Physician Wellness

Lawsuit prevention: Mitigating risk

Disclosure

No disclosures, unfortunately

Objectives

1. To discuss preventive tools to avoid malpractice lawsuits
2. To provide documentation tips that will allow clinicians to defend their malpractice case
3. To provide strategies to help clinicians cope during lawsuits
4. Explain process of malpractice lawsuits within the IHS and tribal system

Three Malpractice Cases: Case 1

Dr. Gambarota: After 4m out of residency…

The case: 38m lower abd pain, CT, labs ordered, tx initiated, CT read “normal appendix seen” by contract Radiologist. I dc pt home with instructions “Return if needed”. 3d later pt returned to RMCH ER and repeat CT showed perforated appy. Pt had open laparotomy with subsequent washout of abscess, prolonged hospitalization. Ultimately made full recovery.

A lawsuit is filed 2y later alleging failure to diagnose appendicitis. I was invited to write practitioner narrative regarding my recollection of the case. I asked Rad colleague to review the CT scan, and they told me the report had been misread, appendix did not appear normal on the initial visit. Notified shortly thereafter that a settlement for $86,500 has been made “on my behalf.” Responded with statement to NPDB but name remains listed on the NPDB.

My experience: Shame, anger, feeling I had minimal involvement in case proceedings
Self-doubt, made me want to quit (but unable due to student debt)
Isolation, advised not to discuss case prior to settlement

What helped: Job change, spending time with friends and family. Redefining work, prioritizing hobbies, friends, interests. Later: being a friend and support to other physicians undergoing lawsuits. Realization this is quite a common experience in EM. Having no trouble getting new licenses, MP insurance, jobs. Most recently: diagnosing appendicitis in pt with neg CT read, doing this presentation to be of service to peers.

Case 2

Dr. Rubai: After 18 years out of residency…

The Case: A near 36w old baby is born at night in L&D by C/S due to fetal tachycardia; Apgars 7,8; vigorous, given to GM. Two hours after birth, GM brings baby to RN in full cardiac arrest. An overhead code is called in L&D.

ED staff follow NRP guidelines to attempt resuscitation, rhythm is asystole. No ROSC despite ventilation, intubation, CPR, UVC placement, repeated epi, IV bolus via UVC. Glucose is nl. Autopsy did not reveal any findings contributing to cause of death.

A lawsuit is filed 2 years later, alleging multiple malpractice actions by multiple departments. 2+years later, the case is settled for $600,000. Informed by email that settlement was not due to the merits of the case, and that retained experts had concluded that all care had met the standards and was not the cause of death.

My Experience: Relief, shame, anger, self-doubt made me want to quit, extreme isolation, delays in resolution due to COVID

What Helped: Speaking with Chief (required to notify supervisor), deep research, long-time personal experience as a legal consultant for my brother, urging GIMC change to require AAP NRP of ED medical staff within 6 months to 1 year of hire.

Case 3

Dr. Sanchez: After 2 years out of residency…

The case: 45yo man with AUD presented with AMS, intoxicated. Normal VS, requiring 1L O2. Obs x 2h in ED. Etoh 345. Sent for CT as he was not awakening as expected. Escorted by RN to CT, without monitor. Code blue called at CT. Pt cyanotic. Code blue called, CPR initiated, intubated in CT, when monitor placed pt in PEA. Code ongoing x 45 min then pt pronounced dead.

5 years later informed lawsuit had been initiated claiming wrongful death. Notified case would be reviewed by another provider. Internal review. Anesthesiologist determined pt should have been intubated. Requested second review by EM physician. Upon this review, it was determined that standard of care was met by physician but this was a systems error. Undisclosed settlement. MD found not negligent, not placed on NPDB.

My Experience: angry, scared, incompetent, failure, wanted to quit, embarrrassed.

What helped: family, speaking with immediate and distant family, prayers, thinking about the case, realizing there was nothing I could have done differently in the patient who had been stable for 2 hours. Most important, time gives perspective. Review cases for New Mexico Medical Review Commission.

10 steps to lawsuit prevention

1. Patient Satisfaction
2. Documentation
3. Transfer of Care
4. Care within the ER
5. Reexamination
6. Consultation Management
7. Disposition
8. Higher Risk Scenarios
9. EMR Issues
10. AMA

Patient Satisfaction

Introduce yourself, take time to make pt comfortable, sit down with full attention on pt, body language. Establish rapport. Be culturally appropriate. Thank them for coming. Invite them back. Let them know they are the reason we are here.

Set expectations for the visit “it will take - hours for your work up.” “It took you - days to get this sick; give us a few hours to help you slowly get better” “We may not find a specific diagnosis today but we want you to feel better and will do our best to find out if you need medications or surgery to treat your condition today.

Provide creature comforts (blankets, pillows, water if appropriate).

Documentation: Defending your care

Your chart is your opportunity to defend your care.

Date/time stamp entries; include rechecks, critical events, procedures.

Maintain consistency in documentation; findings supporting diagnosis and disposition.

If you see “CP” in triage note but pt denies to you, write this down to demonstrate whey no further testing performed re the complaint. Also include any additional information gleaned from family, RN, EMS.

Justify why a therapeutic intervention is or is not indicated.

Document serial exams (ie, abdominal exams), include times.

Documentation: Defending Your Care

Include conversation with patient, family and need for follow up. Include in MDM and in your Discharge Instructions. BE SPECIFIC. Do not say “Return if needed.” Say “If you develop ‘x’ then return to the ER within ‘x’ hours.”

Transfer of Care

A risky time: both receiving pt care and transferring care

Clear communication and documentation with person you are receiving pt from or transferring pt to (either EM colleague or consultant).

Introduce yourself to patient. Examine them.

If changes in plan of care arise, reason needs to be reflected in chart.

Transfer of Care

ED provider to admitting provider: Document time of discussion with admitting provider, as well as clinical information discussed and a synopsis of conversation.

Care Within the ED

Don’t wait to initiate aggressive care in patients who will be admitted, ie, antibiotics, transfusions, heparin, etc..

Be Proactive, don’t wait for admitting services to write the orders. If there is a bad outcome, it will be hard to defend why treatment was not initiated sooner. If delays, document.

Pain control: provide analgesia, respond if RN is asking for pain meds.

Care within the ED

Communication:

1. With EMS- VS, glucose, interventions, and responses; “What did the vehicle look like?” “Were there drugs/bottles in the house?”
2. With RNs: changes in mental status, vital signs, heart rhythm? May be prudent in our era to check yourself Q1h or more. Listen to your (trustworthy) RNs. Thank them.
3. With Patients: Take time to speak with family if asked. Take time to answer their questions. Strict return precautions with timelines.

Reexamination

Vital signs: include in note if normal or there may be a benign reason (anxiety/tachycardia or baseline low BP) for abnormal VS. Describe your thought process.

Extremes of age:

Child/infant: If they came in vomiting, be sure to document they are tolerating pos prior to discharge. If they are not, consider admission. Infants: remember breastfeeding/bottle feeding is a “baby stress test”. Document: “baby observed feeding without nasal flaring, retractions, increased WOB, etc…”

Elderly fall: Verify they are at baseline prior to DC, ie, if they could walk before the fall they need to walk after the fall. If not, consider additional imaging studies (ie, hip)

Consultation Management

Before you call, have an action plan in mind, supported by data. Don’t allow consultant to make patient care decisions without seeing the patient.

The chart is NOT the place to air grievances with consultants. Do so at your peril; this type of documentation is a plaintiff lawyer’s opportunity to demonstrate lapse in pt management and will not exclude you from a lawsuit. Use professional, non-accusational language “just the facts”. Disputes with consultants may be addressed outside the chart, as an incident report or with the department chair. If you must put it in writing, you may journal later if need be.

Disposition Issues

Discuss and document all abnormal findings with patients, particularly “incidentalomas” and give clear guidance regarding follow up (ie, adrenal nodule/pulmonary nodule requiring repeat imaging study). Document who was present during the discussion (RN, family member). Write in discharge instruction the incidental finding with specific plan for follow up. Consult PCP with the incidental finding to ensure follow up.

If diagnosis is unclear, tell the pt and family, explain ED work ups may be limited. Avoid saying “nothing is wrong.”

Follow up instructions: Clear, concise, with a timeline and name of PCP. Let them know if you discussed case with PCP.

High Risk Scenarios

Mistakes (ie, air instead of iv contrast injected, wrong electrolyte given); Be truthful with patients/families regarding unexpected or accidental occurrences. Let them know what is being done about it. Do NOT delay: Contact your immediate supervisors. Place iStar.

High Risk Scenarios

Elders: Liberal imaging: consider CT head with CT C-spine to avoid missed C-spine injuries. CT abdomen if pain; CT head, injured areas after a fall. (my case)

Intoxicants: check blood glucose, monitor SaO2, if AMS, consider CT head+/- c-spine.

Musculoskeletal: immobilize painful joints and get follow up. Let patients know some fractures cannot be seen immediately.

High Risk Scenarios

Psychiatric patients: do a thorough medical exam, including labs, particularly if abnormal VS (ie, hallucinations may indicate encephalitis)

High utilizers: examine with fresh eyes each visit. Pay attention to abnormal VS or fresh signs of trauma. Revisit prior note, consider additional imaging if injuries not noted on most recent visit

EMR Issues

Template mistakes: be sure to go in and make changes in ROS and PE to indicate concern of the day. Free text specifics that will allow you to recall the case if it leads to a lawsuit.

Ask RN about their documentation/concerns

METADATA: be aware timestamps will be placed in record; in our EMR they are placed whenever someone goes into the chart; it is not stamped when notes are being written.

AMA

Indicate in your note that the patient HAS CAPACITY to make the AMA decision (ie, “patient is clinically sober”)

Identify WHY the patient is leaving AMA and indicate in your note that you worked with them to try and resolve the issue. Involve family members if possible to try and persuade pt in these cases to stay.

Maintaining Wellness and Sanity During a Lawsuit

1. Remember… you are not alone. Lawsuits are part of the Emergency Medicine experience. More than half of EPs experience a lawsuit during their career by age 55 (52% per AMA).
2. You will not experience financial ruin from a federal case. You will be able to find other work and obtain medical licenses.
3. Reach out to others who have been through it. Avoid detailed discussions of your case if in process.
4. Continue to do things you enjoy that re-energize you..exercise, cooking, pets, friends, or whatever else you may enjoy.
5. Avoid unhealthy coping mechanisms, ie, drinking too much
6. Seek professional support/counseling if needed
7. Realize this is not the end of your career. Being sued does not make you a bad doctor

Reference

ACEP Top 10 Principles on How to Avoid Getting Sued in Emergency Medicine (ACEP medical legal committee 10/13)

https://www.ihs.gov/riskmanagement/manual/manualsection13/