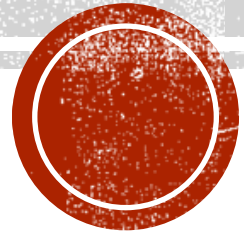
YOU'VE BEEN SERVED…NOW WHAT?

MEDICOLEGAL REVIEW: A CASE ANALYSIS



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DEFINITIONS

- Malpractice – need all 4
  - Duty: duty of care owed to patients.
  - Breach (negligence): deviation of standard of care.
  - Proximate cause: injury was natural and direct cause of negligence
  - Damages: economic/ noneconomic losses suffered as a result

ALMOST INEVITABLE

- 7.4% physicians had malpractice claim/year
  - 1.6% led to payment
- Claims by age 65
  - 75% of physicians in Low Risk
  - 99% in High risk – yes, EM and Anesthesia are High Risk

- Jena AB, Seabury SA, Lakdawalla DN, Chandra A. Malpractice risk according to physician specialty. *N Engl J Med.* 2011

NUMBERS TO CONSIDER

- 2/3 claims dismissed
- 30% settled without trial
- 1% end with plaintiffs verdict

ADVERSE EVENT VS ERROR

- Claims correlated with adverse event, not errors
  - Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. N Engl J Med. 1996 Dec 26;335(26):1963-7.

- Risk of Error
  - Diagnostic Errors in the Emergency Department: A Systematic Review, Newman-Toker DE, et al. Agency for Healthcare Research and Quality (US); 2022 Dec.
  - 1/18 ED pts are incorrectly diagnosed, 1/350 suffer disability or death as a result

DIAGNOSES

- Top 5 conditions with misdiagnosis related harm (mostly pre-2015):
  - Stroke (17%)
  - MI (1.5%)
  - Aortic Aneurysm/ Dissection (36%)
  - VTE (20%)
- 6 million ED visits/year with CP*
  - ACS = 5% (300,000)
  - PE = 0.5% (30,000)
  - AoD = 0.05% (3000)

*Hsia RY, Hale Z, Tabas JA. A National Study of the Prevalence of Life-Threatening Diagnoses in Patients With Chest Pain. JAMA Intern Med. 2016 Jul 1;176(7):1029-32.

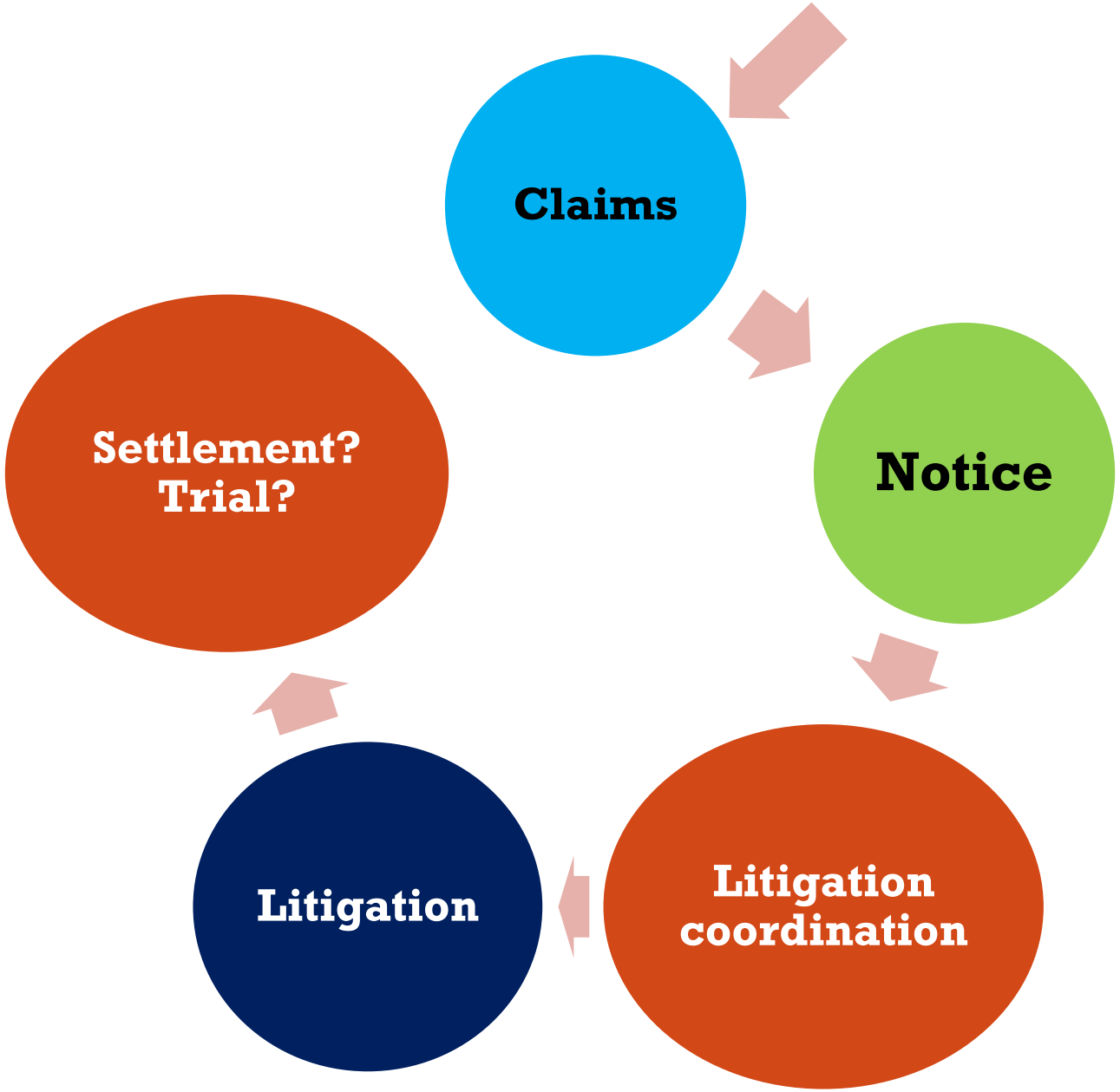
ATYPICAL "ERRORS"

- Delayed or missed diagnosis occurs most commonly with nonspecific, mild, transient, or "atypical" symptoms

- High risk "atypical" symptoms
  - MI – Syncope, N/V, fatigue, AMS, SOB
  - Dissection – Syncope, abdom pain, SOB, back pain
  - VTE – Syncope

Harm/ contact attorney

PROCESS



WHAT DON'T YOU DO?

- Do not throw the notice in a drawer and avoid it
- Do not go back into chart to refresh your memory
- Do not change any documentation
- Do not talk to anyone about the case except your attorney
- Do not blame yourself

KNOW WHERE YOU STAND

DEPOSITION – BIG DEAL!!

- Practice with your attorney
- Only answer the questions that are presented
  - Tell the truth, don't embellish
  - Nothing is "authoritative"
  - Avoid "always" and "never"
- If you don't understand the question – ask for clarification
  - 3 sources (documentation, memory, "custom and practice")
  - "Based on my education, training and experience…."
- Plaintiff's team loves to try to get you to mess up
  - Information available to you at the time of your evaluation.

STRESS

- This is an extremely stressful time
- Waiting - There is ALOT of time between segments of the suit
- Make sure the suit doesn't have harmful effects on your personal or professional life
- Healthy stress relief, emotional support are crucial – take advantage of any that are offered

DON'T LET THEM BEAT YOU TWICE

PROCESS CONTINUES

- After the suit and depositions the opposing sides will decide if they should go forward with a trial
- At this point, you may no longer have any say
- Important to remember: at this point it is barely about the medicine
- Work with your team to navigate the best possible outcome

TRIAL

- Possibly the most frustrating and stressful event of your career
- It has nothing to do with medicine at this point
- Win or lose – it will have a significant impact on you personally

BEST PRACTICES FOR DEFENSE

- Thorough documentation that support rationale
- Informed consent/ informed refusal
  - AMA forms?
- Return precautions/ follow up plans
  - Incidental findings
- Supervise those that need supervision
- Communicate (and document!)

STRATEGIES – DEFENSIVE CHARTING

- Charting - don't need to test for every diagnosis, but need to chart why risk is acceptably low
  - Don't chart "Doubt this is ACS"
  - Do Chart: Atypical story, non-ischemic ECG, negative troponins
  - Don't chart "Doubt this is Dissection"
  - Do Chart: Atypical story (not sudden onset, worst pain of life, or crossing 2 compartments) without known AoD risk factors, symmetric BPs, normal mediastinum on CXR

STRATEGIES

- Vital Signs
  - beware "mild tachycardia" and "soft pressures." Almost 90% of med mal cases involve an abnormal vital sign, most commonly the heart rate
- RN notes – read them!
  - Especially triage notes. Address discrepancies
- "Dot phrases" – customize!

STRATEGIES

- Document a re-exam/ repeat vitals
- Document shared decision making
- Discharge diagnoses:
  - Instead of "GERD", document "chest pain" and "suspected GERD."
  - Instead of "constipation", document "abdominal pain" and "suspected constipation"
- Insert a follow-up visit between your visit and the patient's death

TAKE HOME POINTS

- Optimize charting to improve defense
- Beware of abnormal vital signs
- Re-assess, follow-up and strict return precautions
- Communication is key!

THANK YOU

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- Paul Baleria, JD
- Francis Leary, JD
- Amal Mattu, MD
- Jeff Tabas, MD

QUESTIONS?

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