BEST CASE SCENARIO

2017 Loss Prevention Seminar for Physicians

Presenter

Stephen Shows
Sr. Risk Resource Advisor
ProAssurance Companies
Birmingham, Alabama
205.877.4487 direct
205.868.6407 fax
Birmingham, Alabama
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Learning Objectives
• Explain the relationship between patient safety and professional liability risk;
• Recognize the need for a risk reduction strategy in a patient scenario; and
• Apply a risk reduction strategy while providing patient care.
Introduction

• Anatomy of a Claim
  o Defense perspective
  o Challenges associated with defending claims

• Best Case Scenario
  o Physician perspective
  o Fundamental risk management themes
  o Changes made to practice
  o Lessons learned from litigation

“The good doctor learns from their mistakes, and the great doctor learns from the mistakes of others.”

- William Mallon, MD, Associate Professor, Keck School of Medicine, University of S. California
Our Physicians

- Timothy Trainor, M.D.
  Orthopedic Surgeon
- Robert Stroud, M.D.
  Radiologist
- Mary Ellis, M.D.
  Pulm/Critical Care
- Gary Zaid, M.D.
  Emergency Medicine
- Iad Hammad, M.D.
  Pediatrics
- Jodie Benton, M.D.
  OB/GYN
- Michael R. Canady, M.D.
  General Surgeon

Physician Interviews:
Risk Management Lessons Learned

Fundamental Themes

- Physician-patient relationship
- Communication
- Documentation
- Tracking and follow-up
The Physician-Patient Relationship

- Who is my patient?
  - Treatment provided
  - Medical advice provided
  - Examination for purposes of treatment or medical advice

- What about these situations?
  - Consultations
  - On-call or call coverage situations
  - Specialty differences

Dr. Ellis – Facts

- ICU Patient – post long & complicated hip repair surgery (EBL – 2500 ml)
- Dr. Ellis contacted by nurse x2 for hypotension
  - 500cc NS IV bolus given each time with appropriate BP response
- Patient again hypotensive – Dr. Ellis ordered cardiac enzymes with troponin, CBC & another bolus of NS
  - Pt responded to fluids & stabilized
  - Troponins mildly † – may indicate non-infarction cardiac injury or early MI
  - Additional fluids; Hb stable, no signs of bleeding

Dr. Ellis – Facts

- Last involvement by Dr. Ellis – she received no other calls & provided no other patient treatment
  - She did not communicate directly with patient or any of patient’s physicians
- Pt diagnosed with hypoxic encephalopathy 2° to prolonged hypotension due to significant blood loss
Suggestions for Consultations

- Physician-Patient relationships can be based on consultation encounters, even "curbside" consultations
- Clear communication of limitations with requesting party
  - "Based on what you have shared about patient’s condition, I recommend…"
  - "I recommend _____ based on the information available to me"
- Documentation
  - Description of circumstances of request
  - Advice given
  - Helpful even without formal chart
- Consistency within practice group

Dr. Benton – Facts

- Dr. Benton performed emergency C-section; one fetus pronounced dead @ birth; one resuscitated
- Patient’s condition deteriorated & expired in hospital
- Lawsuit filed against Dr. Benton alleging she should:
  - Not have discharged patient after observation night in L & D
  - Have ordered patient to return to L & D when she called back next evening
  - Have ordered tests during the patient’s overnight stay to confirm absence of acute fatty liver of pregnancy/HEELP/preeclampsia

Suggestions for Call Coverage

When on Call:

Any patient you communicate with or treat = your patient
- Communicate any follow-up issues with patient & established physician
- Document call coverage encounters thoroughly
Suggestions for Specialty Differences

- Opportunities for patient interaction vary among specialties
  - Interaction with patient not crucial to form the relationship
  - Even brief, positive interactions can make a difference

Effective Patient Communication

- During all phases of treatment
  - Before (informed consent)
  - During
    - After (disclosure, addressing patient complaints)
  - With family members


- 2014 study about the role of communication in treatment of chronic back pain
- Half received mild electrical stimulation; half sham stimulation
  - Placebo worked reasonably well (25% reduction in levels of pain)
  - Real stimulation – pain decreased by 46%
The Conversation Placebo, New York Times Jan. 19, 2017, Danielle Ofri, MD

• Further divided: half received limited conversation from physical therapist, other half asked open-ended questions and listened attentively, expressing empathy about the patient’s situation, and offering words of encouragement.
• Sham w/ active listening: reported 55% decrease in pain.
• Communication alone was more effective than treatment alone.
• Real stimulation w/ active listening: 77% reduction in pain.

Dr. Trainor – Facts

• 57 YOM patient undergoes hip replacement surgery with Dr. Trainor and experiences complications
• Intra-operative complication included fracture to right greater trochanter which was immediately addressed by open reduction
• Post-op complication includes right foot drop
• Patient sues Dr. Trainor and his practice group, alleging Trainor placed extrinsic pressure at level of patient’s right fibular head during surgery, resulting in right lower extremity peroneal neuropathy causing foot drop

Dr. Canady – Facts

• Dr. Canady performs laparoscopic banding procedure on 27 YOM without any apparent complications
  - Patient discharged the same day
• Several days later – presented to ED with SOB & pain for 5 days
  - Patient coded & died before admitted to ICU
• Autopsy revealed perforated esophagus from lap band surgery
• Lawsuit filed against Dr. Canady, alleging perforation of esophagus did not meet standard of care
Suggestions for Communication Before Treatment

- Informed consent
  - Physician provides information to patient about treatment
  - Patient provides consent to physician

- Communication with patient about reasons for & risks of treatment is important in all treatment scenarios
  - Use visual aids when appropriate
  - Use non-clinical or lay terms in description
  - Include substantial & most serious risks
  - Allow for patient questions & discussion
  - Manage patient expectations

- Document conversations

Suggestions for Communication During Treatment

- Continuous communication throughout treatment is valuable
  - Builds trust
  - Clears misunderstandings
  - Creates confidence in relationships

- Document, even if not clinically relevant

- Sit down with patients to emphasize the commitment

Importance of Effective Communication after Pt Complaint

Patient complaints as a predictor of future surgical complications

"For the surgeons in the highest quartile of patient complaints, the adjusted rate of complications was 14 percent higher than those in the lowest quartile."

https://news.unchealthcare.org/news/2017/february/study‐shows‐link‐between‐patient‐complaints‐and‐increased‐risk‐of‐postoperative‐complications
Importance of Effective Communication after Pt Complaint

Why is disclosure/communication so important?

"...expressions of sympathy, and a discussion of what is being done to prevent recurrence. Surveys have shown that patients are less likely to pursue litigation if they perceive that the event was honestly disclosed. Research demonstrates that disclosure of adverse events is associated with higher ratings of quality by patients, an improved rate of recovery, a decrease in the number of malpractice suits, and a decrease in the average settlement amount." (footnotes omitted)

Suggestions for Communication After Treatment

• Timely response helps mitigate risk of litigation
  o Pt. less likely to think you are hiding something
• Open/honest communication
  o Builds rapport
  o Increased confidence
  o Shows physician cares
• Actively listen and address concerns/questions
  o Feels more "collaborative"
  o Pt. part of care team
• Document
• Consider witnesses

Suggestions for Communication With Family

• Family members are often stakeholders in patient care and should be included in communications
  o Balancing privacy v. openness
  o Clarity
  o Consistency
• Just as important to document
**Documentation**

- Whether paper or electronic, the same issues are important
  - Timeliness
  - Thoroughness
  - Accuracy
  - Consistency

**Dr. Hammad – Facts**

- 15 YOF to ED - severe headache, vomiting, Hx of migraines w/similar symptoms
  - Referred to Dr. Hammad, her PCP for follow-up
- Dr. Hammad’s office – headaches, dizziness, & symptoms similar to prior migraines
  - Patient denies any visual problems
  - Diagnosis - migraine headache
- Patient returned to ED same day - severe headache
  - 2 Days later - Patient returned to Dr. Hammad’s office visibly ill
  - Referred to ED with order for head CT scan
  - CT – brain hemorrhage
  - Pt airlifted per Dr. Hammad for emergency craniotomy
  - Neurocognitive functional deficits & several months recovery

**Suggestions for Tracking & Follow-up**

- Areas of focus
  - Labs and diagnostic tests
  - Referrals
  - Appointments
- Systems may vary by practice and specialty, but some system for tracking results, referrals, and appointments and following up with patient is important
- All tracking & follow-up systems should include documentation of both the tracking and follow-up components
Physician Interviews:
Practical Lessons Learned

Physician Interviews:
Litigation Lessons Learned

Litigation Lessons Learned
• Lawsuits take time
  • Preparation time
  • Out of normal routine
  • Away from practice
  • 2 – 5 years from start to finish
The Emotional Toll

• Changes schedule
• Can seem illogical
• Enlist support from friends, families, colleagues, etc.
• Be open with what you are going through
• Physician Litigation Collaboration Network

Preparation

• Work with defense team
• Know the record
• Understand the process & terminology

Importance of Depositions

• Defense case based on defendant deposition
• Can happen months/years before a trial
• Be prepared
• Consistent testimony
• Plaintiff attorney’s role