When is a Consult Not a Consult? And Other Compelling Revelations from Closed Claims

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Objectives

- ✓ Understand the implications of “curbside consults” as related to diagnostic safety and claims management.
- ✓ Describe and apply damage and risk mitigation strategies learned during the management of liability claims.

Claim #1

The Case of the Not So Cute QT

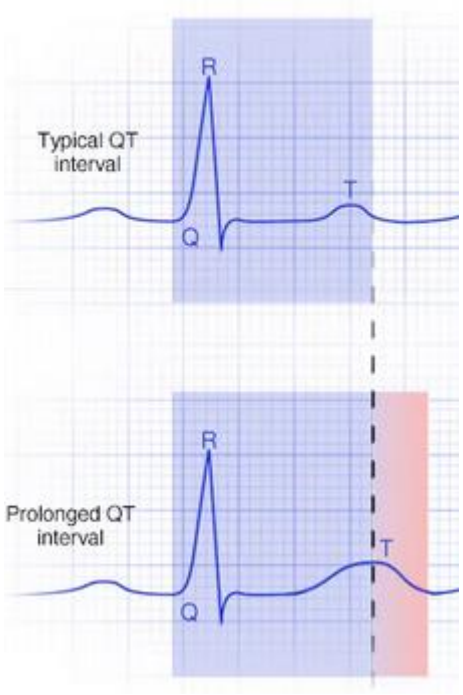
Claim #1 - Facts

- 38-year-old female drove herself to the emergency department.
- **4:14pm:** Arrived in ED
- Nausea and vomiting x 1 week; low abdominal pain
- Temp. 99.9 F, HR 102, Resp 24, B/P 151/106, Pulse Ox 100%
- Had been taking Zofran at home without relief
- History of medical marijuana use
- History of chronic vomiting, likely related to marijuana use, with multiple ER visits and hospital admissions
- Presentation and mild distress suggested a gastrointestinal issue
- **4:25pm:** Placed on a cardiac monitor
- **4:42pm:** Initial EKG performed
- Interventions: IV insertion VS monitor, labs drawn, blood gas obtained **5:02pm:** 0.9NS IV fluid bolus, Zofran **5:21pm:** Dilaudid **5:40pm:** IV Potassium infusion **5:42pm**: CXR **5:43pm:** CT Abdomen & Pelvis

Claim #1 - Facts

Tests Performed	Results	Treatment
Initial EKG	Sinus rhythm, possibility of old infarct, **prolonged QT wave QT/QTc = 468 / 600** (<460 QTc in women)	Cardiac monitoring
CXR	No acute cardiopulmonary disease	
CT Abdomen/Pelvis	Negative	
Sodium Level	**132.7** (134.5-145)	
Potassium Level	**2.95** (3.5-5.1)	IV potassium chloride infusion began at 5:40pm
Glucose Level	**135** (74-106)	
Lactic Acid Level	**2.79** (0.7-2.1)	
ABG Result	PH **7.822** (7.35-7.45) PO2 **137** (85-100) PCO2 **8.6** (35-45) HCO3 **14.1** (22-26)	Results indicate patient was hyperventilating

Causes of Prolonged QT Interval (>440ms)



- Congenital
- Hypokalemia
- Hypomagnesaemia
- Hypocalcaemia
- Hypothermia
- Myocardial ischemia
- ROSC Post-cardiac arrest
- Raised intracranial pressure
- Congenital long QT syndrome
- Medications/Drugs – Multiple medications belonging to different drug classes that are of low, moderate and high risk of causing long QT syndrome.

Claim #1 - Facts

6:01pm: Runs of V-tach

6:10pm: Phenergan (Promethazine) IV

7:12pm: Multiple PVCs and short runs of V-tach noted

7:15pm: ER physician began arranging for patient transfer

8:13pm: K-dur 40 mEq Oral

8:14pm: Metoprolol IV

8:28pm: Second dose of Zofran given

8:51pm: Second EKG: Ventricular rate 148. Handwritten note, “wide-open tachycardia V-tach”

9:22pm: Re-evaluation by ER physician – Patient stable

9:35pm: Manual B/P taken by RN 150/78; Respirations 20.

Claim #1 - Facts

- **9:40pm:** RN notes V-tach on cardiac monitor and entered patient's room.
  - Unresponsive
  - Pulseless
  - Grunting
  - Clammy
- Code Blue called, CPR initiated, and patient intubated
- **9:45pm**: Initial Epinephrine given (Total of 2 doses)
- **9:51pm:** ROSC achieved
- **00:45am:** Ambulance transfer to receiving hospital for higher level of care
- Patient expired 11 days later
- Cause of death per death certificate: Hypoxic ischemic encephalopathy due to cardiac arrest and prolonged QT

Lawsuit / Allegations

- **Wrongful death and survival act claims against hospital, based on alleged agency of ED physicians**
- **Plaintiff claims Hospital is vicariously liable for ER physician's actions. ER physicians were not employed by the Hospital**
  - Failure to test and administer magnesium
  - Failure to appropriately treat potassium deficiency
  - Failure to treat worsening clinical changes
  - Failure to treat prolonged QT intervals
  - Failure to treat ventricular tachycardia
  - Failure to respond to cardiac alarms
  - Failure to read EKG correctly
  - Failure to respond to the Code in a timely manner
  - Failure to monitor in light of risks of cardiac arrest
  - Failure to recognize seriousness of decedents clinical presentation

Allegations/Lawsuit/

- **Wrongful death/survival act claims against hospital for actions of nursing staff**
  - Failure to respond to worsening clinical changes
  - Failure to alert the doctor of worsening conditions
  - Failure to respond to cardiac monitor alarms
  - Failure to notify the doctor after the alarms sounded
  - Failure to respond to the Code in a timely manner
  - Failure to monitor the patient's condition
  - Failure to recognize the seriousness of clinical presentation

Causation and Damages

- **38-year-old wrongful death**
  - Survived by husband and three minor, teenage children
  - Loss of society, love, affection, companionship and support
  - Claimed funeral expenses

- **Claimed damages under Survival Act**
  - Pain and suffering plaintiff suffered prior to her death
  - Medical expenses
  - Loss of normal life, lost wages and emotional distress

Case Strength and Weaknesses

Strengths:

- Verbal consent of patient to a form that clearly stated the ER physicians were independent contractors and not employees/agents of the Hospital
- Patient signed same form on previous Hospital visits
- Treatment of dehydration / abnormal electrolytes appropriately initiated
- Multiple causes of abnormal prolonged QT wave including pre-existing history of drug use. Urine screen at receiving hospital positive for THC.
- Treatment alleged to correct hypokalemia wouldn't have prevented sudden cardiac arrest - those medications take time to be effective in preventing hypokalemic induced V-tach
- Other aggressive treatments for prolonged Q wave aren't options for physicians in ER setting
- No indication Magnesium was indicated or would have made a difference as level was normal at receiving Hospital

Case Strength and Weaknesses

Weaknesses:

- Administration of Zofran and Phenergan in a patient with prolonged QT could increase risk of ventricular tachycardia
- Second dose of Zofran administered even though EKG showed V-tach
- Jury sympathy: Decedent had a close relationship with her children who spent a great deal of time with her – more so than with their father

Demand

$8,000,000 demand was made to Defendants

Discussion Points and Considerations

- What are the care strengths and weaknesses?
- What deviations from the standard of care if any did you identify?
- Thoughts about demand?
- Should an attempt be made to settle this case?
- If so, what is the case settlement value?
- If so, what amount is too much to pay where it should instead be taken to trial?
- Rationale for settling case versus taking case to trial?
- Do you believe that there are any aggravating factors in this claim?
- Settlement Outcome

Risk Management Implications

Claim #2

The Case of
Two Wrongs Don’t Make it Right

Claim #2 - Facts

- 82-year-old female diagnosed with a torn meniscus
- Presented for right knee arthroscopy and meniscectomy
- General anesthesia
- H&P , Timeout & Consent identified right knee
- Right knee correctly marked by surgeon
- Surgical suite set up for left leg surgery -patient put in that position
- Left leg prepped
- Left knee arthroscopy and meniscectomy performed
- Surgeon realized surgery performed on incorrect leg near completion of procedure
- Disclosure made to family
- Spouse requested surgeon proceed with right knee surgery

Claim #2 - Facts

- **Hospital received Attorney Lien within a month of the surgery**
- **Surgeon was not a hospital employee**
- **Hospital and surgeon's attorney worked together towards pre-suit settlement**
- **Patient sought her post-op care with a different orthopedic surgeon**

Allegations

- **Surgeon and hospital staff liable as established protocol ignored.**
  - Gross medical negligence
  - Battery - no consent given for procedure

Causation and Damages

- **Violation of Universal Policy by OR team**
  - Final verbal verification of surgery/procedure “time out” immediately prior to start of procedure to ensure correct patient, site, position and procedure
  - Resulted in wrong site surgery
- **Pain, suffering, disability, indignity.**
- **Spouse suffered loss of consortium damages.**

Specific Damages

- **Lengthened recovery**
- **Restricted ability to perform daily activities**
- **Limited ability to care for herself and her elderly spouse**
- **Additional pain – left knee**
- **Further treatment required at one-month post-op primarily for left knee:**
  - Physical therapy
  - Medication for pain and disability
- **Additional treatment lasted 8 weeks**
- **Additional expense associated with left knee surgery**
- **Unsure of long-term sequelae**

Case Strengths and Weaknesses

Strengths:

- Only $5000 in claimed medical expenses.
- No apparent permanency.

Weaknesses:

- Clear violation. Surgeon and hospital staff failed to follow written procedure.

Demand

- $500,000 Global

Discussion Points and Considerations

- What are the care strengths and weaknesses?
- What deviations from the standard of care if any did you identify?
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Risk Management Implications

When is a Consult Not a Consult?

When is a Consult Not a Consult

Case #1:*Case of the On Call PCP* Facts

- 65-year-old patient presented to ED
- Symptoms included severe pain in posterior neck and trapezius area; fever and a bug bite on his arm
- Diagnosed with torticollis; discharged home. To see PCP the next day.
- Returned to the ED three days after discharge
- Airlifted to another hospital. Diagnosed with spinal epidural abscess
- Expired nine days later

Case #1 Litigation Information

- Suit filed against hospital, ED physician, on call PCP and group
- On call PCP testified he never examined patient and did not make a decision regarding admission vs. discharge
- On call PCP and group filed a Motion for Summary Judgment on the grounds the phone call did not create a physician patient relationship
- Trial court agreed and entered summary judgment for on call PCP and group
- Plaintiff appealed. Appellate Court reversed summary judgment for on call PCP and group
- "*The special relationship giving rise to a duty of care may exist even in the absence of any meeting between the physician and the patient where the physician performs specific services for the benefit of the patient.*"

Case #1 Litigation Information

- **On call PCP**
  - Consulted for the patient's benefit to render medical advice and took "affirmative action to participate in the care, evaluation, diagnosis or treatment"
  - Collaborated on a medical opinion that patient was not in immediate danger nor required admission
  - Was paid for his on-call services; had final admitting authority
- **ED physician did not have admitting privileges**
- **Conversation between the physicians was a formal exchange "contemplated by hospital bylaws"**
- **Outcome**

When is a Consult Not a Consult

Case #2: *Case of the On Call Surgeon* Facts

- 23-year-old male presented to ED with abdominal pain that began the day before.
  - Had cramping, bloating, vomiting, lower back pain
- Appendicitis ruled out by physician exam
- Abdominal CT w/o bowel obstruction – *correlate for enteritis or ileus*
- ED physician diagnosis: Gastritis
- Norco, Pepcid & Zofran prescribed. Patient discharged home
- Few hours later, severe abdominal pain noted
- **6:39am**: Patient returned to the ED
- **6:45am**: Nursing assessed patient:
  - Tenderness in all quadrants, flat, rounded, non-distended abdomen with active, bowel sounds

Case #2 Facts

- **7:01am:** ED physician examined patient and documented he was in severe pain, onset 14 hours earlier; pain worse on palpation
- **7:14am** Phenergan administered. Pain 10/10. Dilaudid administered
- **8:35am:** Abdominal x-ray:
  - Nonspecific gas pattern, mildly distended loops of small bowel that could represent ileus, enteritis or developing small bowel obstruction
- ED physician suspected a blockage which might require surgery.
- Spoke with surgeon; relayed information from initial and current visit.
- Surgeon relayed opinion that patient didn't have a bowel obstruction.

Case #2 Facts

- **8:59am:** Pain 10/10: Second dose of Dilaudid given
- **9:11am:** ED physician documented discharge meeting with patient
- **10:00am:** VS normal
- **10:18am:** RN documented goal of acceptable pain level achieved
- **10:30am:** Discharge papers signed. Patient walked unassisted out of the ED – did not express pain at time of discharge
- **1:30pm:** Family arrived with patient at their second home.
- **3-4pm:** Patient awoke from nap. Stumbled to bathroom. Unable to urinate. Returned to bed.
- **6pm:** Awoke to use bathroom and fell. Could not urinate. Shortly after Mother gave pain medicine, began vomiting and pain returned.
- **6:30pm**: Drank water, vomited again, went back to sleep

Case #2 Facts

- **7:30pm:** Parents woke patient
- **7:45pm:** Patient pale, weak. Began convulsing and vomitted black emesis
- **8:11pm:** EMS call received. Mother performing CPR
- **8:45pm:** EMS arrived at remote home location
- Patient regained heart rate - Coded upon placement into ambulance. CPR continued
- **9:25pm:** Arrived at hospital
- **9:26pm:** Coded once again
- **9:43pm:** The patient could not be resuscitated and expired
- Autopsy final diagnosis: Small bowel obstruction, small bowel infarct, proximal small bowel dilation to 16cm diameter and bloody intraluminal fluid

Case #2 Litigation Information

- **Suit filed against hospital, ED physician, surgeon, ED nurse, radiologist and group. Radiologist and group dismissed early on**
- **Hospital had a motion for summary judgment pending as to apparent agency for on-call general surgeon and ED physician and his employer**
- **ED physician's testimony:**
  - Agreed that distended loops of small bowel on the abdominal x-ray could represent small bowel obstruction
  - Reason why he called the on-call surgeon
  - Second conversation with on-call general surgeon was brief.
  - Recalled that after surgeon looked at CT and x-rays. He told ED physician he agreed with the radiologist's interpretation of no overt signs of small bowel obstruction

Case #2 Litigation Information

- **General Surgeon's testimony**
  - He was not performing a formal consultation
  - Denied he told ED MD that x-ray wasn't consistent with a bowel obstruction and testified it could be
  - He had the ability to view the patient's chart
  - He made no recommendations on patient care or write any orders
  - He testified he could have seen the patient, but ED MD never asked
  - No written consult order
- **Outcome**

When is a Consult Not a Consult

Case #3: *Case of the Bowling Alley Consult* Facts

- 54-year-old presented for a planned laparoscopic Roux-en-Y (Gastric Bypass) and cholecystectomy
- Due to risk factors, Pulmonary evaluation recommended
  - Snoring, sleep apnea, hypertension and hyperlipidemia
- Pulmonary impressions:
  - CAD, morbid obesity, BMI 36, HTN, dyslipidemia and dyspnea on exertion.
- Underwent a cardiac catheterization two years prior with progression of disease noted at that time when compared to an earlier study
- Spouse was a nurse in medical group office where patient's Cardiologist was previously employed
- Cardiologist treated patient previously with this medical group but hadn't seen him since joining a new group

Case #3 Facts

- Five weeks before scheduled surgery, spouse sent text message to patient's cardiologist requesting her help in obtaining clearance ASAP for surgery
- That evening, patient and spouse came to the bowling alley where they were participating in a bowling league and spoke with Cardiologist
- A text message was exchanged between cardiologist and patient's spouse in regard to faxing a clearance letter and providing Lovenox & Plavix instructions
- Cardiologist prepared a "*To whom it may concern*" letter for surgical clearance advising he was a low cardiac risk for conscious sedation/general anesthesia
- Cardiologist classified patient as an ASA II

Case #3 Facts

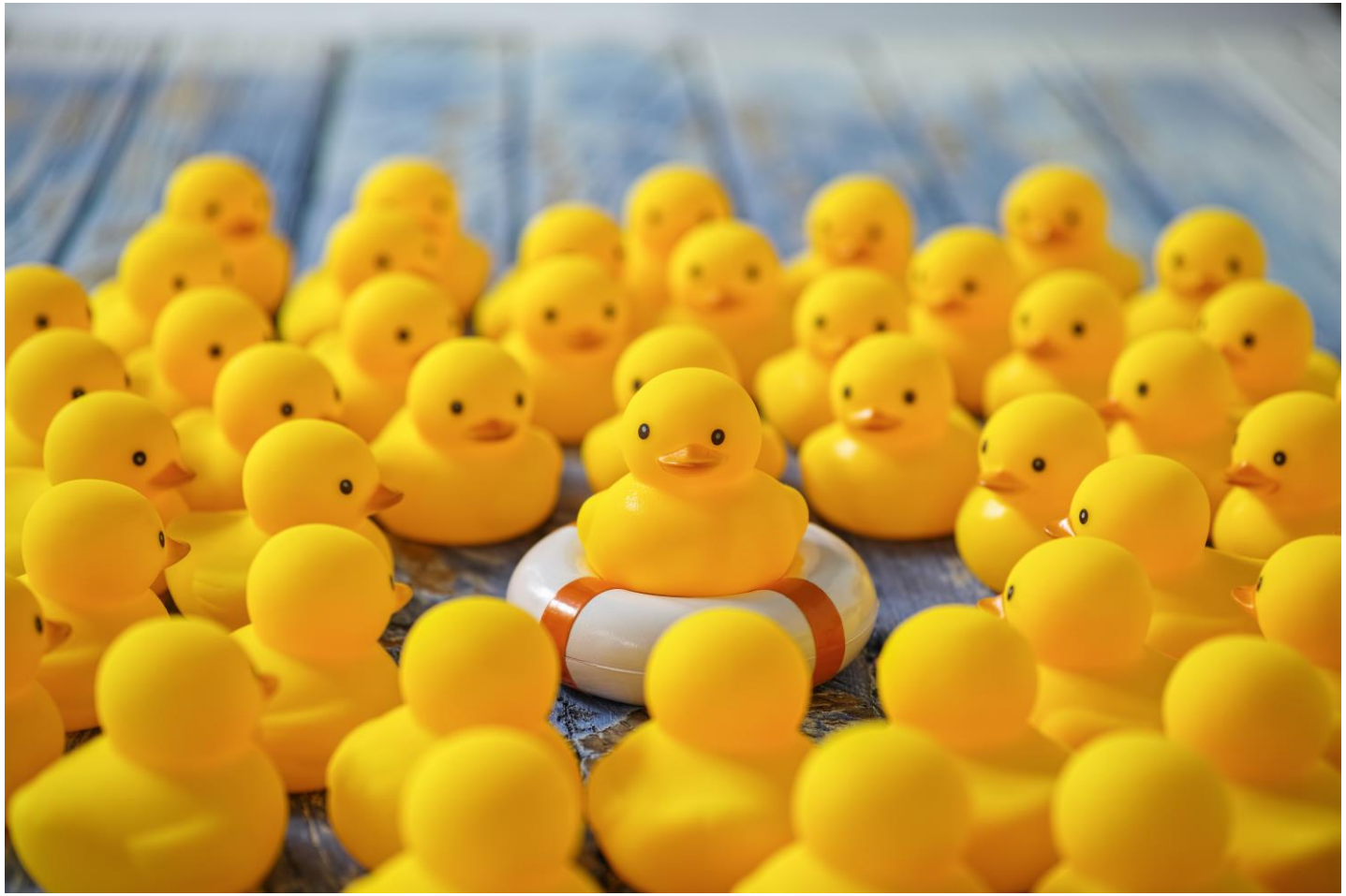
- Patient underwent scheduled surgery as planned without complications
- Morning of POD 1, patient had five episodes of bloody sputum.
- CT of the abdomen, chest x-ray and Tylenol were ordered that afternoon. UGI ordered for the following morning on POD 2.
- Evening of POD 2, patient had a fever of 102.8 with elevated heart rate of 114
- POD 3 at 1:52pm, a rapid response was called due to patient having uncontrolled rigors, temp of 103.1 and an increased heart rate in 140's
- NG tube was inserted to decompress the stomach and plans for a possible exploratory laparotomy were made for the following day
- 6:35pm: Patient found unresponsive.

Case #3 Facts

- Supraventricular tachycardia developed into ventricular fibrillation. CPR was initiated and a Code Blue called. The patient expired at 8:08pm.
- Report of Autopsy Immediate Cause of Death: Acute myocardial infarct involving lateral and posterior wall of right ventricle -18-24 hours old. Also noted was severe coronary atherosclerosis with ruptured atheromatous plaque of the right coronary artery.
- Final Pathological Diagnosis within Autopsy revealed acute localized suppurative peritonitis in the vicinity of the gastrojejunal anastomosis and the gastric remnant suture line with no evidence of dehiscence.

Case #3 Litigation Information

- **Suit filed against hospital, general surgeons and group, cardiologist and group, pulmonologist and group**
- **Radiologist and group voluntarily dismissed**
- **Outcome**



What is a Consult?

1. The physician provides a specific service for the benefit of a specific patient
2. The consult is part of established procedures, protocols, or contractual obligations to be available for consultation
3. The physician is on call
4. The physician or employer was paid for the interaction
5. The physician ordered or interpreted tests
6. The physician gave medical advice regarding care
7. The physician made decisions regarding care
8. The physician is named in the medical record as having been consulted, or makes an entry in the medical record

What is an Informal, “Curbside” Consult?

Informal and brief conversation between colleagues	No compensation	No review of records
No patient contact	No written report	Not named in patient record
Not asked to confirm a diagnosis	Not asked about specific tests	*Be wary…there is potential liability for curbside consults*

Questions