CASE #1

Clinic policy comes under fire

A young girl treated for flulike symptoms fails to improve. When her parents call the clinic, they are not encouraged to return.

IMAGE SOURCE / ALAMY

Ms. L is 35 years old and a recent graduate of a nurse practitioner program. She found her first job in a multiphysician pediatric group near her childhood home. Things went smoothly during her first two years at the clinic. Ms. L enjoyed her work and the community she served. She had the unique experience of looking after the children of lifelong friends, and this made her job all the more satisfying. But one particularly tragic case dampened her enthusiasm over a two-year period and haunted her for years afterward.

The patient was a young girl who was first seen by Ms. L with a 24-hour history of fever, vomiting, and diarrhea. Ms. L examined the child and found her to be fussy and febrile but adequately hydrated and alert. Having seen some very sick children during her training, Ms. L was well aware of what to look for. She felt confident in advising the parents to take the child home with a sheet of printed instructions regarding hydration, fever control, and monitoring of her temperature, as well as instructions to return to the clinic if she did not improve in 24 hours. Ms. L entered her provisional diagnosis of "viral syndrome" in the chart.

The pediatrician also observed a rash over the girl's chest and back, and he started her on antibiotics. Twenty-four hours later, however, her condition had worsened.

On the second day, the parents called the clinic, noting continued fever, vomiting, diarrhea, and increasing lethargy. A nurse took the call and, according to the parents' later testimony, discouraged the girl's parents from bringing her back to the clinic. They called again the next evening just before the clinic was due to close for the weekend and stated that the patient was doing worse and seemed more lethargic. The nurse informed them that they should take the child to the clinic's other office, which was roughly the same distance away on the other side of town. At that visit, the girl was seen by the pediatrician on call, whose chart notes recorded a one-day history of vomiting, diarrhea, and fever (a discrepancy that would surface in the lawsuit that followed). The pediatrician also observed a rash over the girl's chest and back and started her on antibiotics. He discharged her with instructions to follow up in one week.

Cases presented are composites of actual occurrences. Names of participants and details have been changed. Cases are informational only; no legal advice is intended. Persons pictured are not the actual individuals mentioned in the article.

Twenty-four hours later, the patient was more lethargic, had high fever, and was difficult to rouse. The parents rushed the little girl to the local ER, where she was diagnosed with "sepsis, origin unknown." She was admitted to the ICU but died the following day. The family was devastated and quickly sought the advice of a plaintiff lawyer.

Ms. L received notice of a malpractice lawsuit after a particularly stressful week at work. With a heavy heart, she gave a copy of the documents to her supervising physician, who received a similar notification the next morning. Reading the notices together, they learned that the plaintiff was claiming pain and suffering for the 24-hour period during which the child had the "preventable sepsis" and "loss of companionship and services" on behalf of the parents. The physician forwarded the papers to the insurance company, which assigned a lawyer to the case.

After a slow start, requests for documents and charts were submitted, followed by answers to written questions. Depositions were not taken until nearly a year later. The patient's mother began by testifying that when she feared the child was not improving on the second day, she called the clinic as instructed but was discouraged from coming in for an examination. The plaintiff-expert pediatrician claimed that the child should have been followed more closely after the mother's phone call. Furthermore, the physician at the second visit (in the clinic across town) should have recognized that the presence of a rash indicated "a dangerous infection."

A few days later, Ms. L was in her defense lawyer's office being sworn in by the court reporter and describing what she had found at the patient's first clinic visit. Fortunately, she had kept adequate notes and was able to reconstruct her findings in fair detail. After four hours of meandering questions, the plaintiff lawyer finally addressed the clinic's callback policy. Ms. L testified that there was no ironclad protocol. Patients who were not doing well after two days were asked to come back to the clinic to be re-examined. This subject invigorated the plaintiff lawyer. The deposition finally ended two hours later.

After all the depositions were completed, the insurance company claims adjuster and the defense lawyer got together to review the evidence presented. Based on the plaintiff's high sympathy value and the plaintiff-friendly jurisdiction, they decided to make a settlement offer despite the case's medical weaknesses. They noted that Ms. L was a strong and organized witness who projected herself as a caring, competent, and compassionate provider. She was "money left on the table," the adjuster said, referring to the reduced value of the lawsuit because of Ms. L's strong performance. After considerable negotiation, the case was settled for $225,000.

Legal background

All cases are supposed to be decided under the same standard of law by an impartial jury. In reality, standards vary widely, depending on the beliefs and biases of each local community. This variation is reflected by the makeup of the juries. Sympathy, prejudice, and political leanings also play a major role in jury decisions. Providers have a built-in credibility and, unless they show themselves unworthy, are given the jury's trust with regard to what was said by whom. Ms. L deserves a large part of the credit for the relatively modest settlement in this case. Her detailed knowledge of the patient and her unflappable grace under pressure helped convince the plaintiff lawyer that she would be a formidable defense witness.

There are nearly as many different types of damage claims as there are plaintiff lawyers. The plaintiff lawyer in this case creatively claimed pain and suffering for the child during the 24-hour period before her death. His claim for loss of the child's "services" on behalf of the parents covered a wide variety of activities, including emotional and financial support in their old age.

Callback and return-to-clinic policies are valuable risk-management strategies that should be designed carefully to ensure workability and applicability.

Risk-management principles

The plaintiff lawyer expressed a great deal of interest in the clinic's callback policy and was prepared to argue that the providers had violated it. Callback and return-to-clinic policies are valuable risk-management strategies that should be designed carefully by the providers to ensure workability and applicability to the types of cases seen in that practice. Once designed and implemented, these policies should be followed conscientiously to negate the assertion that a patient was "discouraged" from returning to clinic.

In her deposition, Ms. L was able to give a competent defense of her actions. Her testimony relied on adequate medical notes taken at the time of the visit and use of these to reconstruct the events. Although documentation can be a chore, it remains the basis for effective risk management. Forcing clinicians to justify their decisions on paper can also lead to improved decision-making.