Best Case Scenario

A Risk Resource Seminar

Presented by
Course Objectives

Participation in this seminar will better enable participants to:

• 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.

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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

Physician Payments Reported to NPDB

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<tr>
<td>Total</td>
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- 6% active physicians involved in paid claim
- Higher prevalence of claims
  - Neurosurgery
  - OB/Gyn
  - Orthopedic, general, & plastic surgery
- 1% physicians accounted for 32% of NPDB claims


“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
Initial Reaction to Being Sued

- 70% surprised upon receipt of notification
- 27% suspected threat
- 3% expected lawsuit


Physician Interviews:

Risk Management Lessons Learned
Fundamental Themes

• Physician-patient relationship
• Communication
• Documentation
• Tracking & follow-up

The Physician-Patient Relationship

• Who is my patient?
  o Treatment provided
  o Medical advice provided
  o Examination for purposes of treatment or medical advice
• What about these situations?
  o Consultations
  o On-call or call coverage situations
  o Specialty differences
Dr. Ellis’ Example

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

Dr. Ellis’ Example (Cont’d)

- Last involvement of Dr. Ellis – she received no other calls & provided no other Pt treatment
  - She did not communicate directly with Pt or any of her 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
  o “Based on what you’ve shared about Pt’s condition, I recommend…”
  o “I recommend _____ based on the information available to me”
• Documentation
  o Description of circumstances of request
  o Advice given
  o Helpful even without formal chart
• Consistency within practice group

Dr. Benton’s Example

• Dr. Benton performed emergency C-section; one fetus pronounced dead @ birth; one resuscitated
• Pt’s condition deteriorated & expired in hospital
• Lawsuit filed against Dr. Benton alleging she should:
  o Not have discharged Pt after observation night in L&D
  o Ordered Pt to return to L&D when she called back next evening
  o Have ordered tests during the Pt’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 Pt & established physician
- Document call coverage encounters thoroughly

Suggestions for Specialty Differences

- Opportunities for Pt interaction vary among specialties
  - Interaction with Pt 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

Patient Satisfaction

- Studies suggest
  - Positively linked to patient safety
  - Effective communication is key

- Traditional measurement of scores can be misleading/skewed

- Analysis
  - Mean scores
  - Use of tertiles
  - Minimum satisfaction scores

Francis A. Fullman, “The link between patient satisfaction and malpractice risk,” white paper, Rush University Medical Center, Chicago, IL, 2010.
Boosting Patient Satisfaction

- Make human connections quickly
- Identify patients’ true concerns
- Pay attention to details impacting Pts’ lives
- Communicate with family often
- Perform simple acts of kindness/show respect


- 2014 study about 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%

• Further divided: half received limited conversation from physical therapist, other half asked open-ended questions & listened attentively, expressing empathy about Pt’s situation, & offering words of encouragement

• Sham w/ active listening: 55% decrease in pain reported

• Communication alone - more effective than treatment alone

• Real stimulation w/ active listening - 77% reduction in pain

Communication Before Treatment
**Dr. Trainor’s Example**

- 57 YOM underwent hip replacement with Dr. Trainor and experienced complications
- Intra-operative complication included fracture to R greater trochanter - addressed immediately by open reduction
- Post-op complication included R foot drop
- Pt sues Dr. Trainor & his practice group, alleging Trainor placed extrinsic pressure at level of Pt’s R fibular head during surgery, resulting in R lower extremity peroneal neuropathy causing foot drop

**Dr. Canady’s Example**

- Dr. Canady performed laparoscopic banding procedure on 27 YOM without any apparent complications
  - Pt discharged the same day
- Several days later presented to ED - SOB & pain for 5 days
  - Pt coded & died before admitted to ICU
- Autopsy - 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
  o Physician provides information to Pt about treatment
  o Pt provides consent to physician
• Communication with Pt about reasons for & risks of treatment is important in all treatment scenarios
  o Use visual aids when appropriate
  o Use non-clinical or lay terms in description
  o Include substantial & most serious risks
  o Allow for questions & discussion
  o Manage Pt expectations
• Document conversations

Communication During Treatment
Suggestions for Communication During Treatment

• Continuous communication throughout treatment is valuable
  o Builds trust
  o Clears misunderstandings
  o Creates confidence in relationships
• Document even if not clinically relevant
• Sit down with Pts to emphasize the commitment

Communication After Treatment
Why is Disclosure Important?

“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)


Importance of Effective Communication after Pt Complaint

Pt 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% higher than those in the lowest quartile.”

Suggestions for Communication After Treatment

- Timely response helps mitigate risk of litigation
  - Pt less likely to think you are hiding something
  - Helps build trust
- Open/honest communication
  - Builds rapport
  - Increased confidence
  - Shows physician cares
- Actively listen & address concerns/questions
  - Feels more “collaborative”
  - Pt part of care team
- Document
- Consider witnesses

Suggestions for Communication With Family

- Family members are often stakeholders in Pt care & should be included in communications
  - Balancing privacy v. openness
  - Clarity
  - Consistency
- Just as important to document
Whether paper or electronic, the same issues are important:

• Timeliness
• Thoroughness
• Accuracy
• Consistency
Patient Tracking & Follow-up

Dr. Hammad’s Example

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

• Areas of focus
  o Labs & diagnostic tests
  o Referrals
  o Appointments

• May vary by practice/specialty, but some system for tracking results, referrals, appts & follow up with Pt is important

• All tracking & follow-up systems should include documentation of both components of tracking & follow-up

Litigation Lessons Learned
Litigation Lessons Learned

• Lawsuits take time
  o Preparation time
  o Out of normal routine
  o Away from practice
  o 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

Hours Spent on Defense Preparation

Importance of Depositions

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