HEALTH LAW

The "O-Ring" in Medical Malpractice Cases

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The moment is forever etched in my mind. It occurred while I was in my fourth year of medical school during a radiology rotation in Scottsdale, AZ. I was doing everything I could not to fall asleep while sitting in the dark film-reading room, listening to a tonally flat radiologist dictate plain film reports.

I got up to splash some cold water on my face and as I was walking back from my drinking fountain bath, I witnessed history. On that cold day in January (36 degrees in Florida at launch time) the Challenger spacecraft took off from Cape Canaveral, FL carrying six astronauts and one civilian school teacher.

Fifty-nine seconds into the flight, two "O-rings" failed which allowed hot gasses and flames from the booster engine to burn through the joints holding the solid rocket booster to the external fuel tank, ultimately causing an explosion and the disintegration of the Challenger.

The subsequent 12,000-page document produced by the blue ribbon panel appointed to review the disaster opened Chapter 5 of their report with this understatement; "The decision to launch the Challenger was flawed."

Engineers at Morton Thiokol, the group that designed the solid rocket motor, never tested the O-rings below 53 degrees. They warned NASA engineers repeatedly about their concerns and argued unsuccessfully to delay the launch. NASA, at the time, was under immense pressure to get the flight off and ultimately disregarded the warnings.

I use the Challenger disaster to illustrate a point common to most medical malpractice events: It is seldom one mistake or error that leads to a medical misadventure that ultimately results in a malpractice suit.

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I will use a case I recently was involved in as an attorney to further illustrate this point. At the end of the brief overview, I will review all the different medical "O-rings" which allowed the event to occur unchecked.

Case History

A health plan nurse triage line instructed a 35-year-old obese woman complaining of chest pain and shortness of breath to go to a local urgent care center for evaluation. Dutifully, the patient presented to an urgent care center located in her Eastern seaboard hometown with the complaint of a non-productive cough, URI symptoms, and chest pain with deep breath.

Upon questioning, she admitted to dyspnea on exertion and was in fact tachypneic on presentation. Her heart rate was recorded at 120 beats per minute. Her temperature, weight, and BP were not recorded. Her pulse ox was 92%. She was a smoker and on oral contraceptives; however, neither of these facts were recorded on the patient-completed medical history assessment because the pen she was given ran out of ink and the staff were in a hurry to close up for the day so they accepted the partially completed form.

Further history was not obtained.

If it had been, however, it would have revealed that the patient had just returned from Hawaii three days before her visit. The patient's brief exam was recorded as unremarkable

on a check-box sheet form. A chest x-ray was performed and read as "possible hilar infiltrate" by the second-year family practice resident moonlighting in the clinic.

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An EKG was not ordered. No blood tests were performed despite the fact that the clinic was able to perform a d-dimer (the patient's health plan refused to pay for the test). Her old history was not obtained from previous records (the patient had a family history of DVT).

The patient was diagnosed with bronchitis versus early pneumonia and was prescribed a short course of an oral antibiotic and discharged home with instructions to follow up in five- to seven days if she was not better. Her vitals were not rechecked before discharge.

Typically, the clinic called patients two days after their visit to inquire about their status. However, in this case, the second post-visit day fell on a Sunday and the weekend crew historically had not been performing these calls (they felt they were too understaffed make them).

On the third day post-visit, the patient called the clinic to report that she was coughing up mucus mixed with blood. The call was taken by a medical assistant who told her that this was normal with a diagnosis of bronchitis.

By day 4 the patient was dead. She collapsed in her kitchen in front of her children while taking her antibiotic. Cause of death was determined on autopsy to be a pulmonary embolus.

Medical O-Ring Analysis

Inappropriate triage by nurse call line: The triage may have been appropriate if the urgent care center was set up to evaluate patients with suspect pulmonary embolism. In fact, this clinic was set up to evaluate the presence of blood clots, but the plan refused to reimburse the center for the cost of the d-dimer test so it was not performed.

Misaligned health plan reimbursement: The health plan paid urgent care providers on a case-rate (flat fee) basis. The head of their contracting section stated that their "system could only handle case rates billed via a dummy code." The plan refused to pay urgent care providers on a fee-for-service basis, so providers were reluctant to order high-cost tests on the particular plan's enrollees.

Inadequate history completion by patient: The inclusion of the recent plane flight, the use of the oral contraceptive, history of smoking, or the family history of DVTs would have probably led the provider to consider the correct diagnosis.

Incomplete vital signs by staff: The patient was tachycardic and tachypneic, both of which are consistent with PE (as well as with other potential life threats). Her pulse ox was low on presentation and no effort was made to see if this was her baseline from her old records.

Failure of the clinic to utilize standing orders for specific complaints: Standing orders for selected complaints are useful for a variety of reasons, the most important of which is to ensure the patient receives the appropriate tests when the clinic's staff is busy and the provider is being pulled in multiple directions.

In this case, an EKG should have been performed, as well as the d-dimer. Even if the clinic elected to send the test out to an outside lab, they would have had the results back within two days and could have warned the patient.

Inexperience of physician staffing the clinic: Few second-year residents have the breadth of experience or have treated enough patients to have a great gut instinct. In this instance, the resident had telephone back-up available but did not want to bother the on-call physician on the weekend.

Urgent care medicine is like emergency medicine inasmuch as it is incumbent upon the provider to exclude life threats and document the reason for their exclusion.

Some of the issues with the care of this patient are inadequate history and exam, misreading the x-ray, and failure to appreciate the potential for a life-threatening illness given the patient's vitals, which ultimately led to the incorrect diagnosis and treatment.

No mechanism to have films over-read by a radiologist: The center's owners testified that having 100% of their films over-read by a radiologist was too expensive given their health plan reimbursement.

Not completing pre-discharge vital signs: I suspect that this patient's discharge vitals would have been similar to her admission vitals and would have clued the provider in to the fact that something more serious was wrong.

Inappropriate follow-up instructions: The majority of urgent

Continued on page 40

- Conduct a telephone interview. A gracious, self-confident telephone presence is important in sales and can be readily judged. Ask the candidate what questions they may have about the position after reading your materials. Minimal questions or comments are generally a negative.
- Invite final candidates for a personal interview. Send them, via e-mail, a hypothetical sales scenario and ask that they come prepared to discuss the scenario. Some candidates will be intimidated by this process and back down. Those you do interview will provide you with a tangible series of comparable skills such as preparedness, articulateness, problem-solving, and basic sales instincts.

What to Look for During the Interview

Evaluating the candidates who make it to the interview stage is just as important as the steps you've taken up to this point. Knowing *what* to look for will help illuminate *who* you are looking for:

- *The "glow"*— I often base hiring decisions more on persona than on objective qualifications. You can usually tell in a few seconds if a person has the "glow" that is vital for sales professionals. Be willing to sacrifice some technical qualifications if you can bring in such a winner.
- *A good fit for your marketplace*—I would hire a different candidate in midtown Manhattan than in Topeka. Look for the candidate who best fits your market and who would feel at home with the prototype decision-makers at local companies.
- *A sense of commitment*—Strive for minimal turnover. Scrutinize a candidate's work history. Have they moved around a lot and, if so, why? What is the likelihood they are going to stay in your city/town for a long time? Is your sales position something they really want to do or do they feel it is "just another job?"

The most useful questions are those that help you learn as much as possible about each applicant. Examples include:

- "If I asked the 10 people who know you best what your very best trait as a person, what would they say?" (Follow-up probe: "Why do you think they feel this way?")
- "If you were me and you were hiring a person for this position, what four traits would you look for in a candidate? Why?"
- "You've had the chance to review our program materials. If an employer asked you why they should use our program, what would you say?"
- "If you could use only one word to describe yourself, what would that word be?"
- "What is the most important value your parents taught you?" ■

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care patients should be advised to follow up with their PCP or back with the center in two days. This prescribed follow-up is a good insurance policy which helps to engage the patient and their PCP into the treatment plan. If the patient had followed up with either her PCP or back with the clinic, chances are good that another set of eyes would have "beamed up" to the patient's diagnosis.

Not calling selected patients back post visit: This is another means of risk mitigation. If patients are not better or are worse on the follow-up call, they should be directed to return to the center, their PCP, or the emergency department. Again, in this instance, the patient would have been referred back for additional tests and a new set of eyes.

Inappropriate information given when patient called back: Here was the final nail in the coffin. The patient called back with additional symptoms which are consistent with a PE (and other potentially serious diagnoses) and was given incorrect advice by a medical assistant who should not have been giving medical advice at all.

Disaster could have been averted and the patient's life saved at every one of the aforementioned system or personnel breakdowns.

Retrospectively, two of the staff members admitted that they felt this patient was misdiagnosed from the outset; however, when asked during their depositions why they didn't clue the physician in to the seriousness of the patient's condition, they responded that this particular physician was "very nice and kind of timid" so they did not want to step on her toes.

Marcia Bacon, commenting on the Challenger disaster, had this to say: "It is a sad fact about loyalty that it invites...single-mindedness."[1]

In this instance, the final stop-gap measure was other staff in the clinic who suspected the patient may have been seriously ill, yet they did not want to appear disloyal to the neophyte physician so they elected not to sound the warning—at the cost of the patient's demise.

Medical malpractice risk is a cost of doing business. However, it is seldom one mistake that leads to a misadventure. Protecting your patients and your practice from these compounding mistakes should be the primary goal of all center owners. ■

Reference

1. Marcia Bacon. *The Moral Status of Loyalty*. Dubuque: Kendall/Hunt Publishing, 1984.