You be the Jury—Adventures in Medical Malpractice
An Audience Response Experience

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Principles of Malpractice Cases

Four criteria must be met for a plaintiff to prevail in a medical malpractice case:

- The physician must have a *duty to provide appropriate* care to the patient
- The physician must have *breached* that duty
- The patient must have suffered an *injury or a loss*
- The breach of duty must have directly *caused* the injury or loss

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Good news and bad news

- Good news: Pediatricians are 24th out of 25 specialties in likelihood of being sued
  - 3.1% of pediatricians sued each year
  - About 20% of suits result in a payout (80% find no liability)
- Bad news: Claim payouts in the event of being found negligent are 5th highest of those specialties
  - Cases take a long time to be filed and resolved
  - Only OB, neurosurgery, pathology and neurology have higher average payouts

Jena AB, Chandra A, Seabury SA. Malpractice risk among US pediatricians. *Pediatrics*. 2013;131(6):1148-1154. doi:10.1542/peds.2012-3443

Schaffer AC et al. Rates and Characteristics of Paid Malpractice Claims among US Physicians by Specialty, 1992-2014. *JAMA Intern Med*. 2017;177:70-718. doi:10.1001/jamainternmed.2017.0311

The “Standard of Care”

That which a competent physician in the same field would do under similar circumstances (*McCourt v Abernathy*, 457 S.E.2d 603 (S.C. 1995).)

- “minimally” competent (*Hall v. Hilburn*, 466 So. 2d 856 (Miss. 1985). Same field
- Same circumstances (sometimes includes geographic location)
- DOES NOT DISCUSS OUTCOME
- DOES NOT REQUIRE PERFECTION

Moffett P, Moore G. The standard of care: legal history and definitions: the bad and good news. West J Emerg Med. 2011 Feb;12(1):109-12. PMID: 21691483; PMCID: PMC3088386.

Case #1

A 7 year old boy came home from sports camp complaining of pain in his lower abdomen, without nausea, vomiting or fever. He was seen by his pediatrician that evening on an emergent basis. The exam was documented as normal, including **no focal tenderness**, a **soft abdomen** with **normal bowel sounds**, **normal genital exam** and a **positive cremasteric sign**. He was diagnosed with a muscle strain and sent home with analgesics, and **told to return if the pain continued or worsened**.

Records were received from the pediatrician. Review of the chart showed documentation of all of the above.

Case #1, Poll #1: Up to this point, had the standard of care been met?

Case #1

The following day, the pain had worsened, and the child presented to the ED. Ultrasound showed lack of blood flow to the left testicle. Surgical exploration was performed, revealing a necrotic left testicle. Left orchiectomy and right orchiopexy were performed. The parents filed suit alleging negligence in diagnosing testicular torsion, with a missed opportunity to salvage a viable testis.

During discovery, documents were exchanged between lawyers for both sides.

Review of the pediatrician's chart sent by the plaintiff's attorney showed a normal exam, including **no focal tenderness**, **a soft abdomen** with **normal bowel sounds**, **normal genital exam** and
. He was diagnosed with a muscle strain and **told to return if the pain continued or worsened.**

Case #1, Poll #2: What was the outcome of the lawsuit?

Case #1--Outcome

There was a clear discrepancy between records received from the defendant physician and those received from the plaintiff's attorney, specifically concerning the notation "positive cremasteric reflex."

Further inquiry revealed that the parent had requested a copy of the records shortly after the incident occurred. The defendant did not provide records to their attorney until after a lawsuit had been commenced.

During the interval, the records were altered to add the note about the cremasteric reflex.

Case #1—Take home messages

- Altering a record after the fact makes a case difficult to defend, even if the physician was not negligent. A jury will doubt the veracity of anything once alteration is discovered.
- Whenever records are sent from an office, the date, requesting party and receiving party should be documented.
- Knowing that records were already in the possession of a third party should have made the desire to alter the record (wrong in any case) seem even more of a bad idea.
- This case was potentially defensible until the alterations were made.

Case #2

A female newborn is delivered from the vertex position following an uneventful pregnancy. The normal nursery exams x 2 document “hips normal, negative Barlow/Ortolani/Galeazzi signs.” She is seen at the pediatrician for visits according to Bright Futures (see next slide for documentation). Walking is slightly delayed to 15 months, and at 20 months, the parents are concerned about a waddling gait. The pediatrician finds nothing abnormal, but the concerns persist so she is seen by pediatric ortho at 24 months.

The pediatric orthopedic exam documents normal hip mobility, but x-ray reveals bilateral dislocated hips with formation of pseudoacetabulae. She undergoes several surgical procedures, and at followup, the femoral heads remain underdeveloped. The parents initiate a suit against the pediatrician for failure to diagnose DDH early enough to allow non-operative treatment.

Case #2

Child A

NBN– B/O/G negative

2m—Ortolani/Barlow negative

4m—Ortolani/Barlow negative

6m--Ortolani/Barlow negative

9m--Ortolani/Barlow negative

12m-Ortolani/Barlow negative. No walking

15m—takes a few steps

18m—walks well, up steps

20m (concern)—gait nl, hip ROM normal, leg length equal

Child B

NBN—B/O/G negative

2m—hips nl, no clicks/thunks

4m—hips nl, no clicks/thunks

6m—hips nl, no clicks/thunks

9m—musculoskeletal nl

12m—musculoskeletal nl

15m—walking by history

18m—wide gait,stoops and recovers

20m (concern)—hips not tight, gait nl

Case #2, Poll #1: Up to this point, had the standard of care been met?

Case #2 - Questions to Consider

- Was the standard of care met in these children?
  - Examination
  - Documentation
  - Follow up
- Examination may have been appropriate, but how can you tell?
- Documentation
  - Boilerplate which never changes
  - Use of non-standard terminology
- Danger of templates/fixed drop-down menu choices
  - May not be age-specific
  - May not provide adequate choices for responses

Case #2, Poll #2: What was the outcome of the lawsuit?

Case #2--Outcome

- Both cases were tried and ended with verdicts for the defense.
- Child A—O/B/G exams through 6 months met standard
- Child B—physician was convincing that his wording referred to proper examinations which varied with age according to standard
- DDH is well documented to be absent at birth (NOT CDH) and show up many months later despite normal exams
- If even ped ortho can be fooled….

Case #2—Take home messages

- Make sure your exams are appropriate for patient age
- Document the specifics of the exam at every age
- Be careful with templates/dropdown menus
    - If you did not write them, know them in detail
    - Make sure they give you the choices you need
    - EDIT EDIT EDIT
    - Free text if necessary
    - If using AI for office notes, make sure the note reflects your exam and thought process (AI shortcuts from what is heard to what is written)

Case #3

An 18 month child was seen at a pediatric UCC with a history of having grabbed a piece of sharp metal and sustaining a laceration of his left index finger. Immunizations were current, and the physician noted a transverse laceration just proximal to the PIP joint on the index finger. These had been significant bleeding initially which had stopped at the time of the visit. The physician cleaned and bandaged the finger and sent the child home to be followed by the PCP in 2-3 days.

He was actually seen 5 days later, and the pediatrician noted early healing with erythema and no discharge. The mother noted that he was keeping the finger extended, which the pediatrician explained as being due to swelling and discomfort. It was rebandaged and he was told to follow up if there was drainage, persistent pain or other problems.

Case #3, Poll #1: Up to this point, had the standard of care been met?

Case #3--Outcome

When seen several months later for a routine visit, he was noted to be unable to flex the index finger at the PIP joint, and was referred to a hand surgeon. Clinical diagnosis was transection of the FDP tendon.

Surgical exploration was performed. The diagnosis was confirmed, and the proximal segment of the tendon was located, but the distal segment was not, and primary repair could not be done. He has persistent inability to flex the finger at the PIP of what has turned out to be his dominant hand.

The parents filed suit against both the UCC physician and PCP.

Case #3, Poll #2: What was the outcome of the case?

Case #3, Poll #2: What was the outcome of the case?

Following review by experts in pediatrics and hand surgery, it was determined that the standard of care required, at a minimum, referral on the initial visit to a hand surgeon, given the location of the laceration. Repair may or may not have been possible at that time, but the chance for restoration of normal function had been lost. Failure to refer at the five-day visit also missed any chance for repair. Experts could not be located to counter this opinion.

The case was settled before trial on behalf of both physicians, with significant payout.

Take home message: Sometimes the deviation from the standard of care is so clear that it is easier, on both the plaintiff and the defendants, to have a case resolved as quickly as possible. In the (hopefully) unlikely event that you find yourself in a similar situation, a quick resolution provides for compensating an injured patient while allowing you to put the matter behind you.

Case #4

Full term infant born by C/S after failed labor with ROM 12 hours. Maternal GBS unknown, otherwise history benign. No perinatal antibiotics given, no blood work in NBN. Did well in NBN, other than a bili of 16.7 at 94 hours of age. Discharged on day 4 with 24 hour follow up. Weight 3305g.

Seen 4 days after discharge (DOL 8)—wt 3695g, TCB 3.7, afebrile. Exam normal.

Seen the following day (DOL 9) for a rash. Wt 3815g, diagnosis erythema toxicum.

The following day, a call was received from the ED—the infant was seen with T102, HR 220 and was admitted to r/o sepsis. The child deteriorated and was transferred to a tertiary care center. CSF from initial ED visit grew E.coli.

The child had a very stormy course, including brain abscess and infarction. He survives with severe sequelae.

Case #4, Poll #1: Was the standard of care met in the NBN, including discharge planning?

Case #4, Poll #2: What was the outcome of this case?

Case#4--Outcome

- Pediatric review felt that the standard of care was met, both in NBN and at postnatal visits
- E. coli infection is not related to maternal GBS status
- E. coli infection is associated with severe damage in survivors
- However, other factors were in play
  - Severely damaged infant
  - Venue with juries typically sympathetic to plaintiffs
  - Problems with one of defense experts
  - Concern of defendants about trial verdict exceeding coverage levels
- Pre-trial agreement setting upper and lower levels of compensation
  - Plaintiff receives something
  - Defendant risk is limited

Case #5

A 4 year old girl with a history of several episodes of UTI (ED and office visits) presented to the pediatric ED c/o abdominal pain and painful urination. She was afebrile, with normal bowel sounds and suprapubic tenderness. US showed 23 WBC/hpf and UTI was diagnosed and treated with cefdinir. Culture was sent.

Follow up with the PCP 30 hours later again showed her to be febrile, eating without vomiting, suprapubic tenderness but a soft, nontender abdomen with normal bowel sounds and no guarding, rebound or CVA tenderness. Cefdinir was continued (culture results were requested) and she was instructed to return to office or ED in the event of vomiting, anorexia, fever or worsening abdominal pain.

After an additional 24 hours, she was not improving, but still had not developed vomiting or anorexia, and returned to the ED. She was seen by both pediatricians and pediatric surgery, and was admitted with a presumptive diagnosis of pyelonephritis. Renal ultrasound did not suggest pyelonephritis, but did suggest a retrocecal appendicitis, which was confirmed on CT.She was treated non-operatively, and scheduled for an interval laparoscopic appendectomy 8 weeks later, which was performed without complication, and she has continued to do well. The family filed suit alleging delayed diagnosis of appendicitis.

Suit was filed alleging missed diagnosis of acute appendicitis by ED and PCP.

Case #5, Poll #1: Was the standard of care met in the ED and by the PCP?

Case #5, Poll #2: What was the outcome of the suit?

Case #5--Outcome

This case never went to trial. Both defendants separately filed motions for summary judgement. The ED filed on the grounds that the PCP had had a subsequent opportunity to evaluate the child and discover the appendicitis.

The PCP filed on several grounds, including the known difficulty of diagnosing a retrocecal appendicitis, the fact that at the subsequent ED visit, neither pediatrician nor surgeon felt that there was appendicitis and the fact that the child would have needed surgery in any case, and had no complications or loss from any delay.

The Court granted summary judgement to both defendants, noting that failure to make a diagnosis does not necessarily constitute negligence, as long as appropriate care in evaluation and referral was taken. The fact that the surgeon (the usual consultant) seeing the child following the PCP also did not feel that appendicitis was present further supported the PCP claim that the condition was not readily diagnosable even with a careful evaluation.

Case #5

TAKE HOME POINTS

- Thorough examination and documentation, with an appropriate follow up plan, makes a case with adverse outcome easier to defend.
- SUMMARY JUDGEMENT—A judgement in favor of one party, usually without a full trial, where a) there is no dispute about the material facts and b) that the party moving for such judgement is entitled to it as a matter of law. The opposing side may contest the motion, and the judge will decide based on the evidence.

In summary…

- Know your medicine—seek help if unfamiliar
- Documentation is ALWAYS critical
  - Specific to the patient at hand—avoid boilerplate
  - Include differential diagnosis
  - Include your reasoning
- Follow up planning is ALSO critical—the “what to do if….”
  - Document your instructions AND parental understanding (“repeat it back”)
- The standard of care is NOT that you have to be perfect
- You can be wrong, but you cannot be negligent

Thank you!