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Health Law
The Importance of Standard of Care and Documentation
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On first glance, the case of *Conner v Ofreneo* might not seem that compelling. The alleged infractions took place in Chicago, Illinois, and litigation never went beyond the Illinois Appellate court. But if one looks beyond its regional nature and lack of precedent setting, aspects of this trial are important and interesting, especially for physicians. The case was settled in favor of the defendant, Dr Danilo Ofreneo, during the original jury trial. The decision was later affirmed by the appellate court. Yet the case should serve as a warning to all physicians: adherence to practice standards of care and documentation are essential and should not be compromised without good reason.

On February 5, 1980, Deborah Conner took her daughter, Karla (whose age is never disclosed in the appeals court's opinion), to Chicago's Uptown Clinic. Karla had been experiencing excessive thirst, slurred speech, abdominal pain, rapid weight loss, and significant bladder activity [1]. At the clinic, the Conners met with Dr Danilo Ofreneo who spent 15-20 minutes with Karla, during which time she was unresponsive to his questions. Dr Ofreneo did not document any medical history or record any allergies or immunizations; he stated during his testimony that Karla's history was within “normal limits” [1]. Unsure of a definitive diagnosis, Dr Ofreneo ordered blood tests and several x-rays. After the tests were completed he told Ms Conner to call him if anything new developed and to check with the office in about 3 days for the test results. Dr Ofreneo conceded to the court that he did not tell the Conners when to return to the office [1]. Concerned about Karla's worsening condition, Ms Conner took her to Children's Memorial Hospital later that same day where she was examined and had tests run by the hospital staff. It was found that her glucose level was 1126 (compared to the normal level of 126), and she was diagnosed with dehydration, poor circulation of blood to the brain, severe metabolic acidosis, and complications of diabetic ketoacidosis (DKA) [1]. The ketone levels of her urine and her dehydration were discovered when the treating doctor learned by taking Karla's history of her rapid weight loss, increased sleeping, and intense drinking and ran tests to uncover an explanation for these symptoms [1]. Karla was treated for dehydration, acidosis, and high ketone levels [1]. Treating the dehydration and DKA simultaneously was complicated, and the procedures to correct both were high risk. Karla experienced heart failure during the treatment phase and later died. The official cause of her death was listed as cardiorespiratory arrest that caused irreversible brain damage [1]. Following the death of her daughter, Deborah Conner sued Dr Ofreneo for medical malpractice and Children's Memorial Hospital, with whom she settled out of court.

This case is important for 2 reasons. First, it brings attention to the role of standard of care. Standard of care can be defined as "…not a guideline or list of options; instead, it is a duty determined by a given set of circumstances that present in a particular patient, with a specific condition, at a definite time and place" [2]. In other words, standard of care is sensitive to time, place, and person. This is a challenge to physicians who try to adhere strictly to clinical guidelines because the absence of absolute standards forces physicians to make judgments that may prove in hindsight to have been incorrect.

In this case, it appears that Dr Ofreneo missed the typical signs and symptoms of DKA. Patients afflicted with DKA typically present with "nausea, vomiting, and particularly in children, abdominal pain" [3]. Dr Ofreneo's decisions not to test the patient's glucose level or do a urinanalysis also proved to be poor decisions. A prominent medical manual states that "a presumptive bedside diagnosis is justified if the patient's urine or blood is strongly positive for glucose and ketones" [3]. Had Ofreneo performed these simple tests he would have found that Karla's glucose level of 1126 was almost 10 times the norm, but instead he claimed that "Karla had no signs or symptoms specifically indicating that condition [DKA]" [1]. Although the jury found that Ofreneo had not deviated from standard of care, the symptoms that Karla was experiencing were identical to those of DKA, and it seems that he did not make the best medical treatment decisions. In his article, "A Model for Validating an Expert's Opinion in Medical Negligence Cases," Howard Smith reminds doctors that "the standard of care is a measure of the duty practioners owe patients to make medical decisions in accordance with any other prudent practioner's treatment of the same condition in a similar patient" [2]. This definition of standard of care, coupled with the ability of the physicians at Children's Medical Hospital to affirmatively diagnosis Karla based on an interview and routine tests, suggests that Ofreneo was not as diligent as he should have been.

The second aspect of medical care that this case highlights is the need for a physician to document a patient history thoroughly. Documentation is important, secondarily, for the legal protection that it affords. The primary purpose of the documentation is to provide the physician with a record of a patient's history and other details that he or she might not otherwise remember between visits. In a recent *Student BMJ* article, the author explains that "the patient's narrative gives important clues as to the diagnosis and the patient's perspective…"[4]. In this case, even though Karla was nonresponsive, her mother would have been able to fill in some of the history. Karla's own lack of response might also have been indicative of more serious health problems.

Taking a complete history is not always possible, especially in an urgent care situation, but a diligent effort should be made to engage both the patient and the patient's caregiver. Histories do not serve simply as footnotes in a chart but should be ongoing conversations with the patient or the patient's caregiver so that the physician can establish patterns and trends and provide the best possible treatment course. In taking a history, the physician listens to the patients' past medical experiences and hears how the patients perceive their own illnesses. As stated in the *Student BMJ* article, "to a large extent, this means making sense of the symptoms that the patient presents with...You

can attempt to link the symptoms to the diagnosis" [4]. A verbal exchange with the patient, however, is not the only responsibility of a doctor. Physicians must also *write down* the responses of the patient as well as their own medical impressions of a particular situation. Ofreneo did not document allergies, past illnesses, or vaccinations that might have provided clues about Karla's current condition [1]. As a result he was forced to give testimony from memory. Luckily for him, the jury found that this shortcoming was not a significant factor in Karla's death.

Ethical, as opposed to legal, responsibility might rest at least in part on Dr Ofreneo. His failure to recognize some of the obvious symptoms of DKA may have contributed to pushing Karla's illness to a critical level. The jury found that he did not deviate enough from the accepted standard of care to be legally liable, but he seems to have failed in his professional obligation to recognize and treat a serious illness. The professional duties of a physician extend beyond the clinical encounter. Physicians must effectively communicate with the patient, his or her caregivers, and other members of a patient care team. Dr Ofreneo's failure to accomplish this puts him in a compromised ethical position.

Based on the court records, Dr Ofreneo is lucky that his defense was presented to a sympathetic jury. His professional conduct with Karla Conner appears to have met minimal basic standards, and his medical decision making seems to have been weak, at best. It is vital that physicians learn from this case that they must be aware of the symptoms and patterns that a patient has been experiencing—information often best gathered via a complete medical history and a thorough exam. Physicians should also adhere closely to standards of care as a general rule and, before deviating from them, be convinced that the planned departure is soundly justified.

References

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