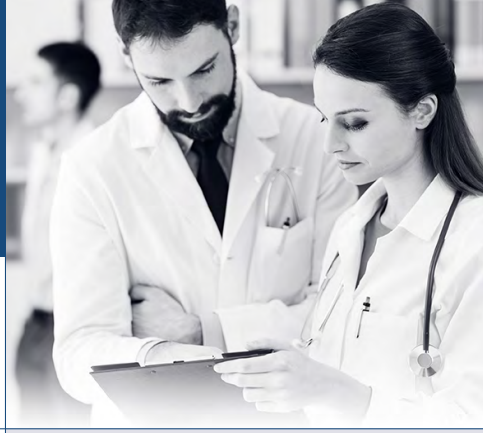
MLMIC®
Medical Liability Mutual Insurance Company



CASE REVIEW

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

March 2018

CASE STUDY #1

Conflicting Cardiac Clearance Letters Leave a Suit Indefensible

Timothy Howell, CPCU, AIC
Claims Unit Manager
Medical Liability Mutual Insurance Company

A 38-year-old male presented to a MLMIC-insured plastic surgeon toward the end of October for consultation regarding the removal of excess skin following the loss of 260 pounds after gastric bypass surgery. Following the surgery, the patient had also developed a large incisional hernia and had a very large abdominal panniculus.

The patient was originally being seen for the procedure by a non-insured plastic surgeon at another facility. However, he was not cleared for the surgery by their cardiologist, whose testing included an exercise thallium stress test that indicated potential trouble in the muscle distribution off of the left anterior descending (LAD) artery system. The test also revealed that the patient had EKG changes consistent with a potential problem in the LAD system. In addition, cardiac catheterization revealed a mildly decreased systolic function and significant single vessel coronary artery disease in the right coronary artery.

Because he wanted to have the surgery completed as soon as possible, the patient then proceeded to the MLMIC-insured plastic surgeon. This surgeon's plan was to correct the hernia and perform an abdominal panniculectomy. After advising the surgeon that he had suffered a heart attack in 1998 and had undergone an angioplasty to stent a total obstruction of the right coronary artery, this surgeon also requested he obtain clearance by a cardiologist for this procedure.

When the patient saw the MLMIC-insured cardiologist on October 30, the patient failed to inform him that he had just recently gone through extensive preoperative testing at a non-insured hospital and was not cleared for surgery. Even though this cardiologist did not know these problematic results, he too determined that surgery should be delayed until the patient had a complete cardiac evaluation and ordered testing to thoroughly investigate his cardiac status. That day, the cardiologist forwarded a "non-clearance" letter to the surgeon.

Subsequent cardiac testing revealed normal ventricular function and a limited inferoposterior myocardial infarction at rest that did not change with exercise. Following this testing, the cardiologist cleared the patient for surgery. On November 30, he forwarded a letter to the patient's non-party primary care physician and sent a copy to the surgeon clearing the patient from a cardiac standpoint to undergo the proposed procedure. The letter indicated that the patient was at "low relative risk" for a perioperative cardiac event. He recommended that the patient continue his atenolol but that aspirin should be discontinued prior to the procedure.

On January 3, the patient appeared at the MLMIC-insured hospital for preoperative testing. The following day, their same day surgery department faxed a request for the clearance letter to the cardiologist. Initially, his office incorrectly sent the original October 30 "non-clearance" letter. Because this was clearly erroneous, the hospital sent the cardiologist a second request. The clearance letter of November 30 was then

continued on page 2

March 2018

Case Review **is published under the auspices of MLMIC's Patient Safety & Education Committee, Donald J. Pinals, MD, Chairperson.**

MLMIC Offices

2 Park Avenue
New York, NY 10016
(800) 275-6564

2 Clinton Square
Syracuse, NY 13202
(800) 356-4056

90 Merrick Avenue
East Meadow, NY 11554
(877) 777-3560

8 British American Boulevard
Latham, NY 12110
(800) 635-0666

300 International Drive, Suite 100
Williamsville, NY 14221
(716) 648-5923

Fager Amsler Keller & Shoppmann, LLP attorneys are available during normal business hours to assist policyholders with a wide range of legal services, including, but not limited to, advisory opinions concerning liability issues, liability litigation activities, lecture programs, consulting services, and legal audits and assessments.

Case #1 *continued*

sent to the department and it was deemed to be sufficient. Therefore, on January 9, the surgery was performed.

The surgery was uneventful perioperatively, as was the immediate postoperative period. However, at some point shortly thereafter, the patient suddenly went into ventricular tachycardia, allegedly after an argument with his mother. The staff was unable to resuscitate him despite immediate and aggressive efforts.

The patient's family commenced a lawsuit against the MLMIC-insured cardiologist, the plastic surgeon and the hospital. The allegations set forth by the plaintiff's expert against the insured cardiologist were failure to meet the standard of care by failing to perform a preoperative cardiac catheterization and failure to properly document his records regarding the patient's aspirin therapy.

Initially, when the case was reviewed by experts, it was felt to be defensible for all three defendants. However, the cardiologist maintained that on January 4 he drafted another clearance letter, which he sent to both the patient's primary care physician by mail and faxed to the hospital's "Anesthesia Department." In this letter, the cardiologist again recommended proceeding with the surgery from a cardiac standpoint and continuing the patient's atenolol in the perioperative period. However, he changed his initial description of the patient to "moderate risk for a perioperative cardiac event." He also changed his recommendation of stopping the aspirin perioperativly to continuing the aspirin regimen.

Both the hospital and the surgeon denied that they ever received this January 4 clearance letter. Further, the primary care physician testified that he did not receive this new letter until January 10, the day after the patient's surgery and death.

The MLMIC experts who reviewed the care all concurred that the cardiologist had conducted a complete workup before issuing the original clearance letter of November 30. He performed two stress tests that confirmed that the patient did not need cardiac catheterization prior to the surgery. They determined that the basis for his clearance was appropriate. However, all of these experts were very concerned about the alleged presence of two different clearance letters. They unanimously questioned whether the January 4 letter was actually sent to the surgeon and primary care provider prior to surgery. Because of the important discrepancies in the two letters with respect to the degree of surgical risk and continuation of aspirin, they were not convinced that this second letter was actually sent.

The experts felt that the cardiologist should not only have forwarded this alleged new letter directly to the surgeon but also called him to alert him to the changes. In addition, the cardiologist had no proof that he actually faxed the letter to the anesthesia department of the hospital or that it was received by them. Further, even if he did fax a letter, he inappropriately failed to direct it to a specific person. The cardiologist, however, continued to maintain that the January 4 letter was his "official clearance letter." In contrast, the surgeon and hospital continued to deny both receipt of this letter as well as knowledge of the changes to the cardiologist's November 30 recommendations.

Because the presence of two clearance letters containing different recommendations would inevitably result in finger pointing between the defendants at trial, the MLMIC experts concluded that this lawsuit would not be defensible. All of the experts consulted strongly recommended that the lawsuit be settled, particularly due to their concerns about the cardiologist's veracity. Negotiations were then initiated, and the lawsuit was settled on behalf of only the cardiologist in the amount of $795,000.

CASE STUDY #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

Donnaline Richman, Esq.
Fager Amsler Keller & Schoppmann, LLP
Counsel to Medical Liability Mutual Insurance Company

This case clearly presented more legal issues than medical. One of the obvious problems in the case was the dishonesty of the patient with the plastic surgeon. Because he was not cleared by the initial plastic surgeon he saw at another facility for the surgery he very much wanted, he lied to the new physician that his surgeon was on vacation and he wished to undergo the procedure as soon as possible. However, he failed to bring any prior medical records with him.

Unfortunately, neither the MLMIC-insured surgeon nor the cardiologist requested any records from, and also failed to communicate with, his primary care physician or the physicians who treated his acknowledged myocardial infarction. The primary care physician may well have had relevant information in the patient's records regarding his prior non-clearance. A patient who is dishonest with a new physician because he wants to undergo a cosmetic procedure may "doctor shop" and/or refuse to provide the records of prior physicians. Had the surgeon requested prior records or at least called to speak to the primary care provider, he too may have declined to perform the surgery because of the information the patient intentionally withheld. Unfortunately, this patient's dishonesty contributed to his demise.

Several of the allegations in the lawsuit were based upon the premise

that the defendant cardiologist failed to meet the standard of care by not performing a cardiac catheterization preoperatively. One of the key elements that a plaintiff must prove in a medical malpractice lawsuit is that the defendant deviated from the standard of care and that this deviation caused the patient's injury.

The MLMIC experts who reviewed this case unanimously agreed that the defendant cardiologist's workup was reasonable and appropriate. They opined that the plaintiff did not require a cardiac catheterization before the surgery since the patient had safely undergone two prior procedures without injury. However, if the defendant had obtained a more detailed history and communicated with the plaintiff's prior cardiologist and primary care provider and reviewed their medical records, the plaintiff's argument that the cardiologist deviated from the standard of care by not performing further testing would have been further weakened.

It also appeared that the defendant cardiologist failed to document his alleged preoperative advice to the patient that he should continue his aspirin regimen. If, in fact, the defendant did tell the patient to do so by telephone, he also failed to document the conversation. This was a problem for the MLMIC expert reviewers. Additionally, during two office visits with the patient, the cardiologist failed to document whether the

continued on page 4

patient actually had been taking aspirin. That documentation alone would have substantiated his position that he had told the patient to continue to take his aspirin and would have shown that the patient was noncompliant. Documentation of a patient's noncompliance is crucial when there is an unanticipated, unfavorable outcome to a procedure.

The lawsuit also alleged that the defendant surgeon breached informed consent. However, his records confirmed that he had completed a very thorough informed consent discussion with this patient. He was aware of his history of a prior myocardial infarction. The surgeon documented that he advised the patient both that this was elective surgery and of the potential risks and alternatives to the surgery. He further documented that the patient clearly understood the risks of the surgery, including the possibility of having another myocardial infarction and dying. Because the discussion was well documented, it would have met the requirements of a valid informed consent discussion. Thus, the allegation of a breach of informed consent could have easily been defended.

The most damaging issue in this case was the apparent lack of veracity of the cardiologist. The sudden appearance of an additional and "real" clearance letter dated January 4 created havoc with the possibility of a joint defense by all three defendants. This alleged "final clearance letter" contained a distinct change in the assessment of the patient's risk as well as whether the patient should continue taking aspirin pre- and postoperatively. While the MLMIC experts questioned whether the aspirin issue was relevant, based upon the patient's autopsy results, key changes to his risk assessment still obligated the cardiologist to call the surgeon prior to the procedure. The surgeon adamantly denied receiving either a call or a copy of the letter from the cardiologist. Further, the fact that the letter was received by the primary care provider on January 10, with a copy allegedly sent to the surgeon, made the cardiologist appear to lack any credibility to all of the MLMIC experts. Additionally, the alleged fax of this letter to the hospital's "Anesthesia Department" was not addressed to a specific person and the cardiologist had no proof this letter was actually faxed. Therefore, this lack of credibility made an otherwise defensible case impossible to defend. Fabricating evidence after a patient has died or a lawyer has requested records often places other defendants in a position to "finger point." This can seriously impact a defendant's position. The presence of multiple "clearance letters" from the cardiologist clearly precluded a joint and united defense. When defendants "finger point" at each other, the only person who benefits is the plaintiff.

The surgeon adamantly denied receiving either a call or a copy of the letter from the cardiologist.

From a risk management perspective, if there is a major change in the preoperative assessment of a patient, a telephone call must be made and documented by the consultant to the surgeon to alert the surgeon or other relevant attendings to those changes. The position of the defendant plastic surgeon was that it was the duty of the cardiologist to advise the patient about discontinuing an aspirin regimen and the risks of doing so. He agreed he would then be responsible for implementing those recommendations to discontinue any medications preoperatively. Further, he insisted that if he had received the January 4 letter, he would have contacted the cardiologist directly to request clarification of the changes in his recommendations.

Ironically, on autopsy, the patient had no salicylates in his blood. This finding further convinced the MLMIC experts that the January 4 letter was neither drafted nor sent to the primary care provider until after the patient's death. Thus, what was originally considered a defensible case for all three defendants was no longer a defensible case for the cardiologist.

Both the alleged fabrication of the January 4 letter and his continued insistence that he had, in fact, properly notified the other defendants in a timely manner of this new letter, resulted in the cardiologist bearing the entire cost of the settlement.

CASE STUDY #2

Improper Penile Implant Results in Postoperative Infection

Ursula Cooper
Senior Claims Examiner
Medical Liability Mutual Insurance Company

A 65-year-old man presented to the MLMIC–insured urologist in mid-October for a consultation about a possible penile implant. The patient's medical history included a prostatectomy five years earlier for prostate cancer and a right-sided renal transplant two years after that. His chief complaint at that visit was erectile dysfunction. A trial of Viagra was reportedly unsuccessful. The urologist performed a Doppler ultrasound and a penile injection test. These tests confirmed adequate blood flow, which made the patient a good candidate for a penile implant.

On January 5, the patient returned to the urologist for a preoperative examination. A cystoscopy was performed to rule out scar tissue in the bladder. The urologist performed an informed consent discussion and gave the patient pre- and postoperative instructions. Additionally, the patient had a cardiac evaluation and was cleared for surgery. Later that month, the urologist placed an inflatable penile prosthesis in the patient and documented that the procedure was uneventful. The following day, he discharged the patient on antibiotics.

Two days after the surgery, a member of the urologist's staff contacted the patient and was told that he was doing well. However, four days postoperatively, the patient's wife called the urologist advising him that her husband had swelling of the scrotum, but no symptoms of pain, fever, chills or vomiting. The patient refused to go to the physician's office to be seen. The urologist told the patient's wife to have the patient seen promptly if the swelling worsened.

The next day, the patient's wife again called. She informed the urologist that the patient's scrotal swelling had increased and that his eyes were now puffy. The urologist was concerned that the patient had renal failure, secondary to the antibiotics he prescribed, and recommended that the patient go immediately to the hospital's emergency department to have a renal sonogram.

When the patient arrived at the hospital, the emergency department physician found not only decreased urinary output, but air under the patient's skin. He ordered a CT scan, which revealed that the implant reservoir was in the patient's sigmoid colon. He called the urologist, who promptly came to the hospital and took the patient to the operating room to remove the implant reservoir. A colorectal surgeon then performed a colostomy and removed the remainder of the implant. Drains were placed in the patient and he remained hospitalized for 10 days.

Shortly after his discharge in early February, the patient developed a groin abscess. He was readmitted to the hospital and treated for three weeks with IV antibiotics and bedside drainage. Approximately three months later, the patient underwent a reversal of his colostomy. However, he then developed a C. difficile infection. Finally, on July 4, he was again discharged.

Subsequently, the patient developed chronic hiccups and vomiting and was hospitalized four times for treatment of nausea, vomiting, and a C. difficile infection. One year later, the patient went to a different hospital and urologist to have penile and scrotal fibrosis removed and to have an inflatable prosthesis inserted. Due to difficulty inserting the prosthesis, this urologist also performed a cystourethroscopy. The patient was discharged the following day with no complications or complaints. Apparently, this second implant was relatively successful.

continued on page 6

Case #2 *continued*

Two years after the initial penile implant surgery, the patient and his wife filed a lawsuit against both the original urologist and the hospital where he performed the surgery. However, after the lawsuit was filed, the patient unexpectedly died. The cause of his death was presumed to be a cardiac event and not related to the initial implant surgery, thereby precluding an additional claim for wrongful death.

The urologist's medical care was reviewed by MLMIC experts in both urology and general surgery. One urological expert opined that while the insured urologist was careful to place the reservoir on the side opposite the transplanted kidney, the reservoir should have been placed under direct vision, rather than by blunt dissection, particularly because the patient had undergone both radical prostatic surgery and a renal transplant.

Another MLMIC urology expert confirmed that the reservoir of the penile implant was not properly placed. When the reservoir was discovered to be in the colon, a large laceration of the colon was also observed. This laceration was unlikely to have been caused merely by erosion of the reservoir into the colon. Rather, the expert opined that this laceration occurred when the urologist placed the implant.

Finally, the MLMIC general surgery expert concurred that blind placement of the implant led to penetration of the posterior wall of the groin, allowing the reservoir to actually be placed through the wall and into the sigmoid colon. He felt that this produced the patient's significant postoperative infection, and caused him to undergo the procedure to remove the apparatus, the colostomy, and, later, the reanastomosis of his colon. This expert was particularly critical of the urologist's failure to speak with any of the patient's prior physicians regarding the stage of his prostate cancer, as well as his failure to find out if there had been difficulties with the renal transplant or the anti-rejection immunosuppressive therapy.

All of these MLMIC experts concurred that the case was not defensible and they unanimously recommended that this lawsuit be settled. Negotiations were commenced and the lawsuit was eventually resolved on behalf of the insured urologist for $575,000.

CASE STUDY #2 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

Donnaline Richman, Esq.
Fager Amsler Keller & Schoppmann, LLP
Counsel to Medical Liability Mutual Insurance Company

This case identifies two issues which arise across the broad spectrum of surgical cases. The first issue is the performance of a procedure blindly, without obtaining adequate views of the operative field. This is particularly true when the involved physician is very experienced and has effectively performed the procedure on numerous occasions in that specialty. The physician may be very confident in his/her skills and thus perform the procedure in a manner or at a speed which inadvertently increases the risk of injury to a patient. Further, there are patients who have unusual anatomical differences or have had prior procedures which must be acknowledged and require procedural adaptations. Failing to do so may well be deemed a breach of the standard of care.

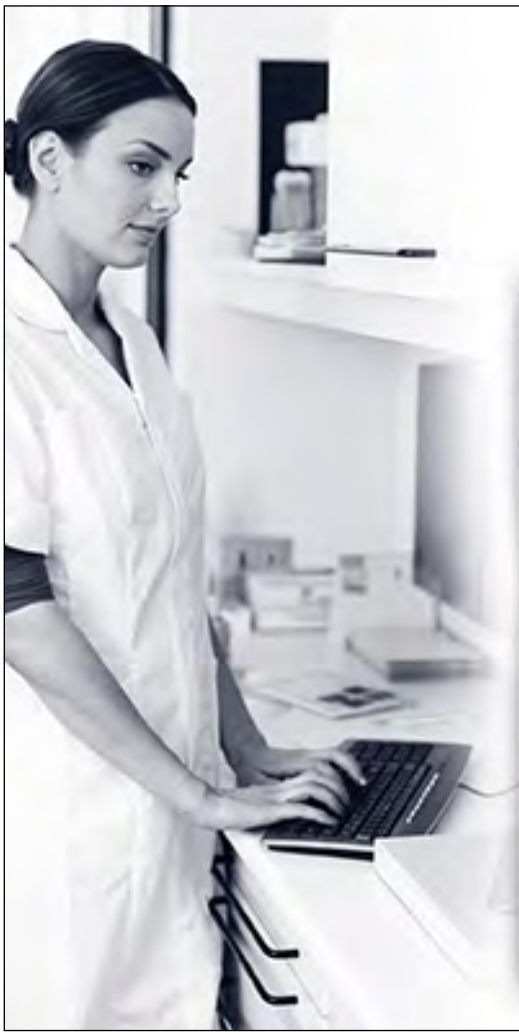
The second issue in this case is closely linked to the first. When a patient with a complex medical history comes to a physician to undergo a treatment or procedure, it is important for the current physician to communicate with the prior treating physicians to determine whether any variations must be made to the planned procedure. The failure to do so can enhance the risk of injury to the patient, as it did in this case.

This patient had undergone two prior extensive renal and urological procedures. Additionally, he was taking anti-rejection medications. Those facts alone justified communication with other physicians prior to even agreeing to perform this procedure. Determining whether the drugs and prior procedures warranted placing the prosthesis visually would have enabled the urologist to perform the procedure with an appropriate technique and the due care this patient needed.

The lack of communication between prior and subsequent providers is a frequent deficit in care we often see when reviewing a variety of medical malpractice cases, not just those requiring surgical procedures. Therefore, from a risk management perspective, we recommend both communicating with prior relevant physicians and reviewing their records when a patient with a complex surgical and medical history is seen preoperatively.

MLMIC®
Medical Liability Mutual Insurance Company
2 Park Avenue
New York, NY 10016

MLMIC.com



The MLMIC.com Blog

For the latest company news and insights into hot topics in the industry affecting physicians today, sign up for the MLMIC blog.

See what the blog can do for you. Visit **mlmic.com/blog**