CASE OF THE QUARTER:
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The "Case of the Quarter" column is a sample case study that highlights best practices in actual scenarios encountered through PRMS' extensive experience in litigation and claims management. Specific names and references have been altered to protect clients' interests. This discussion is for informational and education purposes only and should not be relied upon as legal advice.

FACTS:

Dr. Jane Smith treated 19-year-old John Doe for bipolar disorder from January 2014 to November 2015. John's prior physician had prescribed 1mg daily of Risperdal which he was still taking when Dr. Smith began treating him. Dr. Smith continued to prescribe Risperdal and added Ativan to address John's anxiety. John's condition improved. In September 2015, John presented with his neck bowed down to his right shoulder and turned inward somewhat. John also reported a tremor causing pain in his back. He reported that the problem had started five weeks prior to the visit. Dr. Smith's exam revealed tight muscles on the left side, but no spasms. She noted that John was on a low dose of Risperdal and that adverse reactions typically occur earlier in treatment. Dr. Smith discontinued the Risperdal, started John on Cogentin, and discussed a potential referral to a neurologist. Dr. Smith asked John to return in two weeks, but John did not return. John was subsequently diagnosed with Tardive Dystonia ("TD") after a genetic cause for the dystonia was ruled out.

ALLEGATIONS:

John Doe alleged that Dr. Smith failed to inform him that TD was a potential side effect of Risperdal; thus, she failed to obtain informed consent. He also alleged that Dr. Smith was negligent in prescribing Risperdal for an extended period of time without monitoring for abnormal movements. John alleged that Dr. Smith's negligence caused the TD leaving him with permanent injuries. The state where Dr. Smith practiced had a statute setting forth the procedure for obtaining informed consent, so John also alleged negligence per se for Dr. Smith's failure to follow the statute.

DEFENSES:

Defense experts stated that the prescribing of Risperdal for John's bipolar disorder was within the standard of care, but they were concerned that Dr. Smith failed to document Abnormal Involuntary Movement Scale ("AIMS") evaluations. Dr. Smith was expected to testify that she performed an AIMS evaluation at each visit, but only documented such when there were positive findings. Another issue was that Dr. Smith did not document the informed consent process. The defense is that John came to her on Risperdal and that it was her custom and practice to go through informed consent despite the fact she didn't document having done so. Defense experts noted that TD generally results in permanent impairment without use of treatment to reverse the side effects such as Botox. The defense to John's damage claim was that he did not avail himself of all treatment options available to improve his condition.

LIABILITY ANALYSIS:

Dr. Smith's discontinuance of the Risperdal at the first signs of a movement disorder made the case very defensible. However, the lack of documentation of AIMS evaluations would allow John to argue that TD symptoms arose sooner than the last visit and were missed. The case was settled.

TAKE AWAY:

Documentation of your care is crucial to a solid defense. Document your informed consent process highlighting the serious adverse reactions discussed. Consistently document your surveillance for movement disorders in patients taking antipsychotics. Proper use of the AIMS scale can be used to support your defense in this regard.

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