Avoiding the Pitfalls of "Half-visits"

David M. Lang, Esq

David M. Lang is an attorney practicing medical malpractice defense with Pollara Law Group in Sacramento, California.

A 3-and-a-half-year-old girl presented to a pediatrician's office with complaints of vomiting and high fever (103.3°). She was seen by a nurse practitioner, who diagnosed gastroenteritis, prescribed fluid replacement and acetaminophen, and sent the child home.

The NP did not chart the child's blood pressure, pulse, or respiratory rate. She did note swollen lymph nodes and absence of diarrhea. The NP performed a flu screen but did not order a rapid strep test or urinalysis.

Several hours later, the child was taken to the emergency department with shortness of breath, cough, congestion, tachycardia, hypoxia, dehydration, and lethargy. She was admitted to the pediatric ICU with diagnoses of pneumonia, acute respiratory distress, hypoxemia, neutropenia, and sepsis. She was given IV antibiotics.

Several hours later, the decision was made to transfer the patient to a regional medical center. During transfer, she suffered cardiopulmonary arrest while being placed on a ventilator for transport. Upon arrival at the hospital, she arrested again and required resuscitation for several hours until spontaneous circulation could not be restored.

An autopsy concluded the child died of sepsis and shock from Group A beta-hemolytic streptococcal infection.

It was argued that the NP failed to diagnose and treat streptococcal toxic shock syndrome at the time of the child's presentation. In support of this contention, it was argued that the NP had failed to perform basic follow-up when the child's flu test came back negative and that the child's swollen lymph nodes and lack of diarrhea both mitigated against the NP's diagnosis of gastroenteritis.

VERDICT

The parties in this case reached a $950,000 settlement.

DISCUSSION

Every headache and fever could be an early meningitis, every vague abdominal pain an early appendicitis. So how do we handle innocuous-appearing cases with early, nonspecific symptoms of a very serious illness about to unfold?

We must start by following the Miyagi rule. In *The Karate Kid*, Mr. Miyagi advised that walking on the left or the right side of the road was safe, but walking in the middle would result, sooner or later, in "*squish*, just like grape." Although he related this premise to karate, we can also apply it to medicine: See a patient or do not see a patient; but if you see a patient "so-so," you will be squished—by the patient, by a plaintiff's attorney, and/or by your state's medical board.

A case such as this one strikes fear in the heart of anyone who has seen patients in an ambulatory setting. The initial presentation was modest: a toddler with vomiting and fever. We do not know what the other vital signs were, and we do not know whether the child appeared toxic. The lack of vital signs or *recorded* vital signs represent half-measures. The patient's vitals could have been normal, and the NP's actions could have been fully defensible. The problem is, we don't know—and the clinician is on the hook.

All patients require vital signs. They must be done; they must be complete, and they must be recorded. At a minimum, temperature, blood pressure, respiratory rate, and (generally) O_2 saturation are required. Some specialties may have other requirements (eg, fingerstick glucose for patients with diabetes, visual acuity testing for those with eye complaints). A full list of data you should be obtaining is practice specific and beyond the scope of this article; the point is, decide on the relevant set of vitals and intake data and be sure it is recorded at every visit.

continued on page 13 >>

>> continued from page 8

Failure to obtain and record vital signs—as seen in this case—is sloppy practice, difficult to defend, and sets up an inference of negligence. Even when the care is perfect (and without bad outcome), if the medical board reviews the record for any reason, you will be sanctioned for "failure to keep adequate and accurate medical records" and your license burdened. Here, we are told the defendant NP "did not chart the child's blood pressure, pulse, or respiratory rate." I am willing to bet the NP was not responsible for charting the values in the normal course of practice, but see how responsibility is parked with the clinician? If intake staff do not record vital signs, politely (yet firmly) insist they do so.

Furthermore, the disposition of many child visits turns on whether the patient "appeared toxic." Any child's condition could worsen after evaluation—and in litigation, parents, friends, and family will testify the patient was extremely ill, they "knew something was wrong," and the clinician ignored their loved one. Thus, the jury will be invited to reconstruct how the child appeared.

When assessing children and the question of "toxic appearance" arises, don't state a conclusion—paint a picture. Don't merely state "child appeared nontoxic." Use your powers of observation to record *why* they appear nontoxic: "Child sitting up, watching *Moana* on parent's phone, smiling and laughing appropriately." Get interactive; some pediatric providers carry a small vial of bubbles with them and record the child's response to bubble-making ("Child appropriately reaching for bubbles, smiling, holding one on finger"). The cost is less than $1 for the bubbles, plus the documentation time. The benefit is that it paints a clear picture for the jury of a child responding appropriately. And if your observations suggest a child who is at least unwell—if the movie is poorly received or the bubbles prompt the child to scream or bury her face in her mom's shoulder—you can consider oral antipyretics/analgesics, fluid, and reobservation.

Another way to create a strong and defensible record is to use patient quotations. These can be extremely helpful to your defense in a malpractice action; as an attorney, I have searched 8,000 pages of records in a medical malpractice case, hoping to find a clear description from a human (not a template) of how a patient looked. Make it clear by adding patient remarks to the chart—just remember that "the only thing that belongs in quotes is what comes out of the patient's mouth." Words from an 8-year-old boy—such as "My brother found a legendary scar [a reference to *Fortnite*] and almost won"—may seem silly, but this documentation itself could win your case.

With teenagers, you may have to ask more questions to glean something suitable; you could ask a 13-year-old her favorite sport and when her one-word answer is "Lacrosse," ask why. Even if the response is "Because, I don't know, it's exciting. There are a lot of goals," write that down exactly (along with any other observations, such as *Teen texting on her phone*). These notations tell the plaintiff's attorney, the judge, and the jury that the patient was behaving normally and interacting with the environment. Should this teen later deteriorate with meningitis, the plaintiff will claim she was toxic in the office. The medical record, however, will show that the patient's condition changed, and it was a departure from how she looked in your office.

Also, it never hurts to get backup. In any close call, ask the nurse to reevaluate the patient as to whether he or she is "toxic appearing" or is interacting normally with the environment. Have the nurse or medical assistant record facts, such as "patient trying to make a plane out of two tongue depressors, pretending to land it on sister's leg." This will create a strong and defensible record: two clinicians relaying two sets of detailed observations.

Likewise, encourage intake staff to document what they *see* rather than what they *conclude* from it. Buzzwords (eg, listless, lethargic) should be avoided. If such characterizations find their way into the record, you must take active steps to address them. Either agree with the characterization and perform appropriate work-up, or establish

why you do not agree using the methods described (detailed description, verification by another clinician).

Taking these steps will help to protect you in the event of a changing clinical course. But also be wary of those predictable circumstances that lead you into Mr. Miyagi's middle of the road (what I call "half-visits"): a quick look at a sibling in the room during a patient's appointment; a "curbside consult" on the medical assistant's child; the neighborhood acquaintance who asks you to "just take a look." Why are these dangerous? Because they remove the clinician from his or her usual routine: proper examination on a properly undressed patient, formal assessment of vital signs, and review of relevant history in the chart, among other things. (In this way, phone and email communications with patients require similar caution.) Skipping the routine leads to shortcuts, and shortcuts lead to bad medicine. And if that doesn't worry you, remember: All these scenarios create a full legal duty and clinician/patient relationship—making them potential pathways to misdiagnosis and eventual loss of license.

IN SUMMARY

Don't be party to a "half-visit"; insist on full vital signs and a complete visit following your usual routine. Use observational powers and patient quotations to paint a picture of how a patient looked, get backup from another clinician with similar observations. If you can't document a reassuring record, protect the patient and make the required intervention. **CR**