Using Closed Malpractice Claims as Teaching Tools

Much of what physicians and other health care providers “know” about malpractice claims they obtain from water-cooler gossip, poorly prepared media reports, or aggregated data analyses that focus on historical trends rather than on what happened in a particular incident. While these sources can provide insider knowledge, sensational story angles, and some valuable data, they rarely help clinicians learn from others’ specific experiences.

For the past 20 years, Harvard Risk Management Foundation (HRM) has been compiling details from claims and lawsuits filed against institutions and clinicians insured through CRICO. Staff from HRM’s claims, loss prevention, and information services departments continually study that data in order to select and develop abstracts that offer teaching opportunities. Over that time more than 100 closed claims and suits have been researched and abstracted for publication in Forum or HRM’s monthly audiotape, Resource. Others have been abstracted for use in HRM-sponsored grand rounds or continued medical education (CME) programs.

Feedback from readers, listeners, and program participants invariably cites the closed claim abstracts as the single-most valued element of those educational services. Because the CRICO-insured population is constantly changing and growing, revisiting some of the more enduring claim abstracts previously published or presented in this Forum seemed to be worthwhile.

Planning Ahead

Closed claim abstracts combine clinical information about the patient with a description of the actual adverse events that did or could contribute to provider liability. As such, closed claim abstracts present an important opportunity for providers to learn by exploring what went right, what went wrong, and what could have been done differently. Although these cases often represent negative and emotionally charged circumstances, positive learning can emerge from examining them.

Presenting closed claim abstracts in programs for physicians allows the participants to recognize the important loss prevention points for themselves, without the need for a lecture on “do’s” and “don’ts.” This format helps disperse the negative emotion that sometimes accompanies discussions of “what went wrong.”

Since physicians are exposed to case-based study from medical school on, most have been on “both sides” of a case discussion; i.e., they have played the role of both student and facilitator. As Forum readers, Resource listeners, and CME program participants, clinicians again fill the role of “student.” But when they are asked to serve as a case discussion facilitator, knowing how to understand and communicate the lessons embedded in a closed claim is essential.

Advance planning is key to any educational program. Therefore, it is a major part of any discussion of closed malpractice claims. Because some of the material in claims may be unfamiliar to them, clinicians interested in using abstracts often seek help from their risk managers, insurance company representative, or colleagues to help them plan this type of program. These individuals can be particularly helpful with the non-clinical material that may be useful to the group, such as claims statistics, or relevant case law.

Clinician facilitators who choose to incorporate abstracts from malpractice claims into their clinical presentations should read the suggestions offered in 10 Tips for Presenting Closed Claims Abstracts for Grand Rounds, which follows on Page 2.

Selecting Abstracts for This Issue

The 10 cases presented in this Forum involve issues of communication or coordination of care: two areas of risk often linked in malpractice claims. Modern health care’s environment of multiple providers, complicated procedures, and better educated patients demands more effective communication and more efficient coordination of care.

Although coordination of care issues may surface in the inpatient setting, multiple care sites increase the chance that information may be lost, resulting in adverse events. Inefficient or ineffective system linkages across delivery sites and among geographically diverse providers court communication breakdowns and potential liability.

Data from CRICO claims in which communication and coordination of care are primary reasons why a claim was brought, is presented in Forum’s Fall 1996 issue. While statistics can be useful to identify factors that can lead to claims, abstracts from closed claims may be more effective in alerting providers to potential problems. Once awareness has been raised among providers, behavioral and system changes that can support good patient care and reduce liability are more likely to follow.

Note
1 Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.
Ten Tips for Presenting Closed Claim Abstracts for Grand Rounds

1. Assess the needs and agenda of the audience prior to the discussion.

Many educational sessions are less than 60 minutes. Therefore, polling audience members about their needs at the beginning of the program is impractical. However, gathering some information in advance about who is likely to attend is worthwhile.

If the audience for a presentation is unfamiliar, ask the person setting up the meeting about the likely participants. Ask some people likely to attend the program what they are interested in hearing, or any special issues that they see as relevant to their practice. This helps you prepare relevant examples that increase the participants’ learning, their satisfaction, and your credibility.

2. Consider the basic ideas you want to present and how to present them most effectively.

If the objective is to cover several issues (i.e., multiple caregivers, failure to diagnose, poor physician-patient communication), try to pick one case that illustrates all the issues rather than one case for each issue. Limit the number of main points to be discussed—figure on two to four for a one hour program. Keep track of the points you believe the participants should mention, so that you can guide the discussion to any that they have missed if you have time.

Allow the discussion to evolve slowly as the participants think about the issues of the case, and as they hear their peers’ ideas, rather than rushing to finish two or more cases just because those are prepared. If the time allotted for the case discussion is less than 30 minutes, expect to present just one case (but have a second prepared just to play it safe).

3. Encourage participation.

If possible, have participants sit face-to-face with minimal space between them and you. Some rooms are better designed for case discussion (e.g., those with movable chairs and tables are ideal). But even in a standard auditorium, you can improve the program by encouraging the participants to talk with one another rather than with you. For example: “Dr. Brown, do you think the patient was angry for the reason that Dr. Green gave?” You can also employ body language: e.g., selecting one participant to speak while directing the conversation to another participant by walking or gesturing in his or her direction.

4. Start on time.

Dealing with seating arrangements may be easy compared to getting everyone there on time. Those who are on time should not be asked to wait idly. You might ask them to read through the cases while they wait, or have a short scenario printed or projected for them to focus their attention. Consider having a participant read the case aloud to signal the beginning of the session.

5. Emphasize the value of everyone’s contribution.

Many cases are appropriate for joint discussions between attending physicians and residents, or between attending physicians and medical students. But a mixed audience can be intimidating to some members, so efforts need to be made to make all feel included, and all opinions heard. To encourage broad participation, set a ground rule that each opinion be valued equally for the purpose of the discussion at hand. Asking for opinions without putting the less experienced clinicians on the spot is a good way to proceed. “How does this issue affect your work?” or “Have you ever encountered a patient like this one?” may be good questions to ask of trainees.

Sources for Closed Claims

1. Clinical risk managers are the best source of malpractice claims material to present in a discussion format. Closed cases from your own practice setting are usually the best because the facts are familiar. These claims also address the loss prevention issues most important for your staff. The disadvantage of using your own facility’s cases is that the case (even with facts and names changed) may be inappropriate or embarrassing to defendants for open discussion.

2. Your risk manager and your malpractice insurer’s claims personnel can help select closed claims in which the circumstances are available and instructive. These cases come from a common pool of claims and are likely to include many of the same issues in-house files would reveal.

3. Risk managers in several institutions may share closed claim scenarios (with identifiers and facts altered to preserve confidentiality). This could be through a state risk management organization, from the insurer’s risk management program, or through informal arrangements with other risk managers in similar institutions.

4. Claims data appearing in national publications can be used. To avoid the attitude that a national case “can’t happen here,” relate the “outside” case to other case scenarios that did happen in your institution, or use the facts and experience of the institution to demonstrate that such an event could happen there.

5. If no one case on a particular issue is suitable, a composite of several similar claims can be created to illustrate the loss prevention points to be covered.
Open with questions that focus the topic but allow for a wide range of responses.

Instead of “Are there any questions about this case?” ask “What are some different ways...?” or “What was the physician’s dilemma?” Be careful not to answer your own questions... silence is okay. Wait 10-15 seconds in order to give the participants some time to consider their responses.

If the case is a good one, you rarely need more than one provocative opening question. The attendees will generate plenty of discussion with little prompting. The more common problems are getting the participants to wait until a colleague has finished before talking, and keeping them on the case you presented (rather than discussing their own experiences).

Record the participants’ main ideas.

Write your comments down on a board or flip chart to help participants confirm that their ideas are being heard. This also makes it easier to reference those ideas later in the session. If possible, have an assistant do this to free you to concentrate on the group interaction. Record the main ideas discussed to check that all the important points in the case are mentioned.

Encourage participants to share their own relevant experiences.

You can also plan to have participants share their own experiences, although the discussion may have to be “controlled” if one individual starts dominating it. Saying “Thanks for sharing that...let’s hear from someone who has not spoken” may help move the discussion along. If the talkative individual becomes too persistent, you might offer to discuss his or her specific situation (privately) afterwards. Gently bring the discussion back to the topic at hand.

Plan sufficient time for discussion.

Schedule time to a) talk about the case, b) review the lessons to be learned, c) deal with questions that may surface as a result of the discussion, and d) summarize the important points. If the case is short and the time allotted is brief, consider sending the written material out in advance for participants to read beforehand. A quick review of the facts should then be sufficient to begin the discussion.

Anticipate being asked questions you cannot answer.

You may not be able to answer every question raised. Having a team of co-presenters (risk manager, claim representative, attorney) available may be useful for addressing the variety of questions that could surface. If you are leading the discussion alone, ask participants to write down any unanswered questions so you can consult an appropriate colleague and get back to the questioner. You might also ask your risk manager or in-house attorney to do a follow-up session, if a particularly troublesome issue has been raised. Following up with additional written material on that specific issue could also help.

Selecting Claim Abstracts

1. The clinical facts must survive simplification. Abstracts used for discussion must be short; clinical facts must be kept to the minimum necessary for participants to understand the case. Do include enough pertinent information so that participants don’t feel that relevant facts were left out.

2. The loss prevention issues must logically follow from the case facts. What went wrong and what could have been done differently to change the outcome should be clear.

3. The facts described should reflect current medical practice, be clinically correct, and make sense in this shortened version of the case.

4. Although the claims are closed, some circumstances could cause embarrassment for certain participants, or might be too politically sensitive to use. If you think a case might be too close to home, select another.

5. Use claims in which the defendant prevailed as well as those in which the plaintiff proved negligence. Such claims (defendant prevailed) can illustrate what practices may have contributed to a defendant verdict (e.g., documentation) and any issues that could have been a problem but did not result in liability (e.g., delayed diagnosis resulting in no change in outcome).

Conclusion

When learners can articulate important concepts themselves, they retain them more readily. A facilitator or discussion leader—through appropriate questioning and management of discussion—helps participants recognize issues and propose solutions. The leader keeps the discussion on track, highlights the important issues raised, encourages everyone’s participation, sets and maintains boundaries for discussion, acts as timekeeper, summarizes important issues, and teases out relevant points not mentioned by the group.

Closed malpractice claims provide a powerful focus for case discussion and are particularly relevant to physician audiences when a peer is the discussion leader or one of a team of presenters. Risk managers can provide claims to be used for case discussions, advice on the relevant issues, and an eagerness to help physicians prepare case discussions for other caregivers. Physicians and risk managers can form effective partnerships to use claims-related education as a powerful loss prevention tool and to promote positive learning from negative circumstances.

Acknowledgment

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Specialty consult (malignant melanoma missed)

Incident
A patient died from a melanoma that was diagnosed one year after a visit to his primary care physician.

Clinical Sequence
During an annual physical, a 47-year-old patient told his primary care physician of 20 years that he was concerned about a lesion on his back that seemed to be bleeding. The physician examined the lesion, recommended that the patient be seen by a dermatologist, and gave him three names. The patient said he would see another dermatologist whom he already knew.

A year later, the patient returned for another physical and again complained about the lesion. He told the physician he had not seen a specialist. The physician immediately called a dermatologist in the same office building who saw the patient right away. A biopsy was positive for malignant melanoma. The patient later underwent a wide excision, but the melanoma had metastasized and he died the following year.

Claim Sequence
The patient’s wife sued the physician, alleging that he failed to diagnose and treat the malignant melanoma and that this resulted in her husband’s death. She maintained that her husband told her, after the appointment in which the lesion was first mentioned, that the physician said not to worry, he would check it again next year, and had not referred her husband to a specialist. The patient’s wife said that she made the appointment for her husband with the dermatologist the following year because the lesion continued to bleed intermittently and the physician had “done nothing about it”.

Disposition
The day before the trial was to start, the plaintiff dropped the suit.

Discussion Points

Coordination of Care: Experts who reviewed the case agreed that the physician appropriately referred the patient to a dermatologist, even giving him the names of three to choose from.

The physician tried to accommodate the patient’s wishes by allowing him to make his own arrangements with a dermatologist the patient already knew. He may have avoided liability by documenting the referral in the record, including the name of the physician, and then calling him or her to verify that the patient had actually made an appointment, and that the specialist would notify him of his/her findings. Alternatively, the physician may have asked his office staff to call the specialist that the patient chose and make an appointment for him before he (the patient) left the office.

Documentation: The physician may have been monitoring that lesion and others throughout the course of the patient’s care, but the record does not reflect those facts. Even if the physician had not felt that the lesions needed further attention, a brief note that he had examined them and decided against treatment at that time would have helped.

Thorough documentation should include information on what the physician and patient discussed and the physician’s rationale for the plan suggested. Written discharge instructions can be particularly useful so patients can refer to them after the visit if they have questions about the next step in their care. They would have been particularly useful in this case, since the primary care physician did not contact the specialist.

Communication: If the patient really misunderstood the recommendation or the seriousness of the condition, the provider could have found out by confirming the patient’s comprehension before he left.

In some circumstances, physicians may feel that the consequences of non-compliance may be so dangerous for the patient that they should follow up with a phone call to the patient, explaining once again the risks of not complying with the treatment plan, which in this case, was seeing the specialist immediately. Written instructions to the patient may have indicated how serious the situation was.
Follow-up of abnormal finding (metastatic breast cancer)

Incident
A 37-year-old woman who presented with a breast mass at the time of childbirth was diagnosed a year later with metastatic bone cancer that led to her death.

Clinical Sequence
In her last month of pregnancy, a 37-year-old woman noticed a lump in her right breast. One week after delivering her baby, she mentioned the lump to her physician, who had been her primary obstetrical/gynecological care provider for more than 10 years. Documentation in the patient’s chart—by both the resident on duty and another physician from her obstetrician’s group practice—noted a small mass in the right breast. The physicians concurred with a diagnosis of a blocked milk duct and prescribed heat treatments. Further documentation of the lump consisted of a note by the resident three days before discharge that the mass had decreased in size. Documentation by the patient’s primary obstetrician did not specifically mention the lump, its progress, or indicate a related discharge follow-up plan.

At her six-week postpartum visit, neither the patient nor her physician mentioned the lump. The physician did not examine the patient’s breasts since she was lactating and had not mentioned any concerns about them.

Over the next eight months, the claimant experienced increasing muscle and bone pain, and consulted an osteopath. Subsequently, while weaning her baby, she noticed that the lump was still present. The osteopath recommended that she finish weaning and then have a mammogram. Before she could do this, she was hospitalized with severe muscle and bone pain. A bone biopsy demonstrated metastatic bone cancer; mammogram and breast biopsy confirmed the diagnosis of a primary breast cancer in the right breast. The patient died two years later.

Claim Sequence
A suit was brought against the obstetrician alleging failure to diagnose breast cancer.

Disposition
The suit was settled in the high range ($500,000-$999,999).

Discussion Points

Documentation of Diagnostic Options: Women who discover breast lumps while pregnant or lactating represent one of the highest potential dollar losses in failure to diagnose breast cancer claims.

When traditional diagnostic procedures (mammograms) are inappropriate, or when lactation may obscure a lump during physical exam, patients should be informed of these limitations and the options available. The rationale for not doing a test or exam should be documented.

Coordination of Care: Key to this case was the fact that the breast lump which had been noted and treated during the patient’s hospitalization was not addressed during her follow-up visit.

Careful review of records of previous treatment (in this case, the inpatient record and discharge summary), as well as urging patients to discuss all conditions and concerns, is essential for providing the earliest possible treatment for progressive disease. When the hospital course has been marked by a complication, it is important to route pertinent patient information to the physician’s office, no matter how benign the information may appear. There should be a system in place which would flag this information for the physician’s attention and investigation when the patient presents for a follow-up visit.

Patient Education: The patient alleged that she had never been taught or encouraged to perform regular breast self-examination, and thus didn’t know what to watch in terms of changes.

The responsibility for delegating awareness and responsibility for the patient’s self-monitoring of health care rests with the physician. “It’s nothing to worry about” might be very comforting and usually true, but such phrases have the effect of reducing the patient’s initiative to inform the physician of any changes. The patient needs to be educated as to possible outcomes, what to watch for, what the physician would like to be told about, etc. Patients—and physicians—are better served with phrases such as “It is probably nothing to worry about, but you should be aware of...... and let me know if...” Giving patients written material that they can refer to at home after a visit may aid their understanding and compliance. Providers should always document discussions and the fact that they gave the patient written materials.
Physician-patient communication (infected biopsy site)

Incident
A patient suffered an infection of the operative site following a biopsy done in her physician’s office and required hospitalization and additional surgery.

Clinical Sequence
A 35-year-old woman was referred to a general surgeon for biopsy of a firm, right breast mass. The surgery was performed in the physician’s office. The patient later stated that the surgeon’s discussion with her before the procedure was very short and that he seemed to be in a hurry. She did remember being told about infection but said she was not told about pain. A review of the physician’s office record shows no details of the discussion, only the words “risks and benefits explained to the patient.” There was no evidence that any written discharge instructions were given.

Two days later, the patient experienced increased pain, redness, and swelling at the operative site. She called the physician’s office at 8 a.m., and left a message with the answering service for the physician to call her back. At 10 a.m., the patient called the office again to talk to her physician. According to the patient, the receptionist told her that no one had yet gone through the answering service messages. The patient tried to explain her symptoms to the receptionist, and insisted that she be given an appointment that day. The receptionist told the patient that she could come and wait at 5 p.m. to see the physician after his last scheduled patient.

The patient came to the office at 4:45 and saw the surgeon at 6 p.m. He placed a drain in the wound and prescribed an antibiotic (Keflex). A culture of the wound was not obtained. The physician told her to return to the office in two days, saying he would leave a note for the receptionist to call her with a time for that appointment.

When she did not hear from the office by 3 p.m. the next day, the patient called the office to confirm an appointment time. The receptionist informed her that the physician had not told her about an appointment but that she would squeeze her in. At that appointment, the surgeon removed the drain, continued the antibiotic treatment, and assured the patient that “everything would be all right now.”

Two days later, the patient returned to the office (without scheduling an appointment) complaining of fever and intolerable pain at the operative site. She was admitted to the hospital and taken to surgery for debridement of the infected area. Cultures revealed that the organism was highly sensitive to Keflex. The patient’s wound required several more debridements, and eventually a skin graft, before the area healed.

Discussion Points

Consent: This was the patient’s first visit to this surgeon (not an unusual circumstance in the case of a referral from another physician). Her perception of being hurried through the consent discussion may have set the stage for her anger that obviously increased when she had an adverse outcome for which she felt ill-prepared.

Scheduling longer appointments for first-time visits is a good idea, especially when an invasive procedure is contemplated.

Documentation: The note in the chart concerning the consent discussion with the patient was very general: “risks and benefits explained to the patient.” Procedure-specific risks or questions and answers the patient and physician exchanged were not mentioned.

Some documentation of the discussion is better than none, but a note that personalizes the discussion to that individual patient is more valuable. Physicians may want to use informed consent forms that can be modified for each patient and procedure.

Office Environment: The patient alleged that, when she experienced a complication after the procedure and sought help from the physician, the office staff demonstrated inadequate compassion or concern.

An office staff with a helpful and gracious manner usually assuages a patient’s anger. Evidence of inefficiency, such as messages not attended to, long waits, and apparent lack of communication between physician and office staff, erode the physician’s credibility. When a patient is experiencing complications, especially unexpected ones, they want to feel they are not abandoned and will be cared for promptly and efficiently. Fear can quickly turn to anger.

Communication: Whether or not the patient was warned about looking for any other specific symptoms, or informed about what to do if such symptoms occurred is unclear. The failure of initial treatment to cure the infection may have further diminished the patient’s belief in the physician’s care.

Patients who are warned about potential unpleasant side effects (e.g., pain) and what to do about them feel more in control, are less anxious, and are less likely to decide that their side effects are the result of the physician’s negligence. Good communication was especially important in this initial visit because the physician and patient had no previous relationship and no trust had been built. Clear understanding on both sides at this initial stage could have set a more positive tone for subsequent visits, whether the patient suffered complications or not.

Disposition
The patient eventually dropped the suit, but expenses to investigate the case and prepare a defense were high.
A difficult patient (undiagnosed stroke)

Incident
A patient with psychiatric history suffered a stroke after being referred for outpatient evaluation.

Clinical Sequence
A long-time psychiatric patient at a community health center presented with a headache, drooling, slurred speech, and stumbling. She was referred to a neurologist at another facility, but did not keep the appointment.

Six weeks later, the patient came to the emergency department affiliated with her clinic, complaining of dysarthria, left-sided weakness, diplopia, and headache. She was seen by a first-year psychiatry resident serving a neurology rotation. He did not have access to previous records. He documented neurological findings similar to her earlier visit to the clinic: abnormal extraocular movements, mild left facial droop, gait disorder, and slurred speech. A CAT scan was non-diagnostic.

The chief neurology resident examined the patient about two hours later, and when he could not reproduce the junior resident’s neurological findings, they decided not to order an arteriogram or initiate anticoagulant therapy. Instead, the patient was referred for follow-up to the outpatient psychiatric unit where she was seen the next day by a psychiatrist. After conducting another neurological exam, that psychiatrist believed the patient exhibited signs of a classic conversion disorder, the transformation of emotions into physical problems, rather than true neurological symptoms. He also described her in the notes as a “mean, nasty, unpleasant person.”

The patient wanted to be admitted to an inpatient psychiatric unit, and another hospital agreed to evaluate her for admission. When she arrived, physicians at the receiving hospital decided she was not a good candidate for admission and told her to return to the referring hospital. She returned home instead.

The next day she was admitted elsewhere with a stroke. Her resulting disabilities include memory loss, speech impairment, and partial paralysis for which she must use a cane.

Claim Sequence
The patient brought suit against the two residents, and the hospital where she was originally seen, for failure to diagnose.

Disposition
The suit was settled in the mid-range ($100,000-$499,999) before trial.

Discussion Points

Coordination of Care/Point One: Six weeks before this patient appeared at the ED, she sought care at the health center for abnormal neurologic symptoms and was appropriately referred to a neurologist. Even though she had been a patient at the health center for years, no particular physician seemed to be in charge of her care. A follow-up call to the patient or the neurologist to see that she had kept the appointment may have averted subsequent diagnosis problems.

Having one physician responsible for coordinating a patient’s care may help to assure that appointments with consultants are kept and follow-up is scheduled. This is especially important when care is to be rendered in different locations.

Coordination of Care/Point Two: The residents in the ED were confronted with a “mean, nasty, unpleasant” patient with an ambiguous set of complaints, and a long history of psychiatric problems. She was initially seen by a relatively inexperienced physician—a first-year psychiatry resident doing a neurology rotation. To add to the confusion, a record of her previous care was not available to the ED staff.

Caring for “difficult” or “challenging” patients may be a special liability risk. Providers may hurry through the history and physical exam (especially in a busy ED and when they have encountered the patient before), and may discount physical symptoms (especially when there is a history of psychiatric problems). Having the patient’s record is vital for current providers to assess pertinent history, particularly when the patient is judged to be an unreliable reporter of her own symptoms and previous treatment.

Coordination of Care/Point Three: At the facility in this case, when a junior resident evaluates a patient, and then seeks a consult with a more senior resident, who also examines the patient, the senior resident is not expected to write a note in the record.

New findings on physical exam should be documented, especially if those facts differ from those found by another provider, and must be addressed. Rationale for why a treatment plan was suggested should also be documented.

Referral: The referral to a psychiatrist was probably appropriate, but he saw what he wanted to see, and agreed with the patient to an inpatient admission. He apparently made the proper arrangements for her transfer. The receiving hospital, after deciding this patient was not appropriate for their facility did not make proper arrangements for her continuing care. This already non-compliant patient simply went home instead of back to the original facility. When she showed up the next day in another hospital with much more definitive symptoms of a stroke, previous documentation did not support the decisions to not treat her in a more aggressive manner (i.e. arteriogram, anticoagulant therapy, etc.) when she first presented to the original facility.

Following up on referrals is an important aspect of good patient care. This is more likely to occur when one physician is responsible for coordinating appointments, especially when care has to be rendered in different locations. This is especially important when the patient is non-compliant, confused, or unreliable.
Informed consent (adverse effects of long-term medication)

Incident
A 53-year-old patient developed bleeding ulcers, cataracts, osteoporosis, and compression fractures of the back after steroid therapy.

Clinical Sequence
A 53-year-old woman, chronically disabled with rheumatoid arthritis, sought treatment at an outpatient arthritis clinic for relief of increasing pain in her hands and knees. The patient’s medical history included ulcerative colitis, now quiescent, treated several years earlier with steroid medication (prednisone).

After experiencing either allergic or adverse reactions to several drug therapies prescribed for her arthritis, her physician determined that she should again start taking prednisone. In addition, he prescribed a non-steroidal anti-inflammatory drug (NSAID) to be taken, as needed, for discomfort.

Over the next few months the patient improved on the prednisone, but her physician became increasingly concerned about her apparent non-compliance with the medication. She admitted to periodic double dosing of the prednisone and to taking extra doses of the NSAID.

The physician discussed medication compliance with the patient and ordered a lower dosage of prednisone. During investigation of the claim, the physician stated he also recalled discussing the "problems" of long-term prednisone therapy.

Approximately one year after the initiation of prednisone the patient required an emergency hospital admission. She had developed bleeding ulcers of the gastric mucosa, severe osteoporosis with vertebral fractures, and cataracts of the eye. The patient required several hospital admissions and a lengthy stay at a rehabilitation facility.

Claim Sequence
The patient brought a suit against the physician and hospital with an allegation of lack of informed consent. She stated that the physician had never discussed the hazards, dangers, or risks related to the chronic administration of prednisone. The physician could not recall the exact problems he had discussed with the patient concerning prednisone therapy nor what, if any, informed consent dialogue had taken place prior to the initiation of therapy. The clinic record lacked any documentation of any patient-physician dialogue regarding the risks of prednisone.

Disposition
After a tribunal unfavorable to the defendant, the case was settled in the mid-range ($100,000-$499,999).

Discussion Points
Communication: The physician stated that he had discussed the potential side effects of long-term prednisone therapy. It was not clear if, when he knew the patient was being non-compliant with the medication (i.e., double dosing on the prednisone and taking extra doses of the NSAID), he discussed with her the dangers of altering dosages. It is also unclear that the physician warned the patient about potential interaction with non-prescription drugs. This patient should have been instructed to use a non-aspirin-based pain reliever. There is also no evidence in the record of attempts to monitor the patient at appropriate intervals.

Patient-physician dialogue concerning the risks, benefits, and alternatives to a proposed treatment are of particular importance when there are material risks to long-term therapy. Physicians prescribing medication, even those previously taken by a patient, should have a comprehensive discussion including take-home materials that have been personalized to the patient.

Documentation: The physician’s memory of the discussion with the patient concerning the long-term effects of the medication was sketchy, and no documentation of the discussion was included in the record. The physician did remember that he was concerned about the patient’s non-compliance with the prednisone and the NSAID (she was taking extra doses of each when the pain became worse).

Discussions concerning potential side-effects involved with long-term drug therapy are particularly important to document when the physician has reason to believe that the patient is being non-compliant with the prescription. Documentation of the patient’s non-compliance in a factual and non-judgmental manner, including the discussion with the patient concerning the risks of non-compliance, is a valuable risk management technique and could have helped to defend this physician after the claim was brought. Involving family members in these discussions, with the patient’s permission, may help the patient to follow the treatment regimen more carefully.
Physician-patient relationship (surgical complications)

Incident
A 38-year-old patient experienced wound complications following outpatient surgery.

Clinical Sequence
A 38-year-old woman was referred to a surgeon after she discovered a lump between her right armpit and breast and received an inconclusive mammography report.

When he first met the patient, the surgeon told her he doubted it was anything to worry about. To put her mind at ease, he offered to perform a frozen section. The surgeon emphasized the routine nature of the outpatient procedure and suggested it would only take 15 to 20 minutes. When the operation took more than two hours, the patient and her husband asked why it lasted so long. They recalled the surgeon dismissing the question with a joke, saying “it sometimes takes 15-20 minutes to put my clothes on.” They also said the surgeon downplayed their concerns about any restrictions on post-operative activity or complications to look for.

As the patient and her husband drove home, she started to bleed heavily from the operative side. They went to a nearby hospital emergency department, where the bleeding was controlled and a hematoma diagnosed. A definitive cause of the bleeding was not identified.

The surgeon saw the patient the next day and tried three times, unsuccessfully, to aspirate the hematoma. He quipped about whether they wanted the name of his malpractice insurance carrier. He placed a compression bandage and told her the hematoma would dissolve by itself. When the patient returned five days later to have her stitches removed, the surgeon made one more unsuccessful attempt to aspirate the hematoma. The patient was still in pain, complained of chills, and was swollen and discolored from the armpit to the waist. Still, the surgeon gave her medical clearance to leave the country in two days for a vacation.

The bleeding recurred while the patient was on vacation. She sought care at a clinic where a physician evacuated two cups of blood and serum from the hematoma. This physician criticized the incision from the frozen section and the follow-up course of treatment.

Claim Sequence
Upon her return from vacation, the patient contacted a malpractice attorney and filed a claim against the surgeon for improper performance of surgery.

Disposition
The case was eventually settled before trial in the low range (<$99,999).

Discussion Points

Communication: This patient, seeing a surgeon (whom she had never met before) for a breast biopsy, was understandably concerned about the outcome. When he made light of her and her husband’s concerns, they became angry. According to a journal the husband kept, the surgeon never gave them details of what to expect post-operatively, including any restrictions on post-op activities. In the husband’s opinion, the physician was very casual about the whole process and “didn’t seem to care” about his wife’s concerns.

Good communication and a trusting relationship takes time to develop, and a paternalistic, overly casual attitude does not help build a satisfactory patient-physician relationship. Physicians, particularly specialists who are seeing a patient for the first time and for a specific problem, should take enough time to understand the patient’s need for information and reassurance, and then address those needs as thoroughly as possible.

Remember that “routine” procedures are not routine to the patient, and extensive media coverage heightens patients’ concerns about certain health issues. Lumps in or near the breast, for example, may cause fears that need to be dealt with simply and honestly. Care must be taken to thoroughly explain even the simplest of procedures and assure the patient that his or her concerns are being taken seriously.

Consent: The patient did not receive written discharge instructions when she left the ambulatory surgery center, and was unprepared when a serious and unexpected complication occurred on the trip home. Possibly, the surgeon’s light-hearted attitude about the surgery and aftermath inhibited the patient and her husband from seeking any more information about possible complications and whom to call with questions.

Because patients’ expectations may be high, they need to understand possible complications that can arise even in “routine” surgery and what to do if they occur. Instructions should be documented and given to the patient in writing. Preprinted instructions, personalized for each patient, may be sufficient for many outpatient procedures.

Physician Performance: When the patient sought care for the bleeding that reoccurred while she was on vacation, the physician treating the bleeding criticized the care given by the surgeon.

Avoid sharing with a patient your criticism of another provider’s care. If you did not see the patient at the time the previous physician was rendering treatment, you may not know all the facts.

In this case, criticism by a physician geographically distant from the original care setting without access to the patient’s record probably added to the patient’s anger. Recalling the length of the original procedure and the physician’s cavalier attitude may also have been precipitating factors in the claim being brought.

Patients become even more angry when they perceive that the physician has made a mistake, and the provider is trying to conceal it. When the physician and patient have little or no rapport and trust between them to start with, anger and doubt can escalate quickly into the filing of a malpractice claim.
Telephone treatment: (damaged newborn)

Incident
A newborn being treated for diarrhea and jaundice developed seizures leading to quadriplegia and retardation.

Clinical Sequence
After a normal delivery, the mother and her newborn girl went home from the hospital. A note in the medical record on the day of the discharge stated that the baby had mild diarrhea and jaundice. A further note stated that the jaundice was of no significance.

The mother later reported that, during the first night home and the following morning—immediately after each feeding—the baby had watery yellow-green stools. That morning, she telephoned a neighborhood clinic to complain that her baby “can’t keep anything down” and expressed concern that something “was definitely wrong.” A clinic nurse advised her to change from one brand of formula to another.

The following day, the mother called the clinic nurse again to tell her that the change in formula had not improved the baby’s diarrhea. The clinic nurse advised her to give the formula “a day or two.”

The following morning, the mother thought the baby looked quite ill. She called the clinic and expressed her concern. The clinic nurse suggested that she bring the baby in to the clinic during walk-in hours that afternoon.

When seen by the clinic nurse, the baby had a high pitched cry, a 101 degree temperature, and appeared dehydrated. The baby’s mother and father were advised to take their daughter to a nearby hospital emergency department (ED). The parents drove the baby to the ED themselves as the clinic did not provide or call for emergency transport.

Immediately on arrival in the ED, the baby began to have seizures. She was admitted to the hospital intensive care nursery with a primary diagnosis of hypernatremic dehydration. She suffered from intraventricular bleeding and seizures secondary to the dehydration. She presently suffers from spastic quadriplegia and retardation.

Claim Sequence
Suit was brought against the nurse and the parent hospital of the clinic.

Disposition
The case was settled in the high range ($500,000-$999,999).

Discussion Points

Telephone Advice: The clinic nurse recalled speaking with the mother only one time, concerning diarrhea and formula. She recalled telling the mother to bring the baby to clinic if the diarrhea continued. The phone conversation between the nurse and mother was not documented, since the clinic’s policy was to document such conversations when the call was from a patient with an existing medical record.

Phone consults are frequently a necessity but are difficult to defend in the event of an unresolved problem and a poor outcome. They can present significant liability to providers because treatment decisions are made on incomplete information and in the absence of a physical exam. Use of a clinical protocol for newborns with this type of complaint may have aided the nurse.

Communication: This baby was discharged with jaundice, and though the record describes the condition as “not significant,” some follow-up on the part of the hospital may have been necessary. The record is not clear about whether or not the mother received specific instructions verbal or written, or what to do or who to call if she had questions. Clearly, the clinic did not expect her to call with questions and was unacquainted with her situation.

Some documentation in the record about the advice given to the mother may have supported the defense. In this case, systems were not in place to help the provider care for the patient: there was no provision for documenting calls except in a patient record, which did not exist in this case.

Facilities must have policies and procedures in place, such as log books, to record: 1) the nature of the problem; 2) the advice given; 3) the name of the provider giving the advice; and 4) what advice was given to the caller about procedures to follow if more serious symptoms developed.

Coordination of Care: When the child was finally seen by the clinic nurse and an emergency department visit was advised, the clinic told the parents to drive the child themselves.

Some arrangement for transportation should be made when it is evident that a patient is in a deteriorating condition. Counting on a family to provide that transportation at a time when they are under a great deal of stress may not constitute the best patient care under the circumstances and runs the risk of additional adverse events.

This has previously been abstracted for HRM’s monthly audiotape, Resource.
Communication among providers (hand injury)

Incident
A patient required corrective surgery and suffered loss of function after a hand injury was treated by clinic staff.

Clinical Sequence
A 23-year-old butcher lacerated his right fifth finger with a deboning knife at work. He immediately sought treatment at a neighborhood health clinic affiliated with a major teaching hospital.

A clinic physician examined his finger and noted in the medical record “no apparent tendon damage.” The wound was cleaned and closed with four sutures. The physician instructed the patient to return to the clinic in one week for suture removal. Verbal instructions were given regarding wound care.

Three days later the patient telephoned the clinic and spoke with an unidentified female. He complained that he was unable to move or feel his finger and was experiencing a sharp pain in his hand. The patient later recalled that the unidentified woman told him that his symptoms were a normal part of the healing process. No other instructions were given. The clinic did not have documentation of this alleged conversation.

On day seven, the patient returned to the clinic for suture removal. He was seen by a registered nurse, who removed the sutures. The patient later recalled complaining to the nurse that he was still unable to move his finger and expressed concern that something was wrong. She noted in the medical record that the patient was “having difficulty bending finger.” The nurse advised the patient that his finger was still swollen, the probable reason for his difficulty in moving the finger. She instructed him to soak his finger in warm water three times a day for five days and to exercise the finger after the swelling decreased. An appointment was made for the following week.

When the patient returned to the clinic the following week he was first seen by a nurse. He again complained that he was unable to move or feel his finger. The nurse then asked another staff member to examine the finger. The staff member expressed concern and advised the patient to go to the hand clinic at the parent hospital.

At the hand clinic, the finger was examined, under microscope, and the patient was diagnosed with a lacerated profundus flexor tendon and laceration of the ulnar nerve. He eventually required three surgeries and extensive physical therapy. His permanent injuries are partial loss of function in the fifth finger and disfigurement.

Claim Sequence
The patient brought suit against the parent hospital, the physician, and the clinic nurse, alleging their negligence in the delayed diagnosis. An expert witness for the plaintiff stated that failure to properly examine the finger with a full range of motion, strength, or sensory tests and the subsequent delay in diagnosis caused the untoward result of three surgical procedures and permanent loss of function.

Although not documented, the physician later recalled doing full motor and sensory tests on the patient when the injury first occurred. An expert witness for the defense stated that although there had been a delay in diagnosis, no negligence had occurred. Furthermore, the witness stated that the delay had not altered the necessary treatment or outcome.

Disposition
Following trial, the jury rendered a verdict for the defense.
Patient at increased risk (post-op fall)

Incident
Following surgery on his left eye, a 79-year-old patient fell out of bed and fractured his wrist.

Clinical Sequence
A 79-year-old man was admitted for repair of a retinal detachment following a sudden loss of vision in his left eye. Five years earlier he had a retinal detachment repair on his right eye and redetachment occurred after a fall. However, he had refused further treatment and had very poor vision in that eye.

Upon admission, nursing personnel made no note of the physical factors that could put him at increased risk for a fall (i.e., poor vision in one eye and remaining eye covered, history of falling, some degenerative changes in the knee joints that may contribute to instability). Additionally, no separate “nursing assessment form” was added to the patient’s record.

No records of previous admission and procedures were available at the time of surgery. However, the procedure was performed the day following admission and went well. After the patient returned to the floor from the operating room, nurses characterized him in their notes as “very sleepy.” One note also indicated that the patient was “easily aroused” and had “voided.”

No mention was made of any instruction to the patient about the dangers of ambulating without assistance nor was there a note describing the position of the side rails. At this time, the family insisted that he be moved closer to the nursing station. This was done, but the attending physician had moved him back “to be closer to the treatment room in case a complication arose.”

In the early morning of the first post-operative day, the patient was found kneeling on the floor beside his bed. He was disoriented and complained of pain in his left wrist and in both knees. X-rays showed a fractured left wrist, and orthopedic care was initiated. The patient’s family was not notified that he had fallen and been injured and they only discovered the injury when they came to visit him. They alleged that they asked that the patient be restrained for his own protection because he “seemed so disoriented” from the anesthesia. No note concerning restraints exists in the record, but mention was made of an incident report being filed after he fell.

The rest of the admission was unremarkable although orthopedic problems inhibited ambulation and extended his hospitalization for five additional days.

Claim Sequence
A claim was filed alleging the hospital failed to insure the patient’s safety.

Disposition
The claim was settled in the low range (<$99,000).

Discussion Points

Coordination of Care: The patient came to the hospital with significant risk factors that could impact his care, such as severely impaired vision, history of falling, and degenerative changes in his knees that affected ambulation stability. No nursing assessment material was added to the record detailing these risks and documenting a plan to address the issues and keep him safe.

In addition, no previous history was available before the surgical procedure was performed.

Ensuring a patient’s safety is the responsibility of the facility and is most often delegated to nursing in the inpatient setting. Assessing a patient for the risk of falling is a basic nursing function. In addition, a record of the patient’s previous admissions and procedures should be reviewed before current treatment is initiated. Any risk factors from a patient’s history which could affect future treatment should be considered and documented.

Documentation: Contradictory notes by nurses after surgery made it difficult to understand this patient’s mental and physical status. No one documented any instructions to the patient about not getting out of bed by himself, or about the position of the side rails. No mention was made, either, about the possibility of using restraints even though family members say they asked that he be restrained because “he was so disoriented after anesthesia.”

Both the attending physician and the nursing staff should document risk factors present after surgery (i.e., continuing effects of anesthesia, etc.) and those actions taken to address these factors (i.e., family awareness, siderails, restraints). Documentation of this information demonstrates awareness of the individual patient’s needs.

The fact that an incident report was filed after the fall is important for loss prevention purposes, but the fact that one was completed should not be included in the patient’s record.

Indicating in the patient’s record that an “incident report was filed” guarantees that anyone who gets a copy of the record will request a copy of the incident report. Not all incident reports are protected peer review documents, and thus, some may have to be released to the plaintiff’s attorney as part of the discovery process if a claim is brought.

Communication: The family discovered on their own that the patient had fallen and injured himself.

If family members are involved with the patient during hospitalization, caregivers need to initiate communication with them. The transmission of appropriate information to the family demonstrates a caring attitude on the part of the caregiver and acknowledges their importance in the care of the patient.

Not communicating proactively with the family may be interpreted as an attempt to cover-up the event, or as disregard for the comfort and well-being of their relative. Such assumptions may lead them to wonder whether the patient was receiving quality care.
Multiple visits: (undiagnosed subdural hematoma)

Incident
After suffering a head injury in a skiing accident, a 40-year-old man died from an undiagnosed subdural hematoma.

Clinical Sequence
A 40-year-old man telephoned the ambulatory clinic where he regularly received health care complaining of a severe headache and blurred vision lasting for four hours. The nurse practitioner prescribed an analgesic and instructed the man to come in the next day for follow-up.

At this office visit, the patient, who had a history of migraine headaches, informed the primary nurse practitioner of a recent fall he experienced while skiing. (This information was not documented in the medical record). The patient was diagnosed as suffering from a migraine headache and given a prescription for analgesics. He subsequently met with his primary care physician who corroborated the treatment.

The patient returned frequently to the clinic, seeing several different practitioners. Upon his seventh visit within 10 days, his primary physician referred him for a neurology consult. Findings from this examination—a bilateral blurring of the optic discs—was indicative of increased intracranial pressure. Additionally, spontaneous venous pulsations of the retinal vessels were identified (a normal indication). A slight narrowing of the cervical disc space was revealed through the cervical X-rays. Head trauma due to a skiing accident was documented in the patient’s medical record at this time with a recommendation from the neurologist that a CT scan be performed if the symptoms persisted.

The patient returned to the office the next night with complaints of a headache, nausea, vomiting, and visual disturbance in his left eye. He was again diagnosed as having a migraine headache, given an injection of Demerol, and sent home with an analgesic. The following night, he returned to the clinic and was seen by yet another physician. A neurological examination at this time revealed an absence of the spontaneous venous pulsations that were present in the earlier examination. Noting this deterioration, the physician tried to send the patient to a hospital for an emergency CT scan. After returning home, the patient became unresponsive. He died en route to the hospital.

Claim Sequence
The patient’s family filed a claim against the provider organization, two nurse practitioners, and all the physicians involved in the patient’s treatment, alleging a failure to diagnose and properly treat a subdural hematoma. A suit was filed on behalf of the estate for conscious pain and suffering, loss of consortium by the patient’s widow, and wrongful death.

Disposition
Prior to the medical malpractice tribunal convening, the case was settled in the high range ($500,000-$999,000).

Discussion Points

Coordination of Care: This claim illustrates the type of system failure that can occur when treatment is rendered by multiple health care providers. The patient received an initial assessment from six physicians on the ambulatory center staff but failed to receive either continuous care or further diagnostic evaluation from any one doctor.

When a patient receives care in one center, but is seen by multiple providers, previous visits must be reviewed before the next treatment decision is made. Use of an occurrence screening system may have prevented this unfortunate outcome by alerting caregivers early on to an impending system failure. “Repeat urgent visits for related conditions without resolution of patient’s complaint” is a screen that provides early warning of a potential problem in an ambulatory care setting. Having one physician responsible for coordinating the care may have resulted in an earlier diagnosis.

Telephone Advice: The initial treatment for the patient’s complaint of severe headache and blurred vision was given over the phone. It is not clear whether he also reported his fall. Advice and treatment given was consistent with his past history of migraines.

Phone consults, while frequently a necessity, are difficult to defend in the event of a poor outcome and an unresolved problem. They can present significant liability to providers because treatment decisions are made on incomplete information and in the absence of a physical exam and a face-to-face discussion with the patient.

Standard of Care: After seven visits in 10 days, the patient was referred to a neurologist who recommended that a CT scan be performed if the symptoms persisted. The next night he was seen again and again diagnosed with a migraine, given Demerol and sent home with an analgesic.

Use of a clinical protocol for emergency CT scans might have also bridged the communication gap among practitioners and prevented a narrow diagnostic focus. By outlining the required clinical indications for this procedure, such a protocol might have alerted the physicians to gaps or inconsistencies.

An accurate patient history and physical findings should always be documented in the medical record. In this case, a failure to initially document the patient’s reported head trauma impaired the subsequent evaluation by treating physicians. A prior history of migraine headaches may have also prejudiced the diagnosis. Furthermore, timely insertion of findings into the medical record is essential. Delays in documenting this information can affect the future evaluation of deteriorating clinical signs.
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>SPECIALTY (DEFENDANT)</th>
<th>DATE PUBLISHED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-related: Cerebral Palsy</td>
<td>Obstetrics (staff MD, nurses)</td>
<td>May 1994</td>
</tr>
<tr>
<td>Communication: Among Providers</td>
<td>Gynecology (staff MD), nurse</td>
<td>Fall 1996</td>
</tr>
<tr>
<td>Communication: Among Providers</td>
<td>Internal Med. (staff MD, resident)</td>
<td>March 1998</td>
</tr>
<tr>
<td>Communication: Among Providers</td>
<td>Obstetrics (staff MD)</td>
<td>July 1993</td>
</tr>
<tr>
<td>Communication: Telephone Treatment</td>
<td>(hospital, nurse)</td>
<td>March 1998</td>
</tr>
<tr>
<td>Complications Following Circumcision</td>
<td>Obstetrics (staff MD)</td>
<td>October 1994</td>
</tr>
<tr>
<td>Coordination of Care: Multiple Defendants</td>
<td>Internal Med. (staff MD, resident), EKG technician</td>
<td>December 1989</td>
</tr>
<tr>
<td>Diagnostic Issue: Adrenal Hemorrhage</td>
<td>Orthopedics (staff MD, resident)</td>
<td>December 1994</td>
</tr>
<tr>
<td>Diagnostic Issue: Appendicitis</td>
<td>Internal Med. (staff MD, resident)</td>
<td>May 1992</td>
</tr>
<tr>
<td>Diagnostic Issue: Appendicitis</td>
<td>Surgery (staff MD, resident)</td>
<td>December 1989</td>
</tr>
<tr>
<td>Diagnostic Issue: Breast Cancer</td>
<td>Gynecologist (staff MD), Internal Med. (staff MD)</td>
<td>July 1992</td>
</tr>
<tr>
<td>Diagnostic Issue: Breast Cancer</td>
<td>Surgery (staff MD), Obstetrics (staff MD), nurse</td>
<td>July 1992</td>
</tr>
<tr>
<td>Diagnostic Issue: Breast Cancer</td>
<td>Internal Med. (staff MD)</td>
<td>March 1995</td>
</tr>
<tr>
<td>Diagnostic Issue: Breast Cancer</td>
<td>Radiology (staff MD), Surgery (staff MD)</td>
<td>June 1996</td>
</tr>
<tr>
<td>Diagnostic Issue: Hodgkin's</td>
<td>Dermatology (staff MD)</td>
<td>August 1994</td>
</tr>
<tr>
<td>Diagnostic Issue: Intercerebral Hemorrhage</td>
<td>Internal Med. (staff MD)</td>
<td>Winter 1997</td>
</tr>
<tr>
<td>Diagnostic Issue: Myocardial Infarction</td>
<td>Internal Med. (staff MD, resident), EKG technician</td>
<td>October 1991</td>
</tr>
<tr>
<td>Diagnostic Issue: Perforation</td>
<td>Obstetrics (staff MD, resident)</td>
<td>Fall 1997</td>
</tr>
<tr>
<td>Diagnostic Issue: Pulmonary Embolism</td>
<td>Internal Med. (staff MD), Gynecology (staff MD), nurse</td>
<td>June 1991</td>
</tr>
<tr>
<td>Diagnostic Issue: Pulmonary Embolism</td>
<td>Radiology (staff MD), Emergency (resident)</td>
<td>December 1994</td>
</tr>
<tr>
<td>Diagnostic Issue: Radiating Back Pain</td>
<td>Cardiology (staff MD)</td>
<td>July 1997</td>
</tr>
<tr>
<td>Diagnostic Issue: Rectal Cancer</td>
<td>Internal Med. (staff MD), Surgery (staff MD)</td>
<td>October 1995</td>
</tr>
<tr>
<td>Diagnostic Issue: Gallbladder Cancer</td>
<td>Internal Med. (staff MD)</td>
<td>May 1992</td>
</tr>
<tr>
<td>Diagnostic Issue: Stroke</td>
<td>Emergency (residents)</td>
<td>March 1998</td>
</tr>
<tr>
<td>Documentation: Good Record Aids Defense</td>
<td>Psychiatry (hospital)</td>
<td>December 1989</td>
</tr>
<tr>
<td>Documentation: Obstetrics</td>
<td>Obstetrics (hospital, resident)</td>
<td>April 1990</td>
</tr>
<tr>
<td>Improper Performance: Anoxic Brain Event</td>
<td>Anesthesiology (staff MD)</td>
<td>May 1995</td>
</tr>
<tr>
<td>Improper Performance: CV Line Placement</td>
<td>Anesthesiology (staff MD, resident), Surgery (staff MD, resident)</td>
<td>November 1993</td>
</tr>
<tr>
<td>Improper Performance: Internal Bleeding</td>
<td>Gastroenterology (staff MD), Radiologist (staff MD)</td>
<td>August 1996</td>
</tr>
<tr>
<td>Improper Performance: Interpreting an EKG</td>
<td>Internal Med. (resident)</td>
<td>December 1992</td>
</tr>
<tr>
<td>Improper Performance: Post-MI Cardiac Damage</td>
<td>Internal Med. (staff MD)</td>
<td>February 1996</td>
</tr>
<tr>
<td>Improper Performance: Resuscitation of Newborn</td>
<td>Emergency (hospital)</td>
<td>May 1995</td>
</tr>
<tr>
<td>Improper Performance: Suicide by Psychiatry Unit Inpatient</td>
<td>Psychiatry (staff MD)</td>
<td>December 1993</td>
</tr>
<tr>
<td>Improper Performance: Tissue Damage Post-venogram</td>
<td>Radiologist (staff MD)</td>
<td></td>
</tr>
<tr>
<td>Improper Performance: Tubal Ligation</td>
<td>Obstetrics (staff MD)</td>
<td>December 1990</td>
</tr>
<tr>
<td>Improper Performance: Tubal Ligation</td>
<td>Obstetrics (staff MD)</td>
<td>December 1993</td>
</tr>
<tr>
<td>Improper Performance: Ureteral Injury During Surgery</td>
<td>Gynecology (staff MD)</td>
<td>May 1994</td>
</tr>
<tr>
<td>Informed Consent: Adverse Effects of Long-term Medication</td>
<td>Internal Med. (staff MD)</td>
<td>March 1996</td>
</tr>
<tr>
<td>Informed Consent: Post-abortive IUD</td>
<td>Obstetrics (staff MD, resident)</td>
<td>October 1989</td>
</tr>
<tr>
<td>Informed Consent: Resident Assignment</td>
<td>Orthopedics (resident)</td>
<td>July 1993</td>
</tr>
<tr>
<td>Malicious Prosecution: Involuntary Hospitalization</td>
<td>Psychiatry (staff MD)</td>
<td>November 1993</td>
</tr>
<tr>
<td>Medication Error: Ordering</td>
<td>Gynecologic Oncology (fellow)</td>
<td>September 1992</td>
</tr>
<tr>
<td>Medication Error: Toxicity</td>
<td>Cardiology (hospital, resident)</td>
<td>December 1991</td>
</tr>
<tr>
<td>Slip/Fall: Failure to Restrain</td>
<td>(hospital)</td>
<td>February 1991</td>
</tr>
<tr>
<td>Slip/Fall: Ophthalmology Patient</td>
<td>Ophthalmology (hospital, clinical laboratory employees)</td>
<td>December 1989</td>
</tr>
<tr>
<td>Slip/Fall: Patient at Increased Risk</td>
<td>(hospital)</td>
<td>March 1998</td>
</tr>
<tr>
<td>Supervision: Coordination of Care</td>
<td>Surgery (resident), Radiology (resident)</td>
<td>September 1993</td>
</tr>
<tr>
<td>Supervision: Moonlighting</td>
<td>Emergency (resident)</td>
<td>December 1989</td>
</tr>
<tr>
<td>Supervision: Resident Named as only Defendant</td>
<td>Senior resident</td>
<td>September 1993</td>
</tr>
<tr>
<td>System Issue: Delayed Emergency Treatment</td>
<td>Physician’s assistant</td>
<td>October 1997</td>
</tr>
<tr>
<td>System Issue: Delayed Referral to Specialist</td>
<td>Pediatrics (MCO)</td>
<td>March 1994</td>
</tr>
<tr>
<td>System Issue: Equipment Malfunction</td>
<td>Radiology (hospital)</td>
<td>January 1993</td>
</tr>
<tr>
<td>System Issue: Follow-up Protocols for High-risk Patients</td>
<td>Internal Med. (staff MD)</td>
<td>December 1989</td>
</tr>
<tr>
<td>System Issue: Follow-up of Abnormal Finding</td>
<td>Obstetrics (staff MD)</td>
<td>March 1998</td>
</tr>
<tr>
<td>System Issue: Incorrect Test Request</td>
<td>General Surgery (hospital)</td>
<td>August 1989</td>
</tr>
<tr>
<td>System Issue: Medication Error: Side Effects</td>
<td>Internal Med. (resident)</td>
<td>June 1996</td>
</tr>
<tr>
<td>System Issue: Mislabeled Specimen</td>
<td>Emergency (hospital)</td>
<td>October 1991</td>
</tr>
<tr>
<td>System Issue: Multiple Visits</td>
<td>MCO, Internal Med. (staff MD), Neurology (staff MD), nurse</td>
<td>March 1998</td>
</tr>
<tr>
<td>System Issue: Retained Surgical Drain</td>
<td>General Surgery (hospital, staff MD)</td>
<td>June 1989</td>
</tr>
<tr>
<td>System Issue: Specialty Consult</td>
<td>Internal Med. (staff MD)</td>
<td>March 1998</td>
</tr>
<tr>
<td>System Issue: Test Results</td>
<td>General Surgery (MCO, staff MD)</td>
<td>April 1996</td>
</tr>
<tr>
<td>System Issue: Use of Restraints</td>
<td>Psychiatry (staff MD)</td>
<td>October 1995</td>
</tr>
</tbody>
</table>

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Forum

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Closed Claim Abstracts Issue Editor: Peggy Berry Martin

1 Using Closed Malpractice Claims as Teaching Tools
by Peggy Berry Martin, M.Ed.
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by Peggy Berry Martin, M.Ed., and Margaret Waterman, Ph.D.
Step-by-step instructions for clinicians and other facilitators.

Closed Claim Abstract Casebook

4 Specialty consult: malignant melanoma missed
5 Follow-up of abnormal finding: metastatic breast cancer
6 Physician-patient communication: infected biopsy site
7 A difficult patient: undiagnosed stroke
8 Informed consent: adverse effects of long-term medication
9 Physician-patient relationship: surgical complications
10 Telephone treatment: damaged newborn
11 Communication among providers: hand injury
12 Patient at increased risk: post-op fall
13 Multiple visits: undiagnosed subdural hematoma
14 Index of Closed Claim Abstracts Published in Forum 1989-1998

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