NAVAGATING TROUBLED WATER:

Why Providers Get Into Deep Water and How They Find Their Way Back to Safe Harbor

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MAGNITUTE OF THE PROBLEM

- Likelihood of malpractice claim
  - Every Year, 7.4 percent of all providers will be sued, regardless of specialty; and 1.7 of these claims will result in payment

Rand Institute for Civil Justice

- Nationally, 68% of these claims will be dropped, dismissed or withdrawn; 7% go to Trial (88% result in defense verdicts)

AMA Policy Research Perspectives (2016 Physicians Practice Benchmark Survey)

SPECIALTY MATTERS

- Neurosurgery 19.1%
- Cardio-thoracic surgery 18.9%
- General surgery 15.3%
- Family practice 5.2%
- Pediatrics 3.1%
- Psychiatry 2.6%

SO DO AGE AND GENDER

- Frequency increases markedly with advancing age
- And women providers are sued about half as often as their male counterparts (some theories: they are younger, in general, and they select lower risk specialities for vulnerability to claims)

WHAT IS THE IMPACT ON THE PROFESSION?

- 56% of providers sued report notable psychological reaction
- 45% report change in practice, especially in how they come to view patients as potential plaintiffs
- 42% pay greater attention to record keeping
- 36% obtain medico-legal training
- 36% order more testing
- 22% avoid specific kinds of patients
- 20% avoid specific procedures

IMPORTANT POINTS TO BEAR IN MIND

- You have a team behind you – ask them for help:

  Risk managers, claim handlers, in-house legal team, assigned defense counsel
- Your assets and livelihood are rarely at risk
- Just because you have been accused by a lawyer, a professional board, or an institution of negligence or unethical behavior doesn't make it so
- There are people with whom you can and cannot speak safely with for support

SPECIAL POINTS OF EMPHASIS ARISING IN BOARD COMPLAINTS

- Who can present an administrative complaint to the Board
- “Hot button” issues for the Board
  - Substance misuse
  - EHR and continuity of care
  - Controlled substance prescribing
  - Prescribing for self, family, and friends
  - Informed consent
- Application for relicensure
- How should providers respond to complaints

WHEN LAW AND MEDICINE INTERSECT (COLLIDE?) MOST OFTEN

- Medical Malpractice
- Defense of Board of Medicine Complaint
- Credentialing issues

No matter what the setting, you need a lawyer ("attorney and counselor at law") you can trust and who has your best interests at heart

WHAT ISSUES ARE RESOLVED IN THESE FORUMS?

- Medical Malpractice: whether provider's care was "reasonable under the circumstances" AND whether negligence alleged was actual cause of harm

- Defense of Board of Medicine Complaint: whether licensee is impaired, clinically unsound, or unethical

- Credentialing: whether provider has clinical skills, character and disposition to function effectively in institutional environment

CASE 1

70 year old male patient sees solo practice PCP. PSA drawn exceeds value of 8, which represents approximate 3-fold increase over previous draw one year ago. PCP recommends repeat labs in 3 months, but appointment scheduled for weekend date. PCP dictates notes; does not understand how to use EHR. When error discovered new date of appointment is set. Two notes are created for same visit: first makes no mention of elevated PSA; second reports discussion of concern for cancer and urgent need for referral to urologist for evaluation, including repeat A1c testing. Note is paginated by dictation service thousands of digits after pagination of first note for same visit on same date. Pre-eminent outside expert offers opinion that timing of dx of PC irrelevant. Earlier treatment would confer no survival benefit or improve quality of life.

CASE 2

Middle age man sees PCP and endocrinologist for palpable lump in neck. After 2 indeterminate FNAs, patient referred to surgeon for further work up. Surgeon sees patient in office and performs repeat FNA (not in chart and not reported in interrogatory answers) and core needle biopsies, which again are indeterminate. Patient is very fearful of thyroid cancer, lymphoma or other dire diagnosis. Scheduled for wedge biopsy of thyroid with excisional biopsy of adjacent, enlarged lymph node. Office note from day before procedure includes report of detailed discussion covering all of this. After surgery, patient develops hoarseness and SOB allegedly due to injury to left RLN. Claim limited to allegation that there was violation of informed consent , because surgeon (a) did not disclose plan to excise lymph node, (b) did not offer use of nerve monitor during the case, which he claims caused the nerve injury. Surgeon and patient sign informed consent document on successive days. Safe surgical practices protocol followed meticulously on date of procedure. Pre-eminent expert witness testifies no breach of SOC.

CASE 3

39 year, 10 month old woman referred by PCP to GYN for AUB (ACOG and Mirena recommend endometrial sampling before the IUD is implanted to manage AUB ^ 40 years of age) . After taking detailed history, GYN implants Mirena IUD. Patient notices immediate improvement for next 2 years, then bleeding recurs. GYN determines that IUD has migrated out of ideal position. After discussion with patient, they agree to replacement of the Mirena, which again reduces bleeding markedly and immediately. But only for a few months before she starts spotting and progresses to more robust bleeding. Unsuccessful Novasure endometrial ablation followed by tissue sampling, which discloses endometrial cancer. Referred to Gyn-Onc for total robotic hysterectomy, followed by adjuvant chemotherapy with devastating emotional injury and loss of marriage. No recurrence of cancer 4 years later. Vastly different opinions by national experts on management of AUB and need for endometrial sampling at time of initial referral and return with recurrence of bleeding 2 years later.

CASE 4

17 year old woman on loestrin formulation of birth control seen in ED after development of severe calf pain while shoveling snow. Meticulous exam fails to disclose any S/S of DVT. 2 weeks later patient sees provider covering for PCP with main complaint of cough and blood-tinged sputum. No evidence that this provider examines ED record from 2 weeks prior. Covering physician orders chest X-rays (interpreted by board certified radiologist as showing an evolving pneumonia) and nebulizer treatment with good effect. Discharged on Abx for presumed community acquired pneumonia. No mention of patient complaint or physician examination of leg. Patient returns to PCP 10 days later and reports improved cough and less sputum. Second appointment with PCP week later for discussion of birth control. Patient has tachycardia, but only after coughing fit; otherwise upbeat without complaints. Next morning, patient arrests, taken to hospital and expires within an hour. Autopsy finds PE, but no report of DVT. Experts focus on timing of PE based on appearance of clot under microscope, as well as absolute and relative risk of PE from administration of low estrogen birth control regimen in teen pt.

CASE 5

Patient transferred to new PCP after retirement of prior physician. Comes to new practice with existing prescription for oxycodone for diabetic nerve pain and arthritis. New PCP "taken in" by patient's story of worsening pain, so prescribes escalating doses of narcotic pain medication, while consulting with colleagues in management of chronic pain and substance abuse disorders. But he trusts patient to accurately report symptoms and relief afforded by medication and is believes sob stories of excruciating pain only relieved by escalating doses of narcotics. Before long patient is prescribed hundreds of tabs of oxycodone every month, which he fills at same pharmacy. Unbeknownst to physician, patient buys supply of small Ziplock bags every time he picks up his prescriptions. Pharmacist grows concerned and reports PCP to BOLIM for abusive prescribing practices. Patient ultimately is convicted of aggravated drug trafficking and sentenced to prison in Otisville, NY, where he is deposed. Claim is that his PCP turned him into a drug addict.

MORE THAN HALF OF ERRORS ARE UNRELATED TO SKILL EXERCISED BY PHYSICIAN

- Most are administrative or system errors, e.g.
  - Lapses in follow-up
  - Poor communication with patient or with other members of care team
  - Role confusion and lack of coordination of care

COMMUNICATION TIPS

- Extra time
- No distractions
- Sit face to face
- Maintain eye contact
- One topic at a time
- Simple words/sentences
- Slowly and clearly
- Listen
- Written instructions
- Charts, models, pictures
- Summarize key points
- Invite questions

“ATMOSPHERICS” ARE IMPORTANT, TOO!

Patient Expectations:

- The doctor is trustworthy
- The doctor communicates clearly with me
- The doctor listens to me
- The doctor spends enough time with me
- Urgent appointments are easy to schedule
- The office environment is friendly, efficient without excessive wait time