three months as requested, there was also no documentation of any follow-up efforts for a 17-month period. Finally, the internist claimed that the patient advised him that his psychiatrist was monitoring his lithium and Tegretol

levels. He testified that he was very concerned with the patient's elevated cholesterol and repeatedly advised him to return every three months for follow up not only at his first visit, but at every visit thereafter. However, he admitted that he never informed the patient that lithium can cause kidney damage. Nor did he make any further effort beyond the first visit to identify or communicate with the patient's psychiatrist. Further, he was never asked to send the results of the patient's creatinine levels to the psychiatrist.

At his deposition, the patient denied that he had ever told the internist that his psychiatrist was following his lithium and creatinine levels. He testified that the internist volunteered to do so. The co-defendant psychiatrist confirmed the patient's testimony.

The MLMIC experts who reviewed the internist's records noted that clinical studies at the time of this incident revealed that it was difficult to vigorously investigate the effect of lithium levels on kidney function. However, the consensus of the experts was that the internist should have discontinued the lithium promptly when progressive renal insufficiency was demonstrated. A nephrology expert confirmed that the internist had an obligation to investigate the patient's creatinine findings and then to promptly refer the patient to a nephrologist when his creatinine level reached 1.6. Finally, all of these expert reviewers were perplexed by the failure of both the internist and the psychiatrist to communicate with each other to coordinate the patient's care. They also opined that both the psychiatrist and the patient had some contributory culpability.

During the early stages of litigation, the MLMIC-insured internist signed a consent to settle the lawsuit. However, the psychiatrist refused to participate in a settlement. Additionally, the patient made an unreasonable demand for damages, thereby forcing counsel for the internist to proceed to trial. However, before the jury rendered a verdict, the lawsuit was settled for $1.7 million. One million dollars was paid on behalf of the MLMIC-insured internist and the remaining $700,000 was paid by the co-defendant psychiatrist.

CASE STUDY #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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There were obvious and serious deficits in the care the internist provided to the patient. His failure to communicate and coordinate the patient's care with the other treating physician, his failure to recognize an increasingly abnormal laboratory result until a panic value was reached, his failure to pursue follow-up of a noncompliant patient, and, most critically, his failure to warn the patient about the very serious risks of the psychotropic medication which he had been taking for many years all led to both disastrous results for the patient and a lawsuit that could not be defended.

Despite the patient's refusal to allow the internist to coordinate his care with his psychiatrist, the physician should not have assumed the psychiatrist would monitor the patient's lithium and creatinine levels. Once the internist regularly ordered these tests, it was his duty to review and respond to them. Further, because the patient's creatinine levels continued to increase at each visit, it is not clear why the internist failed to discuss the relationship between lithium and potential kidney damage with the patient and insist he be able to communicate with the patient's psychiatrist. He should have considered having the patient sign an informed refusal to consent form or sent the patient a letter documenting his refusal.

What was most troubling to the MLMIC expert reviewers was the internist's sole focus on the patient's rising cholesterol, rather than the increasing creatinine levels. From

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a defense perspective, it was problematic to try to explain why the internist not only failed to respond to all abnormal values but also failed to document his rationale for doing so. The internist was never able to explain this failure.

More easily remedied by the internist would have been the patient's continuous noncompliance. This, coupled with his desire to maintain secrecy about his psychiatric illness, endangered the internist. A patient who refuses to provide basic medical information to his PCP should raise red flags. The physician needs to be very vigilant about that patient's compliance. However, the patient's diagnosis should have been obvious, since lithium is regularly used to treat bipolar disorders.

Noncompliant patients are a serious risk to physicians, and the failure to follow up with them often results in liability and litigation. Clearly, this physician's practice lacked a follow-up system for noncompliant patients. Giving the patient a three-month appointment before he left his first and second appointments should have triggered such a system. If the patient then cancelled or failed to keep those or other appointment(s), follow up could be initiated. When a patient is noncompliant, Fager Amsler Keller & Schoppmann, LLP, strongly recommends making at least one telephone call to the patient and then sending a letter warning the patient of the need to be seen within a defined time period or discharge might result. If the patient continues to be noncompliant, he should be discharged with a warning in the discharge letter that his condition needs

prompt follow-up by another physician. By making reasonable and well-documented attempts to have this patient return to be seen as requested, the physician would have protected himself.

By not having or implementing a follow-up procedure, the internist's testimony at his deposition that he was seriously concerned about the patient's abnormal tests results was easily refuted by the patient's failure to return to see him for months at a time without any documented efforts to deal with his noncompliance. Further, the patient's refusal to permit the physician to communicate with his psychiatrist seriously endangered both the physician and patient. Ironically, he gave this clearly noncompliant patient the telephone number of the nephrologist, rather than calling the nephrologist himself to make the appointment while the patient was in his office. He could then have provided and advised the nephrologist of the urgency to see the patient because of the critical levels of creatinine. Because this physician had no follow-up system, he was fortunate the patient went to the nephrologist in a timely manner or the patient might have died.

Interestingly, when the patient saw the nephrologist, he promptly gave him the contact information for his psychiatrist and immediately the lithium was discontinued. The fact that this communication occurred further undermined the internist's defense that the patient continued to refuse to allow him to communicate and coordinate his care with the psychiatrist. Further, there was no documentation in the patient's record that the internist ever asked the patient for this information after the initial visit. Nor did he document that he ever explained the clinical importance of doing so to the patient.

It is dangerous to assume that another physician who also treats

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CASE STUDY #2

Lack of Communication Between Treating Physicians is a Serious Detriment to Patient Care

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A 58-year-old female presented to a MLMIC-insured hospital emergency department (ED) complaining of a cough for the past two days and aches and pains around her ribcage. She had decreased breath sounds on the right side of her lungs, but no rhonchi or rales. The ED physician interpreted her chest x-ray as right upper lobe infiltrates and diagnosed acute pneumonia. The patient was prescribed Zithromax, cough syrup, and Motrin and advised to be re-checked by her own physician in one week.

The following day, a MLMIC-insured radiologist officially read the chest x-ray. His impression was an abnormal density in the patient's right upper lobe. If the patient was symptomatic for pneumonia, treatment was advised; otherwise this density could represent a mass of another variety, perhaps neoplastic. He recommended follow up to demonstrate resolution if the patient presented with infiltrating symptomatology. However, the radiologist did not notify either the patient or the ED of his findings. Three days after the patient was seen in the ED, the reading was transcribed and electronically signed the following day.

Six months later, the patient returned to the hospital's ED complaining of a worsening cough with clear white sputum and tightening of the chest.

The patient was admitted to the hospital by the co-defendant primary care physician. A CT scan was ordered and read by the same MLMIC-insured radiologist. There was a large mass in the right upper lobe to the right of the hilum with at least one hilar node and possible mediastinal node. The mass had no benign criteria. The radiologist noted that the possibility of an underlying neoplasm was greater than demonstrated on the prior film. This information was relayed to the attending. A MLMIC-insured pulmonologist was called in for consultation. He ordered blood work and a bronchoscopy to rule out lung cancer. A bronchoscopy, multiple biopsies and brushings were performed. They were negative for malignancy, although there were reactive bronchial cells present. The patient was worked up for a possible myocardial infarction, but her enzymes were negative. An EKG showed a borderline increase in the thickness of the left ventricular wall.

A PET scan was recommended, but was not available at the insured hospital. The patient was discharged from the hospital and advised to follow up with both the pulmonologist and her primary care physician. The final diagnosis at discharge was a right lung mass of unknown etiology, a tricuspid valve disorder, unspecified chest pain, and a non-specific abnormal EKG. She was status post bronchoscopy and stress test.

Five days after her discharge, the pulmonologist saw the patient. She now was having hemoptysis. Her pulmonary function tests showed mild COPD. He planned to perform a PET scan and obtain a thoracic surgery evaluation. However, the patient did not return to see him. Two months later, her primary care physician contacted the patient to determine why she failed to both undergo the PET scan and to keep two appointments with the pulmonologist. The pulmonologist also sent the patient a letter advising her of the medical necessity of undergoing the PET scan.

Subsequently, the patient advised the pulmonologist that she was being treated by a thoracic surgeon. One week later, the PET scan was performed at another hospital. The findings of the scan were extensive hypermetabolic activity which occupied most of the right upper lobe of her lung. Although she was evaluated to see if a surgical resection of her lung would be beneficial, it was determined that the cancer was not resectable. The patient then underwent chemotherapy and radiation.

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Case #2 *continued*

However, the cancer metastasized and she expired four years later.

A lawsuit was initially commenced by the patient. After her death, her daughter, the administratrix of her estate, was substituted as plaintiff. A cause of action for wrongful death was added to the lawsuit in addition to medical malpractice.

The patient's medical records were reviewed by MLMIC experts. The in-house emergency medicine expert opined that a discrepancy report should have been completed by the radiologist, since his reading differed from the x-ray reading by the ED physician. Hospital policy and procedure required this. Further, the ED staff never alerted the emergency physician who initially read the film of the abnormal reading.

The expert found that at the initial visit, there was no suspicion that the right upper lobe consolidation was cancer. The ED physician appropriately identified this area as a possible pneumonia, requiring antibiotics. However, the expert was very concerned that the radiologist failed to communicate with this ED physician to notify him that he had identified a potentially neoplastic lesion in the right upper lobe, which differed from the original reading by that emergency physician.

Unfortunately, the name of the ED physician was not placed on the radiologist's report. Rather, the report was addressed only to the "Emergency Room doctor." As a result, no specific person received the report and it was filed in the patient's record without being reviewed. Because the ED physician did not make the diagnosis of carcinoma based on this x-ray, the failure of the radiology department to communicate with this physician about this significant and potentially abnormal finding was extremely detrimental to the patient.

The MLMIC radiology expert who reviewed the original ED films found they showed a mass-like density with lobulated, rather sharply defined borders posteriorly in the right upper lobe of the lung. He agreed that, although this could represent pneumonia, this was more suggestive of a mass or combination of masses with surrounding infiltration. Therefore, in his opinion, it was the obligation of the radiologist to communicate this high level of suspicion of a possible malignancy promptly to the patient's physician by telephone to make certain that the patient was closely followed.

The radiologist's suspicion of a neoplasm was sufficiently high that the expert felt the radiologist failed to follow the recommendations of the American College of Radiology for direct communication between the radiologist and referring physician. He concluded that this was clearly negligent. He concurred with the MLMIC emergency medicine expert that the radiologist should have completed a discrepancy report because of the difference between his interpretation and that of the ED physician. Receipt of such a report should have triggered prompt notification of the patient of both the abnormal result and recommendations for follow-up.

The plaintiff initially demanded $1.5 million to resolve the lawsuit. However, the lawsuit was eventually settled for $675,000. Of that sum, the radiologist paid $540,000 and the pulmonologist paid $135,000.

CASE STUDY #2 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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This case confirms the importance of physician-to-physician communication. It also illustrates the need to carefully follow hospital or office policy and procedure when communicating either abnormal results of a test or a discrepancy between a formal reading by a radiologist and a reading by an emergency department (ED) physician.

One of the major legal deficits in this case was that the radiologist failed to follow hospital policy and complete a discrepancy report when his reading of an image differed from that of

a non-radiologist. Further, the report did not specifically name the ordering physician, which required some effort by the ED to identify that individual. Thus, the original ED physician was never alerted that he had missed a possibly abnormal result. The fact that neither the patient nor the primary medical physician were notified about the abnormality precluded the patient from receiving necessary follow-up testing and care, to the patient's detriment.

The failure of physicians to communicate frequently leads to disastrous results such as serious delays in diagnosis and treatment or even a patient's death. This case is particularly concerning because of the recent enactment of Lavern's Law, which extends the statute of limitations for the misdiagnosis or failure to diagnose cancer or tumors to a cap of seven years in most cases. Those cancers or tumors that might have been discovered earlier but were not identified within the prior two and a half years and for which there was no continuous treatment can now be pursued beyond the previous two-and-a-half-year statute of limitations, until the patient has actually or reasonably should have discovered the presence of that undiagnosed cancer or tumors for up to seven years.

The American College of Radiology (ACR) has developed an educational practice parameter for the communication of diagnostic imaging findings.[1] This parameter provides that "effective communication is a critical component of diagnostic imaging" and indicates that "quality patient care can only be achieved when study results are conveyed in a timely fashion to those responsible for treatment decisions." It also provides that a final report is to be transmitted to the ordering physician. This parameter states that "a significant variation in findings and/or conclusions between the preliminary and final interpretations should be reported in a manner that reliably ensures receipt (of the new information) by the ordering or treating physician/healthcare provider, particularly when such changes may impact patient care." The ACR further recommends that all non-routine communication be documented by the radiologist in a log in the radiology department and that the final report incorporate documentation of the communication of discrepancies. It additionally provides that, "when the ordering physician cannot be contacted expeditiously, it may be appropriate to convey the results to the patient, depending upon the nature of the imaging findings." Unfortunately, in this case, none of the ACR parameters were met.

However, the radiologist was not alone in failing this patient. The ED was also subject to serious criticism by the physician reviewers.

However, the radiologist was not alone in failing this patient. The ED was also subject to serious criticism by the physician reviewers. All reports coming back to the ED, and particularly discrepancies, should be reviewed by a licensed individual. Although the ED physician was not specifically identified in the report, the ED had sufficient information to identify that physician by the patient's name and the time of the order. The patient should be informed of the results, before the report is filed in the patient's medical record. Further, if the ED physician who initially read the image was not on duty when the final report was transmitted, the on-duty ED physician should have been advised of the discrepancy in the reading and recommended contacting both the patient and primary care physician. Thus, there was poor compliance with the policies and procedures of the facility and department.

In summary, when there is a serious lack of communication between physicians about a critical discrepancy in a test result in addition to noncompliance with practice parameters and a facility's policies and procedures, patients can suffer serious, even deadly, injuries. The failure to timely diagnose a tumor or cancer due to the lack of communication between radiologists and other physicians will likely be impacted in the future by the extended statute of limitations of Lavern's Law, to the detriment of all physicians.

1. American College of Radiology. The ACR practice parameter for communication of diagnostic imaging findings. (Revised 2014, Resolution 11). Reston, VA: American College of Radiology; 2014:1-9.

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Case #1 *continued*

a patient has assumed responsibility for, and advised the patient of, the results of any abnormal laboratory values or other tests. Further, it is also highly risky to assume that a patient has already been properly warned of the risks and side effects of his medication(s). Therefore, when a primary care physician receives an abnormal test result of any type, despite the fact that a consultant or specialist also receives the result, it is still the obligation of the primary care physician to inform the patient of the abnormal test result and appropriately refer the patient for follow-up. This is particularly critical in light of the extended statute of limitations of the recently passed Lavern's Law governing the failure to diagnose tumors and cancers. When patients are not informed of abnormal test results because each physician erroneously assumes that the other has taken responsibility to inform the patient and arrange follow-up care, disastrous and deadly results can occur.

When this lawsuit proceeded to trial, the defense had to deal with several difficult problems. Despite the frequency of the patient's noncompliance, it is unlikely a jury would have found the patient culpable for his severe injuries. The fact that he had not been advised of the serious risks of lithium by the internist and thus required a kidney transplant would have made him very sympathetic to the jury.

Additionally, the patient's monetary demand to the internist was unreasonable. Therefore, the internist was forced to go to trial, despite being willing to settle the litigation because of the many deficits in his care. However, because the co-defendant psychiatrist refused to participate in a joint settlement, the patient refused to accept only a partial settlement from the internist. Fortunately, as the trial proceeded, counsel for both the codefendant psychiatrist and the patient recognized that they too had serious weaknesses in their cases. As a result, they finally agreed to a substantial joint settlement with the internist.