

Closed Claim Abstract

CASE # 1

A middle-aged man saw an orthopedic surgeon for complaints of chronic shoulder pain. The orthopedist ordered an AP view and interpreted the study himself. No significant orthopedic findings were apparent, so he referred the patient to a specialist for pain management, believing that the condition was chronic pain. The pain management physician treated the patient with medication and did not pursue other diagnostic avenues. Later, the patient was diagnosed with carcinoma of the lung. A subsequent claim was made against both physicians for delay in diagnosis because the original film showed a lesion in the lung that was overlooked.

CASE # 2

The next case was brought for alleged undertreatment of pain. A female patient alleged the surgeon did not provide proper pain relief and failed to evaluate her pain for two weeks postoperatively. This patient received a settlement, as there was no documentation that the surgeon responded to the patient's complaints of pain during that two-week period.

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Pain: What You Can't See Can Hurt You

by John B. Neeld, Jr., MD

Pain that persists after healing or recovery can become a chronic condition and a distinct disease process apart from the original condition.¹ Logic would suggest that all you have to do is find the cause of pain, fix it and the pain is gone, but treatment of chronic pain is not always so intuitive. Chronic pain is both difficult to assess and to treat effectively. It may be disproportionate to the physical injury and diagnostic studies may yield inconclusive results. Primary care physicians treat most of the chronic pain cases in the United States and they often do so cautiously. Many report fear of prosecution and limited training in medical schools and residencies. Because of these factors, undertreatment of pain or mismanagement of pain has become a standard of care issue. To better help physicians in this practice, The Federation of State Medical Boards (FSMB) issued "Model Policy for the Use of Controlled Substances for the Treatment of Pain" in May 2004.²

A review of MAG Mutual closed claims to date where pain management was a contributing factor shows our most costly claims were caused by the misdiagnosis of

the source of pain. Other issues in pain management cases nationally involved narcotics therapy as a cause of addiction and patient deaths.

It is true that the more narcotics you prescribe, the greater the chance of an investigation of your practice. However, if you practice according to generally accepted guidelines, you are unlikely to trigger an investigation and should be able to defend yourself if negative allegations are raised. Risk factors that may lead to investigation include ignored warnings from pharmacists and prescribing for self or family members.³ To support your standard of high quality care, your documentation should include assessment, medication contract, the frequency of prescriptions, plan of care, rationale, success of treatment and early calls for refills. Documentation of assessment of the total patient should include level of function, pain level and activities of daily living as they relate to the progress of treatment. Always document adverse effects such as cognitive impairment, questionable behavior or noncompliant drug-use. Document your rationale especially well if the treatment falls outside the accepted guidelines.⁴

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Caring For Puncture Wounds of the Foot

By Rajnikant A. Patel, MD, Emergency Medicine

Summer is here. 'Tis the season of bare feet and casual footwear. Unfortunately, it is also the season when we see many puncture wounds to the feet. Common nails frequently cause these injuries, although other objects like glass, metal and wood should be considered. Because of the anatomy of

foreign bodies deeper into tissues of the foot. It may be necessary to remove a block of tissue down to the subcutaneous layer to permit better visualization of foreign bodies in the deeper wound. A recent American College of Emergency Physicians (ACEP) article addressed

Pseudomonas infection is usually associated with a puncture that went through a rubber-soled shoe pushing contaminants deep into the wound and may cause development of Osteomyelitis and Septic Arthritis of the foot. Cellulitis is much more common and is usually caused by *Staphylococcus aureus* and *Staphylococcus Epidermidis*. No matter the circumstances, adequate local wound care is essential, and all patients with puncture wounds should be re-evaluated in 24 to 48 hours to detect and treat early signs of infection.

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the foot and the force of the injury, the complication rate from these puncture injuries is very high, and they require thorough evaluation and treatment.

While there is no single treatment approach for all patients with plantar puncture wounds, certain considerations must be addressed. First, local wound care and evaluation of Tetanus immunization status is essential. Thorough irrigation of deep puncture wounds is difficult. Irrigating solutions may not completely drain, and injecting irrigating solution under pressure into the wound tract may actually spread infective organisms or push

coring of wounds and stated this practice has not proved beneficial, although it does make sense to remove devitalized tissue. If wound infection is present, retention of a foreign body is more likely. In such cases, proper imaging and exploration is required.

Widespread use of prophylactic antibiotics is controversial. However, the decision to use antibiotics should be based on the presenting circumstances. Wound infections free from retained foreign bodies usually respond to antibiotics. Antibiotics may be less effective in wounds containing foreign bodies and lead to gram-negative infections.

To learn more, please review the following articles:

- 1) American College of Emergency Physicians: Clinical Policy for the Initial Approach to Patients Presenting With Penetrating Extremity Trauma Annals of Emergency Medicine Volume 33. Number 5. May 1999
- 2) Fitzgerald RH, Cowan JDE. Puncture wounds of the foot. Orthop Clin North AM 1975;6:965-72
- 3) Graham BS, Gregory DW. *Pseudomonas aeruginosa* causing osteomyelitis after puncture wounds of the foot. South Med J 1984;77:1228-30 Abstract
- 4) Inaba AS, Zukin DD, Perro M. An update on the evaluation and management of plantar puncture wounds and *Pseudomonas* osteomyelitis. Pediatr Emerg Care 1992; 8:38-44
- 5) Chisholm CD, Schlessler JF: Plantar puncture wounds: Controversies and treatment recommendations. Ann Emerg Med 1989;18:1352-1357. Abstract
- 6) Schwab RA, Powers RD: Conservative therapy of plantar puncture wounds. J Emerg Med 1995;13:291-295. Abstract

Keeping Your Patients and Yourself Out of Litigious Situations

By Susan Millar, BS, RN and Cheryl Kayes, RN, BSN, CPHRM

Many claims are brought against our physicians - not because of poor medical care but because the physician's actions and documentation do not support an appropriate standard of care when there is an adverse outcome. Physicians' comments, actions or inaction before and after an unexpected or adverse outcome may pre-

vent initiation of a claim, trigger a claim, mitigate damages or negatively impact the defensibility of a medical malpractice case.

This article, on our website, focuses on risk management principles that should be a part of your practice. To read the complete article, please go to www.magmutual.com/risk.



Pain: what you can't see can hurt you*Continued from page one*

The Wisconsin Pain and Policy Studies Group provides extensive resources for the physicians who treat and manage chronic pain including: sample pain assessment tools, discussion of pain control in special populations, and scientific evidence regarding pain management interventions (www.medsch.wisc.edu/painpolicy)⁵.

The new FSMB national guidelines include specific pain management approaches and techniques. Following the guidelines will benefit quality patient care and provide support for your standard of care.

The FSMB guidelines address:

- Evaluation of the Patient
- Treatment Plan
- Informed Consent and Agreement/ Contract for Treatment
- Periodic Review
- Consultation
- Medical Records
- Compliance With Controlled Substances Laws and Regulations

These guidelines have been adopted in part or whole by many states. Please read the complete guidelines at <http://www.fsmb.org/>.⁶

[1] <http://www.mayoclinic.com/invoke.cfm?id=PN00036>

<http://www.mayoclinic.com/invoke.cfm?EC810E19-78FB-47A9-978688CAA02392A7>)

[2, 3] Wayne Guglielmo. Pain: Helping Patients—Protecting Yourself. *Medical Economics* Jun. 18, 2004;81:69.

[4] (Familypractice.com. New legalities in Pain Management Issues, The impact on Family Physicians)

[5] <http://www.medsch.wisc.edu/painpolicy/matrix.htm>.

[6] Individual state and national regulations can be accessed through links in the Wisconsin Medical School at <http://www.medsch.wisc.edu/painpolicy/matrix.htm>

CASE # 3

A young male patient with multiple health problems was treated for long-term, chronic pain. The patient died one night of a medication overdose. The case was brought against the physician for over-prescribing narcotic medications. His documentation did not support frequent reevaluation, attempts to treat with other modalities or the rationale for his prescription history. Further, the documentation did not support standard of care although he stated he had evaluated the patient at each visit.

FAQ:**Do you recommend that physicians utilize chaperones during patient exams?**

Chaperones have been utilized for many years to help avoid allegations of inappropriate exams and sexual misconduct. Patients may misinterpret a physician's actions during a physical exam as a sexual advance.

The following risk management techniques could be employed to reduce the risk of an allegation of sexual misconduct:

- Provide patient education about the various methods of examinations and details of what to expect during an examination
- Have chaperones present during an examination that might be questioned later as inappropriate. Document their presence
- Except in emergency situations, always have chaperones present during pelvic and breast exams
- Be able to recognize the patient who requires too much of the physician's attention or who makes the physician feel

uncomfortable even when sensitive examinations are not taking place

- Do not permit sexual advances by a patient. Strongly consider termination of the patient/physician relationship if they occur

The key to avoiding allegations of sexual misconduct is to recognize patient behaviors and patient-physician encounters that have the potential to be misconstrued as a violation of the professional boundary that exists between the physician and his/her patient. Even when no inappropriate behavior exists, the possibility of an allegation of sexual misconduct still exists. By implementing these recommendations, a physician can reduce the exposure to such allegations and maintain a professional relationship with his/her patients.

For more frequently asked questions, news, valuable information and articles, visit our website at www.magmutual.com.

Physician Obligation to Provide Interpreters

By David Tansill, JD

Physicians treating patients who have hearing impairments or who are limited in their proficiency with the English language may be responsible for providing interpreters for such patients in the medical office at no cost to the patients. These requirements often surprise physicians, who note that the cost of an interpreter may exceed the amount billed to the patient for the office visit. Whether a patient is entitled to an interpreter under these requirements, or whether other means of communication will be appropriate, is heavily fact-dependent.

The Americans with Disabilities Act (ADA) of 1990 has been interpreted to require physicians to provide effective means of communication to their hearing-impaired patients through auxiliary aids and services, including not only interpreters, but also notes, other written materials and telecommunications devices. The physician may not impose a surcharge on the hearing-impaired patient for the provision of such auxiliary aids and services. The physician should consult with the patient to determine the most appropriate mode of communication under the circumstances, whether that means hiring a live interpreter or relying on written notes, but the final choice of appropriate alternatives rests with the physician.

According to the U.S. Department of Health & Human Services (HHS), Limited English Proficient (LEP) persons, or those who do not speak English as their primary language, are entitled to language

assistance services from certain physicians and other healthcare providers who receive federal funds (enrollment in Medicare Part B alone will not trigger a compliance obligation). Guidance issued recently by HHS makes clear that a physician's obligations in this regard are highly dependent on factors such as the volume of LEP patients the physician is likely to treat and emphasizes that no one-size-fits-all strategy applies. For example, the language services required of a small-town physician where virtually none of the population speaks a language other than English would be different from a physician in a county that is heavily populated by immigrants who speak little or no English. Similarly, language services required to be employed by a solo family physician in a metropolitan area may be different from those required of a large, multi-specialty clinic in the same area.

After applying the LEP analysis contained in the HHS Guidance, some physicians may determine that they do, in fact, have an obligation to provide an interpreter at no charge for their LEP patients, while others may determine that they are not required to develop a LEP language assistance plan. Physicians would be prudent to develop policies and procedures within their practices to effectively deal with requests for interpretation services before such requests arise. For more detailed information on this subject, please see www.magmutual.com/risk.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment. This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion. ©2004 MAG Mutual Insurance Company



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