



HEALTHCARE

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Patient Expectations and Disposition Decisions in the E.D.

By: Pete Steckl, M.D., F.A.C.E.P.



The longer I practice, the more I have come to realize that practicing good medicine is the easy part of my job. The more challenging task turns out to be creating the “appearance” of good medical practice. With that in mind, in order to truly minimize risk in our day-to-day life in the Emergency Department (ED),

patient and family expectations must be identified, acknowledged, and responded to. Regrettably, upon retrospective examination of litigation prone incidents in the emergency department, a recurring pattern emerges of physicians discounting or ignoring expressed wishes of the patient and family regarding their treatment and disposition. This approach can be dangerous in that it engenders an impression of lack of concern for the patient’s well being on the part of the evaluating physician as he refuses to entertain informed suggestions on the part of the patient and family.

Teasing out the precipitating causes of this trend is difficult, but it appears that the origins are multifactorial. First, a strong sense of ego may lead the ED physician to believe that he alone should be calling the shots regarding rendered medical care. As the doctor, he believes that he knows what is best. Therefore, it follows that any requests or demands to the contrary may be often reflexly met by digging in heels even harder as pressure mounts from families to heed their requests.

A second contributor to the appearance of arrogance and inflexibility is the fact that many physicians have been reared in a residency environment that nurtures a tradition of extreme selectivity in admission. The time honored attitude of “Be a wall, not a sieve” when it comes to patient disposition, discourages the admission of all but the most serious or clear-cut presentations of illness. Though we all received positive reinforcement for this behavior (macho back slaps, etc.) from our colleagues during training, once we enter the workforce and numbers of patients evaluated begin to accrue, this attitude can come back to haunt us as the not so obvious borderline cases begin to return with bad outcomes.

The types of cases we see returning as incidents vary but appear to have in common seemingly diffuse, nonspecific, or atypical complaints. Though they don’t fall into one neat

grouping, they do tend to encompass the well-documented *high risk categories that surface again and again in closed claim literature: chest pain presenting atypically, seemingly unimpressive abdominal pain in the elderly, fever, and neurological complaints, especially TLA. A frequent accompanying mistake is that of relying on clinical tests alone in decision-making rather than depending more on clinical history and exam.*

In sum, disposition decisions remain complex and often dicey. We try very hard to make the right decision, but numbers dictate that we all will make the wrong call from time to time. **Hence, lessons to be learned from the above are twofold:**

1) Take a more humble approach toward patients and their families. Listen and respond to their expressed wishes and expectations. Once you have developed a plan of action, make decision-making a cooperative exercise by allowing patient and family to voice their preferences. If after prolonged discussion, you are still feeling pressure from the family to admit, seriously consider granting that wish if possible. As you alone are personally evaluating the patient, you do have a tremendous power in tailoring your presentation in such a way that emphasizes clinical findings that support the disposition you want to achieve.

2) When you encounter nonspecific complaints like those listed above, especially in individuals with several risk factors, loosen up that admission filter a bit and allow for further observation in the unclear case. Realize that there is no prize given for being the low admitter in the group and indeed there currently does not appear to be a downside to admitting patients for observation with ambiguous clinical findings. Though you may receive occasional resistance from admitting doctors, a reasoned and tactful discussion is often met with success. This approach, in the long run, should function to decrease your liability and at the same time increase patient safety.

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Top Hits in Obstetrics; an Obstetrician's Commentary

By: Andrew B. Oliver, M.D. F.A.C.O.G.



Obstetricians are blessed with such a truly rewarding field of practice, yet we are cursed with being the largest targets for claims of medical liability aside from neurosurgeons. It seems that we are increasingly being held to a so-called national “standard of care,” which does not take into account perfectly acceptable variations in hospital settings, individual training, preferences, and the like.

Unfortunately, some medical experts who implicitly set those standards by their testimony do a disservice to many competent OB/GYN physicians. The standard of care, is defined as that degree of care and skill employed by the profession generally under similar conditions and like surrounding circumstances.

While MAG Mutual staff, management, and Board of Directors do not set standards of care, certain patterns have been recognized in the claims process and in compiled data. The following commentary is a brief overview of obstetrical claims exposures. It is by no means all-inclusive, but rather intended to hit the risk management highlights relevant to the practicing obstetrician.

‘Bad Baby’ Claim

That sounds a bit strange, right? Maybe it has something to do with a small child who won’t behave? It’s crude language, but it’s actually lingo that some lawyers use to describe medical liability cases involving birth injuries.

Among the most costly obstetrical claims are the ‘bad-baby’ cases. Obstetricians are uniformly aware of the multitude of etiologies related to cerebral palsy and are aware of the ACOG Cerebral Palsy Task Force Report that lists intrapartum conditions related to hypoxic ischemic encephalopathy and subsequent development of cerebral palsy (refer to www.acog.org/from_home/Misc/neonatalEncephalopathy.cfm).

Time and time again, we encounter plaintiff experts who identify one particular area of a strip that is a small and common fraction of a strip that is reassuring overall. Then they hammer away as if that one questionable area contains the key to the baby’s unfortunate outcome. It is certainly prudent to be alert to the possibility of deterioration of fetal status in labor as evidenced by the information at hand and to be solid in fetal monitoring interpretation, ready to intervene promptly when indicated.

In some of these baby cases, it becomes evident after the fact that the monitor strip at presentation was less than ideal in early labor but not requiring intervention, and certainly not predictive. Later, when an unpredictable bad outcome ensues, it becomes clear that the insult occurred prior to labor. This

particular information then becomes extremely important in defending the doctor’s good care. It’s advisable, in cases of unexpected poor outcome, to be alert to the possibility of a pre-existing insult. In the particular case of suspected fetal-maternal hemorrhage, that evaluation might include fetal hemoglobin testing of the mother and placental pathology.

With regard to placental pathology, physicians should have a mindset of sending the placenta for pathology review more often than not. The placental histologic review may well turn up causative factors later down the road.

Shoulder Dystocia.

Shoulder dystocia claims are also troublesome. There is not an obstetrician alive who is not attuned to this largely unpredictable obstetrical emergency. The possibility looms in awareness even with the most seemingly mundane labors. The rightful emphasis to the practicing obstetrician is on management of this obstetrical emergency as no one can accurately predict its occurrence.

Pitfalls from a risk management standpoint include:

- lack of documentation of station of application of vacuum or forceps assistance should either mode of delivery be involved;
- lack of documentation regarding proper management of patients with gestational diabetes, particularly when the patient is non-compliant;
- lack of documentation of obstetric maneuvers during the recognized shoulder dystocia;
- perception of excessive traction on the fetal vertex;
- conflicting history.

Regarding vacuum assistance, it is prudent to document both the reason for vacuum assistance and the station at application. As far as maneuvers to release the shoulder dystocia, all obstetricians are aware of the basic required maneuvers, and are aware that certain situations call for heroic measures simply to deliver the baby. At the same time, it is prudent to avoid, in either real or perceived terms, excessive lateral traction affecting the nuchal region and rather to concentrate efforts on the impacted shoulder to bring the shoulder girdle into an oblique pelvic plane.

Be particularly aware that routine phrases like ‘poorly controlled diabetes’, which in the minds of obstetricians is a perfectly benign and descriptive phrase often meant to denote lack of patient compliance, can be twisted in such a way that the physician is accused of lack of proper diligence in monitoring the patient’s blood sugars which is unfortunate and disingenuous. By all means, document the delivery details in a standardized fashion, fully aware that shoulder dystocia

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occurs in the otherwise routine mother and neonate being delivered and is typically not a predictable event. **Shoulder dystocia drills are a worthy consideration that promote teamwork and hone communication skills among the team members.** Despite a careful history obtained from the patient, there are times after the fact when the history becomes a matter of dispute. Caution is urged so that any previous delivery problems are explored by competent personnel in the process of obtaining enrollment history so that they can be addressed by the attending obstetrician, then and there. Incidentally, should a patient employed in the healthcare field mention outside of the typical office setting a problem with her previous delivery, it's advisable to direct her to give that pertinent history during an appropriate visit in the office setting so that it may be discussed and documented in a more complete fashion.

The Obstetrical Team Communication

One cannot overemphasize the value of effective communication among the obstetrical care team. The renewed efforts for nursing staff to verbally clarify doctors' verbal orders are a good example of the importance of good communication and teamwork. If a member of the team expresses concern about the nature of the fetal tracing that prompts an uneasy feeling in the mind of the physician, it's often worthwhile to verify personally. If a member of the team is reluctant to perform an action that the physician deems perfectly valid, hear the member out whenever possible so as to assist in managing conflict more readily.

In instances where vital information might be overlooked or not reported to the physician, it's advisable to write clear parameters in the orders so that unrealized assumptions are more likely avoided. Documentation of important discussions with patients about key decisions goes a long way in explaining the doctor's careful approach and verifying the patient's inclusion in the process.

While there are certainly limitations as to how quickly a cesarean section can reasonably be performed, it is important to communicate effectively and act with purpose once the decision has been made to proceed with cesarean sections that are not routine. If the cesarean section needs to be done stat or urgently, make sure that that message is conveyed clearly so that it is more likely to be conveyed quickly and accurately.

Because the 'decision to incision' time may become a contested issue, it's good to write it down or ask the nurse to document the time in a clearly visible portion of the record.

Effective communication with the patient-care team is crucial as there are several points along the way that the message can become muddled or misinterpreted. The immediate presence of the doctor as preparations are made, while certainly not mandatory, can serve to spur on the process of signing forms, obtaining consent, prepping, and transporting the patient.

In the real world, there are differences in hospital settings and capability that amount to differences in cesarean section response and prep time. There are certainly unforeseen delays related to exceptional circumstances even in major obstetrical centers. In the final analysis, whatever guidelines are used to measure response time are somewhat arbitrary. One can simply strive to respond with determination and purpose to deliver expediently when a problem warrants urgent cesarean delivery.

A note about records.

I recall our Chairman Dr. Roy Vandiver some years ago discussing some challenges encountered in some claims that can virtually destroy a good doctor's credibility – that challenge being outright or perceived hidden alteration of records. By all means, make every effort to date and initial all late entries and to avoid outright alterations. Other than initialed and dated late entries, let the record stand as it is.

The good people at MAG Mutual are here to serve policyholders in the most cost-effective and responsible ways possible. Please do not hesitate to ask Risk Management staff those questions that might be lingering. When time allows, you are invited to visit the risk management section of the MAG Mutual website at www.MAGMutual.com/risk/

MAG Mutual's guiding philosophy on claims – do everything possible to provide the best defense – is why the company enjoys such a high success rate with representing policyholders. Since the beginning of the company, MAG Mutual has had an 83.3% success rate in trials with 82% of claims closed with no payment. And this year alone, our trial win rate is at 86%.

If you ever have any questions, don't hesitate to telephone MAG Mutual Insurance Company. They strive to make our lives easier so that we can do what we do best and that's providing quality patient care.

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Dealing with the Threat of a Medical Liability Claim

By: Teresa McMillan, Risk Management Consultant

Physicians are not expected to be comfortable in the courtroom or in dealing with threats of legal action. MAG Mutual representatives will assist you at such times. Reporting lawsuits, threats of legal action, claims and potential claims as soon as possible is a policy obligation. Timely reporting can also assure efficient action by MAG Mutual on your behalf.

Post Incident/Damage Control

The time immediately surrounding an injury or unexpected outcome is filled with efforts to meet the needs of the patient and/or family members. Action taken within the first few days or even hours after an injury has occurred may reduce the severity of a loss and possibly prevent a lawsuit.

The following recommendations may be utilized to assist the provider with post incident actions/damage control:

- Contact MAG Mutual at 1-800-282-4882. Basic information will be gathered that will allow a claims representative to provide assistance.
- Communication with the patient and/or family is very important. Be open and honest without admitting guilt. Maintain contact as necessary and do not avoid their request to meet with you.
- Medical devices should be preserved exactly as they were when the incident occurred. The settings should not be altered. The equipment should be placed in a secure location and actions documented. The equipment should not be sent back to the manufacturer, but an independent professional should be obtained to check the equipment. This action will provide information as to whether the equipment contributed to the incident.
- Save all packaging of accessories with printed lot numbers used at the time of the incident.
- Never speak with a patient's attorney, media and/or a private investigator without first contacting MAG Mutual and/or defense counsel.
- Records should only be released with the appropriate authorization or legal process.

- Contact the MAG Mutual Claims anytime that you receive court documents or correspondence from an attorney other than your own.
- Do not keep private notes about the incident or the case without guidance from MAG Mutual representative or your attorney. Such notes may not be protected against disclosure.¹
- Caution: Discussions held outside of MAG Mutual or your attorney may be discoverable.

Reporting

Early reporting of incidents and/or claims will provide MAG Mutual with an opportunity for early review and evaluation. A claims representative should be contacted for the following:

- When you are served with lawsuit documents;
- Whenever you are contacted by an attorney by phone or letter to discuss a patient's care (There are never any "off the record" discussions.);
- When any unexpected death or injury occurs;
- When a patient threatens a lawsuit;
- Whenever a subpoena is received involving another physician or hospital;
- Regarding any correspondence from an attorney to a physician or the hospital requesting records or notifying him/her of a claim with the exception of workman's compensation and automobile claims in which the physician is involved, unless the care he/she provided is in question.

If you are unsure if an incident should be reported, contact MAG Mutual for guidance. Prompt reporting will not have an adverse effect on a your insurability, premiums or **Loss Excellence Appreciation Discount**.

Source:

1. MAG Mutual Insurance Company, Risk Management Handbook by, 2008 Edition.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment. This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion. ©2008 MAG Mutual Insurance Company.



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