Unexpected Outcome: Risk of the Procedure or Negligence?

By William "Mike" J. Johnson, JD

It has been said that the bone that separates the brain from the ethmoid sinus cavity is as thin as a potato chip. In this case the plaintiff had an ongoing and worsening sinus condition and elected to undergo sinuplasty. Since the ethmoid bone was more deteriorated than expected, our insured otorhinolaryngologist (ENT) had to remove or clean out the infected areas to a greater extent than planned. The ethmoid bone was described as “spongy”. After debriding the ethmoid cavity, the ENT noticed some dural dehiscence which he patched with a flap from the middle turbinate. The plaintiff appeared to tolerate the procedure well and regained consciousness but suddenly became unresponsive. The ENT ordered an emergency CT scan which revealed an intraparenchymal hematoma. The plaintiff was life-flighted to another hospital and underwent an emergency craniotomy in which the neurosurgeon evacuated a hematoma from the left frontal lobe, cauterized a bleeding branch of the anterior cerebral artery and repaired two small dural defects. This procedure went well, and the plaintiff went to recovery in critical but stable condition. While the plaintiff initially experienced confusion

and an altered mental state, a later CT showed significant improvement.

In the lawsuit that followed, the plaintiff alleged that the ENT penetrated his brain with either an instrument or caused the ethmoid bone to penetrate the brain. According to the plaintiff, penetration of the brain by either the ethmoid sinus bone or by an instrument was not a recognized risk of the procedure and was evidence of negligence by the ENT. The plaintiff maintained he suffered permanent and severe cognitive dysfunction.

Our ENT was adamant that he did not penetrate the plaintiff's brain with either an instrument or bone fragment. He characterized the ethmoid bone as so riddled with infection that debridement was the only proper way to treat the infection. The defense took the position that intracranial hemorrhage is a rare, but recognized risk of an ethmoidectomy. Counsel intended to prove that the cerebral artery was not lacerated by an instrument but was cut when the ENT was repairing the dural defect with a skin flap which contained a small piece of bone. This method of repair, the defense asserted, was appropriate. Further, if there was a cerebrospinal fluid leak after the surgery, it is not evidence of negligence by the ENT surgeon, but instead resulted from an ethmoid sinus bone that was so severely infected and deteriorated that it could not withstand the procedure.

Roadmap to Success

This case illustrates how early decisions, thorough preparation, commitment by the physician to defend his care, and good judgment calls can bring success in litigation. Very importantly, the ENT recognized the complication during the surgery and repaired the area in question. Then, when the patient's condition declined, a CT was emergently obtained showing the hemorrhage, and the patient was life-flighted to a facility where an emergency craniotomy was performed. The physician took emergent and appropriate action in handling the complication from the outset. These actions were not only lifesaving, but they helped minimize the patient's injuries as much as possible. Even though the patient's prognosis initially did not seem encouraging, he eventually made a very good recovery, and while he alleged that he was greatly compromised, other factors were identified that could be responsible for his complaints.

Defense counsel assembled an impressive lineup of experts. Four ENT surgeons including the defendant were prepared to testify for the defense. Their opinions included that the procedure was medically indicated for chronic and unresolved sinusitis and that the efficacy of ethmoidectomy for the treatment of this condition is recognized. There was good documentation that the defendant physician informed the patient of a variety of risks accompanying the procedure including the risk of bleeding, the possibility of additional surgeries and even death and obtained the patient's informed consent to move forward with the surgery. The defendant physician responded appropriately to the dural dehiscence during the surgery and the repair with a flap from the middle turbinate was appropriate. Further, the ENT took all necessary measures in responding to the patient's sudden decline following the ethmoidectomy. An injury to the dura occurred during the surgery, but injury to the dura during ethmoidectomy is a recognized risk as are

complications that can result from injury to the dura including intracranial hemorrhage. During an ethmoidectomy, it is necessary to remove small pieces of bone with the endoscope and removal of this bone can result in small defects in the dura which produce cerebrospinal fluid leaks. Contrary to the opinion of the plaintiff's experts, an injury such as this does not indicate the defendant ENT was negligent. Intracranial hemorrhage from ethmoidectomy is not a routine risk but it is a risk that is recognized in medical literature. One of the plaintiff's ENT experts asserted that the defendant ENT penetrated the patient's brain with an instrument, and opined that he saw necrotic brain tissue. In contrast, the defense had an ENT expert available to opine that the brain was not penetrated with an instrument and that what was seen was more likely inflamed dura that was healing.

A neurosurgeon expert for the defense was prepared to testify that the intracerebral hematoma resulted from the compromise of the cerebral artery following the repair of the dural dehiscence and despite the cerebral artery injury, the defendant's repair was appropriate. Violation of the dura, including an intracerebral hematoma, is a known risk of an ethmoidectomy. He refuted the plaintiff's experts that the laceration to the cerebral artery was caused by an instrument or that the defendant injured the patient's brain with the endoscope. A neuroradiologist for the defense opined that nothing on the CT or MRI following the ethmoidectomy showed that the brain was directly penetrated or damaged by an instrument or that the brain appeared to be "chewed up."

Preparation and training by the defendant physician gave him the stamina to face the rigors of trial. The defendant testified for one full day and half of the next. He not only survived this grueling challenge but did well. Stamina also became very important as the trial that was forecasted to last five days lasted nine. Throughout the entire litigation process, the physician remained resolute and insisted on having his "day in court."

Even with extensive planning, defense counsel must make judgment calls because of the unique situations that develop during trials, and react to situations, opportunities and events that are not foreseeable. They also must make judgments on how they think the jury is receiving the evidence and when the jury has heard "enough" evidence. Here, one expert testified all day and connected with the jury so strongly, the defense decided not to put on one of its other ENT experts. The defense felt like the jury "got it" and putting on the other expert would be counterproductive. In another instance, evidence presented by the plaintiff was admitted that the defense strongly believed should not have been admitted. Counsel and the defendant weighed their options. In their favor, they felt they had a good jury and their proof was going in well. The question arose: should they seek a mistrial or see the case through to the verdict? After careful consideration by the defendant and his defense attorney they decided to "take their chances" and continue with the trial. The choice was a good one. After nine days of trial, the jury returned a defense verdict in one and one-half hours. The plaintiff did not appeal the verdict, and our ENT was naturally very happy with the outcome.

Time Is Everything

By Elizabeth Woodcock, MBA, FACMPE, CPC

The most precious asset of a medical practice is *your provider's time.* The provider's time represents a non-inventoriable resource, and it's critical to make the most of it. Yet most providers struggle with efficiently moving through the day, often left with significant piles of work at day's end. The electronic world has made these "piles" even more hefty than the physical stacks of work that historically adorned desks. Consider embracing an efficiency tip:

Cautiously leverage your "free" employee (the patient). Encourage patients to participate in their own care, ideally collecting data directly from them. This may include, but not be limited to, past family social history, history of present illness, and current medications. Engage your care team in connecting with patients to determine and document other essential elements, including vitals. Encourage your care team to think of an outpatient encounter like an operating room – the patient should be prepped and ready for the provider when they "scrub" into the exam room.

Perform a morning huddle and an afternoon sweep. Both are brief touch-base

meetings to prepare for the day – and the next. Incorporate a two-minute debrief on what didn't go so well that day, reflecting on mistakes or challenges, gathering suggestion(s) from the whole team. Preparing for the day – and encouraging improvement – are the best long-term investments a practice can make to boost efficiency.

***Tame the inbox*.** The volume of messages has surged in recent years, adding to the challenges related to provider burnout. Train care teams and provide appropriate protocols and guidance that will allow them to scrub messages before they hit a provider's inbox. Messages should be considered a care team responsibility, not a personal message to the provider. Via EHR system settings, establish a minimum-allowed character for messages, auto-sunset messages over a certain age, and carefully purge "thank you" responses. Establish accountability for every inbox, including monitoring the message turnaround time by staff member.

***Manage prescriptions*.** Recognize the symbiotic nature of medications and your collective practice efforts. When medications run out, action is required. Therefore, consider a standard refill reminder for practice staff to proactively schedule patients before renewals are due. Synchronize routine medications on a single annual (or quarterly, as clinically appropriate) visit.

***Route normal test results*.** Unless a provider chooses otherwise, send normal test results directly to the patient portal for patients who are confirmed to use the portal. For those who haven't been verified as portal users, normal results should be mailed. Arrange for pre-visit tests (and address other pertinent care gaps) that can be anticipated, reviewing results during the encounter.

***Pre-visit planning*.** Instruct your care teams to review patients' charts in advance of the visit; consider a checklist based on the provider's expectations. For example, the team may review for any intra-visit messages, referrals that were placed, and the results of testing that was ordered.

***Evaluate your staff's responsibilities*.** The role of the office-based medical assistant has evolved into a multi-faceted position streamlining the flow of information between patient and providers, who need to respond proactively. Consider role-playing the following scenarios: message-taking, working through conflict within a team, collecting medications, and managing a refill, referral, or test result. The mock trial need not be perfect, but it's important to recognize that the role of the care team is changing. Delegate, delegate, delegate!

Mastering the art of working intelligently can enhance the practice's efficiency, but it takes effort. Leaning into time management may be the most important investment a provider make into a medical practice.

Risk Matters - Physicians Treating Oneself and Family

By Jeffrey A. Woods, JD

A recent article in the in the Tennessee Medical Association Legal News was entitled, "*Featured Legal News: Medical Licensing boards seeking to "make an example" out of prescribing to self/family*."[1] The article identifies three physicians who had reported investigations or formal charges brought against them by the medical licensing boards for prescribing to self/family members. One physician reported to the TMA, according to the article, that the licensing board's medical consultant "wanted to make an example" out of the prescriber. This information is consistent with reports SVMIC has received from its policyholders concerning recent board investigations in several states. Accordingly, we thought this might be a good time to revisit the ethical rules relating to the treatment of self/family.

Driven by their training, expertise, and emotional connection, it is natural for a physician to feel compelled to provide care to a family member. It can also be driven by the belief that no other provider can deliver the level of care that they can provide or by pressure from a

family member who doesn't have the time to be seen by another provider or may not have insurance to cover the visit. Similarly, physicians who treat themselves often do so because of a perceived lack of time to be seen by a colleague. Regardless of the reason(s), both situations raise ethical issues that must be considered.

One of the primary concerns surrounding self-treatment and treatment of family members is the inherent conflict of interest. A physician's judgement may be clouded by personal emotions or familial relationships, potentially compromising objectivity and quality of care delivered and leading to decisions influenced by personal biases rather than strictly clinical considerations.

Patient autonomy, the principle that individuals have the right to make informed decisions about their own medical care, is another critical factor. When a physician treats family, the autonomy of the patient can be compromised because the patient may feel pressured to accept the physician's recommendations due to the inherent power dynamics and personal relationships involved. Additionally, the patient may be reluctant to provide the physician family member with sensitive or embarrassing information while at the same time, the physician may be reluctant to perform sensitive or intimate exams or ask embarrassing questions. Both can lead to inaccurate diagnosis/treatment.

Central to the practice of medicine is the expectation of professionalism and accountability. Physicians are held to high standards of ethical conduct, including putting the patient's best interests above their own. Treating oneself or a family member challenges these principles, raising concerns about whether the physician can maintain the same level of detached, objective care that is expected in professional settings. Similarly, in treating oneself or family, physicians are more likely to treat or prescribe outside their normal area of practice, specialty, and/or training. Whereas, in treating unrelated patients in a normal setting, the physician would recognize the need to "stay in their own lane" and refer the patient to another physician.

To address these complexities, professional governing bodies have developed guidelines to provide clarity on the issue. For instance, the American Medical Association (AMA) states, "In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances…" such as short-term, minor problems or emergency situations. Ongoing care or complex treatments should involve another qualified physician as soon as one is available.[2] Many state boards have adopted the AMA Code of Ethics (Op. 1.2.1).

State licensing boards also have formal policies addressing self and family member prescribing. For example, in Tennessee, both the State Board of Medical Examiners[3] and the Board of Osteopathic Examination[4] have adopted formal policies which provide the following language:

Self-Prescribing

1) A physician cannot have a bona fide doctor/patient relationship with

oneself. Therefore, except in emergency situations, a physician shall not prescribe, dispense, administer, or otherwise treat oneself.

2) Prescribing, providing, or administering of any scheduled drug to oneself is prohibited.

Immediate Family

1) Treatment of immediate family members should be reserved only for minor, self-limited illnesses or emergency situations.

2) No scheduled drugs should be dispensed or prescribed except in emergency situations.

Some state legislatures have proposed laws to codify the prohibition against prescribing scheduled drugs to oneself or family members except in acute, emergency situations.[5]

It is important to note that in the AMA Code of Ethics as well as the Policy statements of the state boards identified above, it is mandatory that proper records/documentation of the treatment or care be maintained and provided to the patient's primary care physician on a timely basis even if the patient was only seen for emergency care or for short-term, minor problems. As the TMA article notes, the technical "gotcha" violation for physicians is the failure to keep medical records on family member patients.[6]

The primary area of focus currently, at least in Tennessee, relates to prescribing to oneself or family members. State licensing boards are sometimes notified by pharmacists when a prescription is presented to be filled which indicates a familial relationship between the patient and prescriber. The TMA article states, "At this time, the TMA legal department cautions physicians NOT to prescribe medications to immediate family members for minor, self-limited, short duration illnesses; only for emergencies, and to keep a medical record on the encounter." At SVMIC, we believe this to be a sound recommendation that should be followed not only by our Tennessee policyholders, but those who practice in other states as well.

Should you have any questions or concerns relating to this article, please contact an SVMIC Claims Attorney or a member of the Risk and Practice Management Department by emailing us at ContactSVMIC@svmic.com or calling us at 800-342-2238.

[1] TMA News May 21, 2024. https://www.tnmed.org/news/what-you-need-to-know-about-the-medical-licensing-boards-seeking-to-make-an-example-out-of-prescribing-to-self-family/

[2] AMA Code of Ethics 1.2.1. https://code-medical-ethics.ama-assn.org/ethics-opinions/treating-self-or-family

[3] Policy Statement Tennessee State Board of Medical Examiners (*revised* May 24, 2017). https://www.tn.gov/content/dam/tn/health/healthprofboards/medicalexaminers/Self_Prescribing_Policy.pdf

[4] Policy Statement Tennessee Board of Osteopathic Examination (*adopted* March 2, 2022). https://www.tn.gov/content/dam/tn/health/healthprofboards/osteo/Prescribing_for_oneself_and_one's_family.pdf

[5] Tennessee HB2907 – a proposed bill that has not yet passed. The latest tracking update dated April 1, 2024, lists the bill as "held on desk."

[6] A component of proposed Tennessee HB2907 (referenced in previous footnote) is the requirement that a physician shall maintain records of all treatment provided under that section.
