It Could Happen to Me! Avoiding Malpractice and Errors in Clinical Judgment

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Speaker Background

- President, Academy of PAs in Legal Medicine
- PA Educator, Former PA Program Director
- In 28th year of clinical practice
- Standard of Care Testimony for 15 years
- President PA Experts Network, LLC
- Refer to Handout for take Home points
- Pay attention “Big Tips”

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Tips for the Slides

- Most of the audio is from a live presentation
- Additional comments are made as needed
- Watch for additional notes that may be added
- When audio stops, its time to move to next slide

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GENERAL OBJECTIVES

What is PA malpractice?
Overview of the litigation process.
Most common reasons PAs are sued?
What steps can I take to reduce my risk?
Ethical clinical care is safe care!

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TALK OUTLINE

I. MEDICAL MALPRACTICE DEFINED
II. NATIONAL RISK DATA
III. TRIAL CASE EXAMPLES
IV. RISK REDUCTION RECOMMENDATIONS
V. RESOURCES

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DISCLAIMER

- All information presented is not intended to be legal advice. There is no intention to give legal advice, and information presented should not be misconstrued as legal advice.
- Information presented is based on actual malpractice cases, real life experience, attorney interaction and research.

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PreLecture Question 1

Which of the following is <u>not</u> required to prove negligence?

a) causation

b) contract

c) breech in the standard of care

d) duty

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PreLecture Question 2

True or False. The PA Standard of Care is defined as "What I would do as a PA under same or similar circumstances."

a) True

b) False

c) I don't know

d) I don't want to guess

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PreLecture Question 3

A patient presents with abdominal pain that is reasonably worked up but no source can be found. You document a diagnosis of abdominal pain (ICD-10 R10.9). Is this an acceptable diagnosis that meets the standard of care?

a) yes

b) no

c) maybe

d) yes, but only if a differential diagnosis is included

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I.
WHAT IS MEDICAL MALPRACTICE?

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MEDICAL MALPRACTICE DEFINED

Medical Malpractice is generally defined as Negligence on the part of the Physician, Allied Healthcare Provider or Hospital which causes Physical or Emotional Damage to the patient: Personal or Institutional.

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NEGLIGENCE REQUIRES…

- **Duty**
- **Breach**
- **Causation**
- **Injury or Damages**

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DUTY

Provider to Patient Relationship

Health Care Institution to Patient relationship

Implied Contract

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BREACH

Standard of Care

External / Internal

(State and Federal Regs/Hospital Policies/Bylaws)

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STANDARD OF CARE

"What a provider with similar credential, experience and training would be expected reasonably to know and do under same or similar circumstances." GENERIC

"Exercising the degree of care, skill and judgment which a reasonable provider would exercise given the state of medical knowledge at the time of diagnosis or treatment." WI JI-CIVIL 1023

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CAUSATION

- Cause In Fact – The provider's negligence caused the injury
  (eg: wrong med or dose caused death)
- Or a reasonable close connection existed between the provider's conduct and the patient's injury
  (eg: Inappropriate prescribing led to suicide attempt, DM pt. put on prednisone for PTA)

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INJURY & DAMAGES

INJURY:

- Death – Disability – Deformity – Chronic or Severe Pain

DAMAGES:

- Lost Wages – Out-of-Pocket Expenses – Attorney's fees - Lost Enjoyment of Life
- **(caps on non-economic damages)**

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THE LITIGATION PROCESS

Who All Will be Sued? (respondeat superior)

Time Limits on Filing

Initial Review

Expert Review

Depositions

Mediation

Settlement versus Jury Trial?

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THE LITIGATION PROCESS

Caps on Non-economic Damages

Caps on Attorney Fees

Expert's Fees

Expert's Qualifications

Do you want to be an "expert"?

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II.

HOW DO PA'S COMPARE? WHAT IS OUR RISK?

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17 Year Malpractice Payment Incidence Ratio 1991-2008

Ratio of payments per providers calculated as total payments in the 17 years per average number of providers over the 17 years. "17 year likelihood"

Physician	1:2.7	37%
PA	1:32.5*	3.1%
APN**	1:65.8	1.52%

*12 times less than physicians **APN data includes active and non-active providers

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2005-2014 NPDB Study

- Physician payments per 1000: 11.2 – 19
  Ave: 13.75
- PA payments per 1000 PAs: 1.4 – 2.4
  Ave: 1.83
- NP payments per 1000 NPs: 1.1 - 1.4
  Ave: 1.26

Phys to PA ratio 1:7.5 7.5 times more,

Phys to NP ratio 1:11 11 times more

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10 year "Likelihood"

- Physicians 13.75% for every ten years
- PA s 1.83% for every ten years worked
- NPs 1.26% for every ten years worked

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Conclusions 2005-2014

- Rate of physician malpractice payments has been declining, the rate of NP malpractice payments been steady, and the rate of PA malpractice payments has been slightly increasing.
- Median payments for physicians slightly decreasing, PAs and NPs steady
- Reasons for payments largely unchanged
- PAs and NPs remain much less frequently sued than physicians, though the frequency gap may be narrowing

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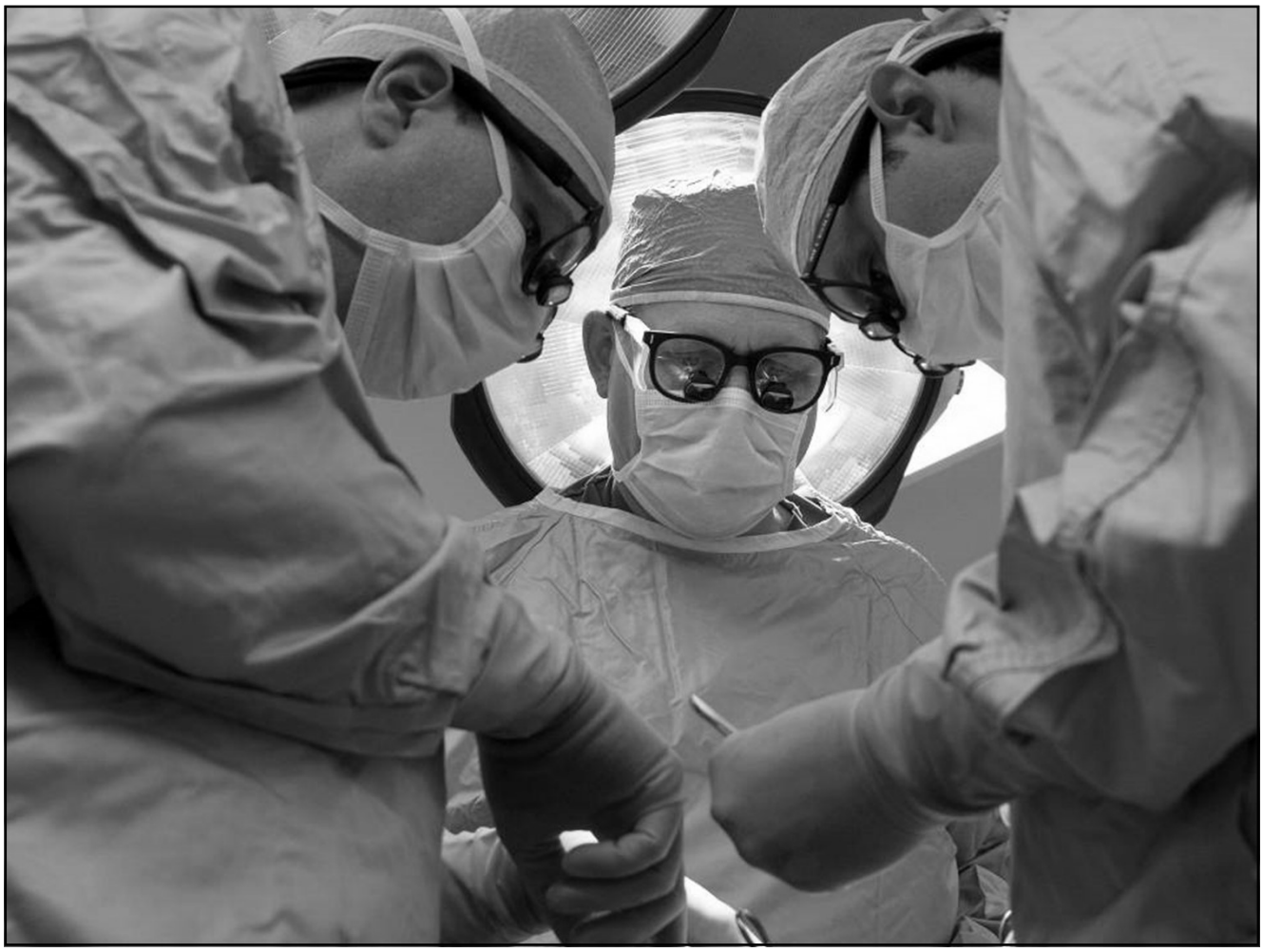

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III.

CASE REVIEWS

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ER CASE

- 19 yr old AA, 1 week post partum, SOB, CP, tachycardia, tachypnea, crackles, 1430
- CXR, neb, IV fluids
- PA dx of pneumonia and staffed with MD who went off shift in 10 min, admit for pneumonia
- Hospitalist came down, did not read film

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ER CASE (cont.)

- Pt in ER all night waiting for room, deteriorating, no vitals or re-evaluation by RN or PA
- Chest film finally read by radiologist at 3am cardiomegaly/CHF/congestion, sent for CT
- Pt expired on way to CT of cardiac arrest, cardio-pulmonary failure; DX Post Partum cardiomyopathy

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ALLEGED BREACHES

- Severity of condition not recognized
- Wrong diagnosis, No differential
- Incomplete workup, UA, EKG, cardiac enzymes, d-dimer, BNP all not done
- Misread CXR by PA – no over-read by MD
- Inadequate PA supervision
- Inappropriate potentially harmful treatment
- Institutional Negligence – vitals, admission

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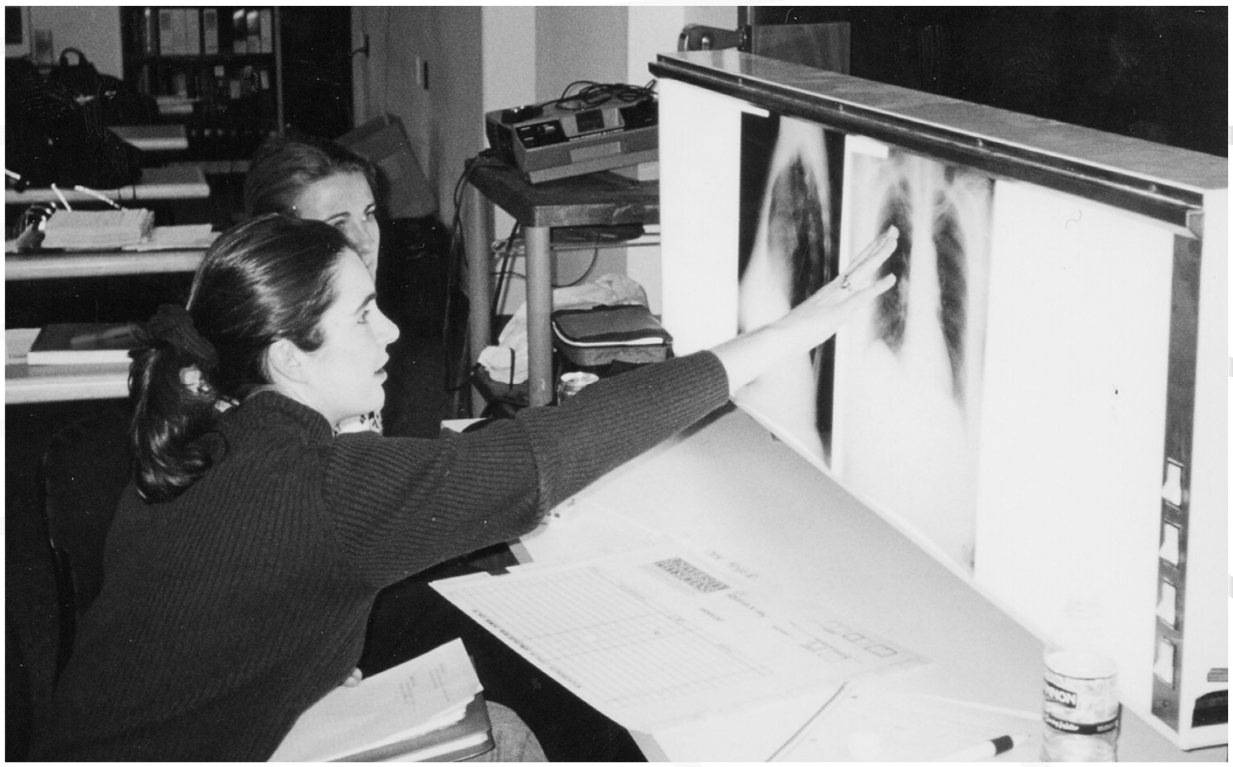

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PA ISSUES

- Staffing with an MD going off shift
- Not continuing to care for your patient – allowing patient to "fall through the cracks"
- PA inexperience or haste, haste, haste
- Where's the communication with the RNs?

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PA ISSUES

- Know the difference bewteen rhonchi, crackles (rales) and wheezing
- Don't give IV fluids to a patient in heart failure
- Be sure your films are overread by SP or radiologist before your final diagnosis
- Settled for $5,350,000 in 2009!

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FP CASE*

- Well known 30 y/o male "chronic depression seems to be getting worse"
- Family h/o depression bro. suicide attempt
- Pt. expressed "suicide ideation at times" "has even thought of a method" but never acutely in the office
- Patient placed on Paxil, dose increased monthly

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FP CASE

- Pt. seen monthly in f/u, Paxil increased from 20, 30 to 40mg. Patient does not improve, legs ache, sees MD for sigmoid-oscopy in between visits
- PA increases Paxil to "50mg for 3 days then 60mg" – above rec. dose.
- Pt. attempts suicide a week later – Dx SSRI intoxication syndrome

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ISSUES/ALLEGATIONS

- FP PA outside scope of practice
  - No psych training, no objective assessment of patient progress (mood scales)
- No referral to or communication with psychologist/therapist
- Exceeded max medication dose
- No discussion with patient or monitoring of side affects
- Failure to follow PA. state regs of seeing MD every third visit (external standard)

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PA Issues/Recommendations

- Do not practice outside of your comfort zone
- S.I. even passively expressed is out of a FP realm
- Get other professionals involved, share the burden (and the blame), communicate with those already involved
- Know your meds, explain side affects

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ORTHO CASES

- 60 y/o woman total knee replacement
- Saw MD in follow up and placed on antibiotic for incision site purulent drainage
- Sees PA a few days later who sees no drainage & tells patient she doesn't really need the antibiotic and allows the patient to decide to take it or not
- Patient d/c'd med, infection ensues, ends with an above the knee amputation

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ISSUES/ALLEGATIONS

- PA contradicts supervising physician medical plan
- PA allows patient to make her own medical decision outside a layman's expertise
- PA does not discuss the change in plan with supervising MD

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ORTHO CASE II

- Missed post op knee infection, patient perceived as a "whiner" - pain out of proportion to expected – patient not taken seriously
- Nosocomial MRSA, eventual sepsis and death
- Allegations of missed diagnosis, treatment, uncaring, unprofessional conduct

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ORTHO CASE II*

- Allegations of poor, incomplete PE
- Failure to appreciate severity (pain and swelling) out of the ordinary post op
- Infection not in written differential
- Patient was previously on clindamycin, failed to get history of prior MRSA?
- Used the word hysterical in documentation

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PA Issues/Recommendations

- Take your patients seriously
- Unexpected pain or unexpected course of treatment is a huge RED FLAG – get another opinion if necessary
- Respect your patients no matter how difficult it may be at times
- Avoid inflammatory comments in your note

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Family Practice Case II

- Persistent new onset headaches in a 24 year old
- Tylenol and Ibuprofem not helping much
- Seen in clinic three times
- Father and son ask about CT scan
- PA dissuades them with talk of radiation
- Young man dies of an aneurysm the fourth week

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FP CASE III

- New grad PAs with a DO in FP. DO claimed to have pain management expertise
- PAs saw mainly pain follow ups – 120 -240 Percocets a month, pain contracts not used
- Multiple OD deaths over several years
- DO and wife office manager in jail

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PA ISSUES

- Need to verify supervising MD/DOs credentials
- No PA training or expertise in pain management - but neither did the doc!
- If uncomfortable in a practice get out!
- PAs will be held accountable in addition to supervising physician

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FP VA CASE

- Painless hematuria in a male repeatedly diagnosed as cystitis without objective UA findings of cystitis
- Procrastinated on referral to urology then took months for system approval
- Bladder CA diagnosis delayed 5 months by both provider and institutional negligence

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FP VA CASE LESSONS

- Continuing down the wrong path without diagnostic evidence
- Don't procrastinate to refer or order tests when your patient is not getting better
- Be your patient's advocate when there are system obstacles to quality care (approval delay), find a "work around"

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Compartment Syndrome UC Case*

- PT fell backward, leg pinched between cart and wooden palette, ER, Dx muscle strain, crutches, Motrin
- Day later first UC visit
- Return in less than 24 hours to UC
- 3 visits in 3 days
- PT seen 4 times in UC over 3 weeks

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PA Issues/Allegations

- Failure to diagnose (leg pain sx not dx)
- Incomplete Physical – no NeuroVasc exam
- Failure to appreciate mechanism/history
- Failure to provide adequate treatment
- Failure to refer, Ignored MRI findings wk3
- Failure to meet state requirements, No…
  - Supervisory agreement on file
  - Chart co-signature

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OTHER COMMON CASES

- Missed ileus/bowel obstruction- film issue
- Missed appendicitis – very common
- Post op infections – very common MRSA
- Rudimentary physical exams –poor documentation
- Lack of sufficient work up or PE– (missed preterm labor)
- Lack of referral or timely referral

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COMMON THEMES

- Failure to appreciate severity
- Delay in reviewing diagnostic tests and getting back to patient
- Practicing outside of training or comfort level
- Failure to formulate or **document** differential diagnosis – my rec!

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COMMON CASE THEMES

- Failure to treat aggressively enough
- Failure to communicate with specialists
- Failure to ensure close follow-up
- Failure to request assistance from supervising MD
- Failure to provide continuity of care
- Failure to treat patients respectfully

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COMMON CASE THEMES

- Failure to clarify and document transfer of care (especially ED setting)
- “Are you taking over or am I still involved”
- Failure to get a “final” read on films by supervising MD or radiologist and timely
- Rushing /Haste
- Minimizing complaints or findings

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IV.

RECOMMENDATIONS

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LESSONS

- Relationships with supervising physicians and staff is tantamount
- Communication is key!
- Relationships with patients. "If they like you they won't sue despite a poor outcome."

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m1
Failure to Diagnose
Referral
PITFALLS OF MEDICAL MALPRACTICE
Examination
SUPERVISION
Documentation
COMMUNICATIONS

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Slide 56

m1 These are the "Pitfalls" in clinical judgement
ms8090, 4/15/2020

RECOMMENDATIONS

- Document a differential or no one will know what your thinking – not the lawyers, not the "experts", not even yourself a year later!
- Your diagnostic work-up must be adequate and appropriate for your differential (Don't be cheap to order tests but don't order out of malp. fear either - practice good medicine.)

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RECOMMENDATIONS

- Have your diagnostic tests – EKGs, imaging studies over read by your supervising MD or radiologist. Don't convince yourself you know more than you do. Know your limitations. (PP-Cardio case, psych case)
- Provide and document close follow up or next step instructions for every patient. (immunocomprised child case)

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RECOMMENDATIONS

- Believe your patients – don't dismiss their concerns when they come back (ortho knee case)
- Don't practice 'over your head." We're not all experts at everything. (FP psych case)
- Know and follow your state regulations carefully (FP psych case, UC Comp Syn)

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RECOMMENDATIONS

- Clarify and document who is the responsible provider and when? (ER MI case)
- Don't withhold treatment – a $4 antibiotic may keep your patient alive and prevent a damaged career (ortho sepsis cases)
- Balance what patient's want with good medicine, keep them ☺ !!

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RECOMMENDATIONS

- Help your institution/clinic/office become more efficient in lab turn around and in patient communication and follow-up - prevent system failures (ER post partum cardiomyopathy case, cardiac echo case)
- Determine who is responsible for what – lab results, patient calls, follow up times

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RECOMMENDATIONS

- Know your supervising docs credentials, training and reputation in the community (Narcotic prescribing abuses).
- Don’t be afraid to leave a high liability situation – get out before you become implicated (Pain Management FP case).

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REVIEW BASED ON NPDB RESEARCH

- **Inadequate Supervision**
- **Inadequate Examination**
- **Untimely Referral**
- **Failure to Correctly Diagnose**
- **Lack of Documentation**
- **Poor Communication**

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Inadequate Examination

- **Always confirm & expand on the Chief Complaint : "OLD CARTS".**
- **Do not accept someone else's triage information, but compare it with your own.**
- **You must always perform and document a complete physical examination for the history taken.**

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Failure to Diagnose

- **BE SURE TO MAKE A DIAGNOSIS!!**
- Know the difference between a symptom and a diagnosis, e.g. cough, nausea, abd. pain, emesis vs. pneumonia, bronchitis, gastroenteritis, appendicitis, etc.
- IF YOU CAN'T MAKE A DIAGNOSIS, YOU MUST AT LEAST DOCUMENT A DIFFERENTIAL AND EXPLAIN WHAT FURTHER STEPS WILL BE TAKEN OR YOU HAVEN'T DONE YOUR JOB!

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Lack of Documentation

- **Five years from now, if someone reads your record on a patient you saw today, will they get an accurate picture of your care or will what is missing in the record speak louder than what you noted?**
- SOMEONE WILL SAY IF ISN'T IN THE CHART, IT NEVER HAPPENED

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BIG TIP: OLDCARTS

- Onset. Location, Duration, Character, Aggravating factors, Relieving factors, Treatments tried, Symptoms associated.
- If its a life or limb threatening condition, you must complete OLDCARTS for every complaint or someone will say you are negligent in your duty. OLDCARTS is just the minimum to get you thinking thoroughly.

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BIG TIP: HISTORY

- "There is no such thing as a poor historian – just a poor history taker."
- "90% of your diagnosis comes from the history!!"
- If you cannot get an adequate history from the patient, your duty obliges you to get it from family, bystanders, witnesses, EMTs, old records.

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BIG TIP: MEDICATION

- At end of note state:
- "The potential side affects and adverse reactions of all medications prescribed were thoroughly discussed with the patient and they verbalized understanding."

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BIG TIP: FOLLOW-UP

- At the end of note state:
- "The patient was told to return, see their primary provider or go to the ER if not improving in the next 48 hours or if getting worse."

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BIG TIP: Communication

- Your relationship with your supervising physician is tantamount.
- Don't be afraid to admit you don't know and ask for help – you are not expected to know everything.
- "The biggest compliment you can receive is…"

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BIG TIP: DIAGNOSIS

- Be sure your diagnosis is a diagnosis!!
- Not a restatement of a symptom, e.g. abdominal pain
- If impression is a symptom, then you MUST delineate differential diagnosis and next steps to rule them in or rule them out.
- Attorneys will crucify you if you don't "rule out the most life threatening conditions first" even if they are not common.

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BIGGEST PEARL!

Treat everyone as if they were your granndmother!

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WHY PATIENTS DON'T SUE

- They know you care
- You kept them informed
- You were honest
- You apologized - "Sorry Works" but did not accept fault or assess blame
- They view their provider as a friend
- It's been too long (more than 3 years)
- It's too much trouble

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PostLecture Question 1

Which of the following is <u>not</u> required to prove negligence?

a) causation

b) Contract injury

c) breech in the standard of care

d) duty

e) injury

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PreLecture Question 1

Which of the following is <u>not</u> required to prove negligence?

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b) contract

c) breech in the standard of care

d) duty

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PreLecture Question 2

True or False. The PA Standard of Care is defined as "What I would do as a PA under same or similar circumstances."

a) True

b) False

c) I don't know

d) I don't want to guess

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PreLecture Question 3

A patient presents with abdominal pain that is reasonably worked up but no source can be found. You document a diagnosis of abdominal pain (ICD-10 R10.9). Is this an acceptable diagnosis that meets the standard of care?

a) yes

b) no

c) maybe

d) yes, but only if a differential diagnosis is included

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VIII.

RESOURCES

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MORE INFORMATION

PA Malpractice, Expert Witnessing Websites:

www.AAPALM.org

ReachMD XM Radio

www.PAexperts.com

Summary of State Laws:

www.mcandl.com/states.html

www.ama-assn.org/resources/doc/arc/capsdamages.pdf

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