



CASE REVIEW

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

Winter 2017

CASE STUDY #1

Breaches in Standard of Care Lead to Meningitis

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The plaintiff presented to the emergency room at 31 weeks gestation with complaints of lower abdominal pain. A vaginal examination showed her cervix was closed and membranes were intact. She was diagnosed with ligament stretching and discharged home. The next day, she returned to the hospital due to a positive fetal fibronectin test which indicated pre-term labor. She was admitted by the MLMIC-insured obstetrician who was on call at the time. Her cervix was 2-3 cm dilated and she had no contractions. She was given magnesium sulfate and dexamethasone to promote the lung maturity of the fetus. A group B

streptococcus culture was performed and she was given prophylactic penicillin G, until the results of the culture were known. The culture was negative, and the penicillin G was discontinued. She was discharged home after a three day stay at the hospital.

Three weeks later, the plaintiff again returned to the hospital with contractions and cervical dilation. She was initially admitted to the hospital to rule out pre-term labor but when her contractions and dilation ceased, she was discharged. However, later that same day, she returned to the hospital complaining of leaking amniotic fluid. She

was admitted under the care of the MLMIC-insured obstetrician at thirty-four weeks and three days of gestation. She was in active labor, with pre-term premature rupture of her membranes (PPROM). She was five centimeters dilated and eighty percent effaced. When she failed to progress, Pitocin was started. Several hours later, the infant plaintiff was delivered vaginally, without complications. The infant's APGAR scores were 9 and 10.

Two hours after delivery, the plaintiff mother developed a fever of 101.1 which was documented by the

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Case #1 *continued*

obstetrical resident. She was placed on antibiotics for chorioamnionitis. The delivering MLMIC physician, who was no longer on call, was never notified of her fever, nor was this information relayed to the nursery staff or to the infant's pediatrician. Twelve hours after birth, the infant plaintiff developed respiratory distress. He was worked up for sepsis and diagnosed with group B streptococcal sepsis and meningitis. He

The case was reviewed by obstetrical experts who concurred that PPRM in and of itself indicates a high risk of fetal infection. Therefore, the mother must be treated promptly with prophylactic antibiotics.

then developed seizures, hydrocephalus, and cephalomalacia. Subsequently, he was diagnosed with spastic quadriplegia, microcephaly, and had severe delays in linguistic and fine motor skills.

A lawsuit was commenced against the MLMIC-insured obstetrician as well as the hospital. The plaintiff mother alleged that because PPRM is an indication of group B streptococcal infection, prophylactic antibiotics should have been given to her at 34 weeks, despite the negative culture at 31 weeks gestation. In addition, she alleged that a cesarean section should have been performed because of the risks associated with PPRM and her infection. Finally, the plaintiff alleged

that there was a failure to timely diagnose and treat her post-partum fever and then communicate this information to both her obstetrician and the nursery staff. Although the post-partum nurse documented the fever and alerted the obstetrical resident, who started the mother on antibiotics, both failed to relay this information to plaintiff's attending obstetrician and the nursery staff. This resulted in a serious delay in treating the infant plaintiff for possible infection with group B streptococcus. Thus, by the time the infant's infection was diagnosed, he had already experienced respiratory distress, was septic, and had suffered severe neurological injuries.

The case was reviewed by obstetrical experts who concurred that PPRM in and of itself indicates a high risk of fetal infection. Therefore, the mother must be treated promptly with prophylactic antibiotics. All of these experts were very critical about the breakdown in communication between the obstetrical resident, the attending obstetrician, and the nursery staff. If the nursery staff had been promptly notified of the mother's fever, the attending pediatrician could have treated the newborn with prophylactic antibiotics, possibly avoiding the devastating outcome which resulted.

Because of the breaches in the standard of obstetrical care, together with the gravity of the injuries sustained by the infant from the group B streptococcal sepsis and meningitis, all experts recommended settlement by both the hospital and the MLMIC-insured attending obstetrician. The lawsuit was eventually settled at a cost of \$4,125,000 representing a value of \$7.1M after application of the NYS Medical Indemnity Fund.

A LEGAL & RISK MANAGEMENT PERSPECTIVE

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This case emphasizes the importance of communication between obstetrical and pediatric practitioners and departments. Unfortunately, the failure to notify the nursery/pediatric staff of a maternal infection is not an uncommon occurrence. It often leads to devastating injuries or even the death of the newborn. It is crucial that a resident at a teaching facility not only notify the attending obstetrician and nursery staff but, most importantly, document that this communication has occurred. In this case, there was no documentation that anyone was notified by either the obstetrical nursing staff or the resident.

The judgments in brain damaged infant cases can be quite substantial, particularly in certain areas of New York State. Fortunately, on March 31, 2011, the New York State Medical Indemnity Fund Law (PHL § 2999-g, h, i and j) became effective. The statutory purpose of this fund was to provide money for future healthcare costs associated with birth-related neurological injuries, with the ostensible purpose of reducing the premium costs of medical malpractice insurance.

The injuries for which the fund is applicable are defined as birth-related neurological injuries. Thus, this fund is available when a live infant is deprived of oxygen or has a mechanical injury during labor, delivery, or resuscitation resulting in an injury to the brain or spinal cord which creates a permanent



and substantial motor impairment or developmental disability.

The healthcare costs covered by the fund are quite broad. They include future costs of medical, hospital, surgical, nursing, dental, rehabilitation, custodial and medical equipment. The fund also covers necessary modifications to a home, the provision of assistive devices, or even modifications to vehicles. Finally, the fund covers prescription and non-prescription medications and other healthcare services deemed necessary by medical and other providers to meet the child's needs.

Plaintiffs qualified to apply to the fund must have had a favorable jury verdict which finds that the baby sustained a birth-related neurological injury due to medical malpractice. Additionally, if a lawsuit or claim based on such a birth-related

neurological injury as a result of medical malpractice has been settled, that individual is also considered a "qualified plaintiff."

The fund is a special account which is administered by the New York State Superintendent of Financial Services. The monies are primarily derived from all health insurers other than Medicare and Medicaid. Neither a defendant nor a defendant's malpractice insurer is obligated to pay qualifying healthcare costs to, or on behalf of, qualifying plaintiffs.

The ultimate intent of this law and the fund was to keep obstetricians and their medical malpractice insurers from bearing the costs of multimillion dollar verdicts, which were creating shortages of obstetricians across New York State, as well as satisfy the healthcare needs of neurologically impaired infants.

CASE STUDY #2

A Delay in the Diagnosis of Breast Cancer

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Lawsuits commenced against physicians in a variety of medical specialties continue to contain allegations of the failure to timely diagnose breast cancer. The most frequent targets of these lawsuits are obstetricians/gynecologists, general surgeons, radiologists, and general medical practitioners. Over the past 30 years, Medical Liability Mutual Insurance Company has paid several hundred million dollars in indemnity payments on these cases.

The impact of media attention, together with the resulting public concerns about breast cancer, seems to have influenced jurors to believe that early detection provides the best chance of survival. Arguments provided by defendants that there is no proximate cause between their care and the diagnosis of cancer are often ignored, especially when there are other weaknesses in the defense.

Frequent allegations in these lawsuits include: the failure to take a complete family and medical history; poor documentation; failure to communicate; the failure to review and follow up on abnormal test results; misread mammograms; the failure to recommend further studies; and delayed referrals.

The following case illustrates some of the problems we encounter when attempting to analyze and

defend claims of failure to diagnose breast cancer.

A 53-year-old married mother of three was a long time patient of her gynecologist, her internist, and the radiology practice where she had her annual mammograms. She had a family history of maternal breast

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and ovarian cancer. The patient was post-menopausal and taking hormonal supplementation in the form of Prempro 0.45/1.5 mg. She had yearly CA-125 levels and pelvic ultrasounds performed.

Her gynecologist ordered an annual mammogram, which was performed approximately 2 months later at the radiology practice. The computer aided detection system was utilized for the study. Digital bilateral mediolateral oblique (MLO) and craniocaudal (CC) views were

obtained and compared to her films from prior years. A mild to moderate amount of fibro-glandular tissue was seen bilaterally. She also had a nodule in her right breast which appeared to be stable. However, within the lateral aspect of her right breast, there appeared to be a developing nodule. In the radiologist's report, additional imaging was recommended for this nodule. However, by the time the mammogram was read, the patient had already left the office.

The radiologist allegedly told a staff member to contact the patient to have her return for additional imaging. A separate report would then be made of the additional views. However, the radiology practice had no documentation that any telephone calls were made or letters were sent to the patient requesting her to return for additional studies. Further, neither her gynecologist nor her internist were contacted about this finding and they never received a copy of the original mammography report containing the recommendation for additional studies.

Although the gynecologist's practice had a tickler system to follow up on whether recommended studies were completed, the staff failed to follow office procedure when no mammography report was received.



The gynecologist and his staff did not even realize that a mammography report was outstanding until the patient returned for her annual examination one year later. At that time, a staff member faxed a request to the radiology practice for a copy of the report. While the report was received that same day, the gynecologist never reviewed it. He did, however, order a CA-125 test.

When the results of that test were received, her CA-125 level was elevated at 40. Because of her family history, the patient was promptly referred to a cancer treatment center for surgical evaluation. She underwent a total abdominal hysterectomy, a bilateral salpingo-oophorectomy, and an exploratory laparotomy. Incidentally, a carcinoid tumor was found in her small bowel. It was described as a well differentiated neuroendocrine carcinoma. Fortunately, there was no evidence of uterine or ovarian cancer.

The center also obtained an updated mammogram. This mammogram demonstrated a notable increase in soft tissue fullness in the upper outer quadrant of her right breast. Additional magnified CC and MLO views, as well as a true lateral view of the right breast, were then obtained. These views revealed spiculation and

calcifications suggestive of a malignancy. The nodular distortion in the right breast measured 4.5x4.8 cm and was considerably more obvious than at the prior examination. This too was consistent with a malignancy.

A color Doppler showed no definite internal vascularity. An ultrasound evaluation of her right breast was then performed. This examination further confirmed the likely presence of a tumor. The echo pattern was very poor throughout transmission. There were rounded lobulated extensions which, in aggregate, measured 4.8 cm. A vacuum assisted ultrasound guided core biopsy was then performed.

The patient was diagnosed with poorly differentiated invasive ductal carcinoma of intermediate nuclear grade. Subsequently, she was diagnosed with stage IV breast cancer with metastasis to the liver and bone, which originated from the breast. Because she was not a candidate for surgery, she received letrozole therapy and chemotherapy.

The patient commenced a lawsuit against both the radiologist and his entity and her gynecologist and his entity. The allegations in the lawsuit included the failure to notify the patient of the need for further mammography studies, and the failure of both the gynecologist and radiolo-

gist to communicate regarding the abnormal findings seen on the initial mammogram. Finally, the patient alleged that her gynecologist negligently failed to review the radiologist's report until a year after it had been sent to his office.

Unfortunately, the defense of this case was severely compromised by the lack of both communication and documentation. Further, while there is now clear disagreement about the use of hormonal therapy for a patient with her family history, at that time, there was some support for hormonal replacement therapy for such patients. However, the experts who reviewed this case were particularly concerned that because of the delay in diagnosis, the continuous use of estrogen fueled this cancer. This made all of the other deficits in her care seem even more egregious. They opined that had the breast cancer been detected in a more timely manner, the hormonal replacement therapy could have been promptly discontinued, making this patient a candidate for a lumpectomy or mastectomy and giving her a better prognosis.

In light of these serious problems, the lawsuit was settled by both physicians and their professional entities for a combined \$1.85 million. The patient was alive at the time of the settlement. However, she subsequently died of metastatic breast cancer.

A LEGAL & RISK MANAGEMENT PERSPECTIVE

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There are several very crucial issues which clearly affected the outcome of this case. The first was the failure of the radiologist to pick up the telephone and call the gynecologist. Further, a letter should have been sent to the patient advising her of the abnormal findings and to return for further studies in plain, understandable language as required by the federal Mammography Quality Standards Act. It appears that the radiology practice either did not have a log or tickler system for follow-up studies or the staff did not use the system. They also did not have a system to contact and then document contact with referring physicians when an abnormal result was seen.

When the gynecologist's office received the mammography results a year later when the patient was present in his office, the gynecologist still did not review the test. This seems to indicate that the practice failed to follow any protocol for reviewing test results and notifying patients of those results. Further, although the gynecologist responded to the CA-125 level, he failed to confirm that the results of her last mammogram were normal.

The other issue of concern is whether a 53 year-old patient with such a strong family history of breast and ovarian cancer should have been prescribed hormone replacement therapy. Because there were very strong dissenting views about

this issue, defending such treatment would have been difficult. It was not possible to locate an expert to strongly defend this treatment. Combining this issue with the obvious lack of communication between physicians and the lack of documentation by both practices, the risk of proceeding to trial with a compliant and relatively young plaintiff with metastatic cancer would have likely resulted in an even more substantial verdict.

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CASE REVIEW

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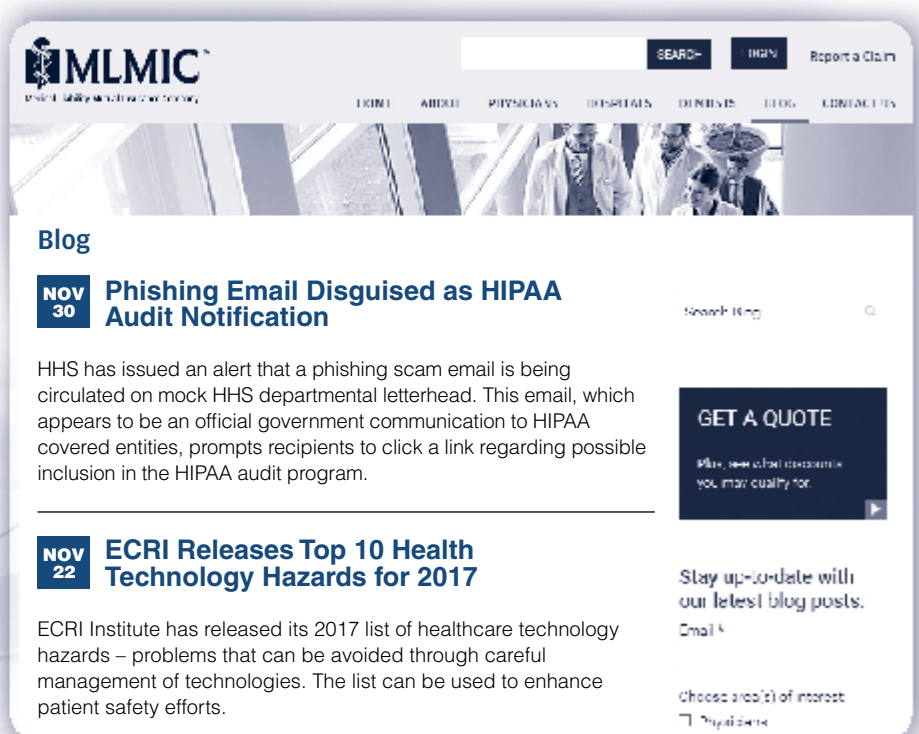
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The screenshot shows the MLMIC.com website header with navigation links: HOME, ABOUT, PHYSICIANS, HOSPITALS, DENTISTS, BLOG, and CONTACT US. The main content area features a 'Blog' section with two articles:

- NOV 30 Phishing Email Disguised as HIPAA Audit Notification**
HHS has issued an alert that a phishing scam email is being circulated on mock HHS departmental letterhead. This email, which appears to be an official government communication to HIPAA covered entities, prompts recipients to click a link regarding possible inclusion in the HIPAA audit program.
- NOV 22 ECRI Releases Top 10 Health Technology Hazards for 2017**
ECRI Institute has released its 2017 list of healthcare technology hazards – problems that can be avoided through careful management of technologies. The list can be used to enhance patient safety efforts.

On the right side of the screenshot, there is a search bar, a 'Report a Claim' button, and a 'GET A QUOTE' button with the text 'How can we help you today?'. Below the quote button, there is a sign-up form for blog updates with the text 'Stay up-to-date with our latest blog posts.' and a 'Choose area(s) of interest' dropdown menu with 'Physicians' selected.