PROACTIVE RISK MANAGEMENT PROGRAM I

COURSE WORKBOOK

MLMIC®


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MEDICAL SOCIETY OF THE STATE OF NEW YORK
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NYSDA

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CME ACCREDITATION AND DESIGNATION STATEMENT

MLMIC is accredited by the Medical Society of the State of New York (MSSNY) to provide CME for physicians.

MLMIC designates this enduring material educational activity for a maximum of 9.0 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NEW YORK STATE DENTAL ASSOCIATION

MLMIC is sanctioned by the New York State Dental Association (NYSDA) as an approved provider of dental education in New York State. The Company designates this educational activity for a maximum of 9.0 continuing education lecture credits. Dentists should only claim credit commensurate with the extent of their participation in the activity.

THE AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) MOC STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 9.0 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

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The material presented in this program is intended for educational purposes only and does not constitute legal advice. In cases of specific legal questions, always contact an attorney.

PROGRAM OVERVIEW

Target Audience

This course is designed to provide continuing medical education (CME) for physicians participating in MLMIC's Proactive Risk Management Program. It contains subject matter that is of current interest to physicians in all medical specialties. The target audience for this program also includes dentists and other non-physician healthcare providers including mid-level practitioners and medical office staff.

Program Overview and Description

The program begins with a prominent defense attorney sharing his knowledge and experience in handling medical malpractice cases against physicians. Key issues are addressed including the need for a coordinated defense, the role of the subsequent treating physician as a non-party witness, and preparation of the defendant physician for a deposition. The importance of the medical record and the use of technology in the courtroom are also discussed.

A panel consisting of a risk management consultant, a defense attorney, and a physician expert discuss the use of electronic health records (EHRs) in the office practice. The benefits of EHRs, as well as the associated liability risks, are discussed. The content also focuses on the proper use of EHR features (e.g., templates, copy and paste function, and auto-population) to preserve the integrity of the chart in the event of a lawsuit. The use of EHR data in litigation is discussed and strategies are provided to help improve documentation and reduce potential liability exposure. The program also reviews the privacy and security issues that physicians should consider when communicating with patients electronically.

Next, a risk management consultant, a physician expert, and an attorney specializing in healthcare law discuss the importance of patient follow-up in the office practice, and how the failure to do so can impact patient care and result in claims against physicians. The program reviews the liability risks associated with patient noncompliance and strategies to manage these patients are provided. Other discussions address the follow-up and communication of diagnostic test results and consultation reports, and the importance of documenting all follow-up measures. This segment also

Lastly, the issues and risks associated with high exposure liability claims are reviewed through a case study presentation. Interviews are conducted with expert physicians in the various medical specialties involved and a defense attorney shares his experience in handling the identified problems. Pertinent risk management issues are addressed including diagnostic error, documentation, communication, and transitions in care or patient handoffs.

The intended outcome of this educational program is to help physicians and other healthcare providers improve the quality of patient care and reduce potential liability exposure in their practices.

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EDUCATIONAL OBJECTIVES

Module 1 – In Your Defense

As a result of completing this module, participants should be able to:

- Describe the risk of "finger pointing" between defendants in a malpractice case.
- Explain the role of the subsequent treating physician as a non-party witness in a malpractice case.
- Describe the steps taken by defense counsel to prepare the defendant physician for a deposition.
- Recognize the negative impact of an altered medical record on a malpractice case.
- Review the effects and challenges of using electronic health records (EHRs) in a medical malpractice case.

Module 2 - Electronic Health Records (EHRs) in the Office Practice – Part 1

As a result of completing this module, participants should be able to:

- Describe appropriate ways to improve documentation in the EHR.
- Explain EHR metadata and its use in medical malpractice litigation.
- Minimize the liability risks associated with the copy and paste function.
- Identify potential problem areas when communicating with patients by email.
- Recognize the benefits of using patient portals in an EHR system.

Module 3 - Electronic Health Records (EHRs) in the Office Practice – Part 2

As a result of completing this module, participants should be able to:

- Explain the benefits and associated liability risks of using clinical decision support software.
- Develop a plan to manage patient information in the event of a system failure.
- Describe ways to enhance patient engagement when using an EHR system in the examination room.
- Explain the elements of informed consent and the proper way to document this process in the EHR.
- Review steps that should be taken to secure patient information in the EHR.

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Module 4 - Follow-Up Procedures in the Office Practice

As a result of completing this module, participants should be able to:

- Develop procedures for tracking and following up patient appointments, diagnostic tests results and consultation reports.
- Recognize the liability risks of treating noncompliant patients and develop strategies to minimize these risks and improve patient compliance.
- Evaluate the role of the coordinating physician when multiple practitioners are involved in a patient's care and treatment.
- Describe situations where it is appropriate to discharge a patient from the practice and the steps that should be taken to properly do so.
- Review strategies to manage patients that forgo care and treatment due to costs.

Module 5: High Exposure Liability: A Case Study Analysis – Part 1

As a result of completing this module, participants should be able to:

- Explain how the failure to conduct and/or document an adequate initial history and physical examination can lead to diagnostic errors and treatment delays.
- Describe the impact of inadequate medical record documentation on the defense of a high exposure liability case.
- Discuss the potential liability issues for physicians who use and delegate responsibilities to mid-level providers.
- Recognize the impact of communication failures or ineffective patient handoffs on patient safety, especially during critical situations.
- Identify the potential liability risks when inpatients are boarded in the Emergency Department.

Module 6: High Exposure Liability: A Case Study Analysis – Part 2

As a result of completing this module, participants should be able to:

- List the key elements that should be communicated and documented to establish a clear transition in care between a referring and consulting physician.
- Describe how an inadequate transition in care from one provider to another can result in a poor patient outcome and malpractice case.
- Explain the proper use of addenda in the medical record.
- Discuss the impact of finger-pointing between physicians on the defense of a case.
- Explain the importance of a physician being well-prepared to testify at the trial.

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IN YOUR DEFENSE

In Your Defense

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Coordination of the Defense Among Defendants

- **Over one half of MLMIC's insured physicians have been involved in a professional liability claim over the past five years.**
- **Many cases involve multiple defendant physicians.**
- **Physicians may try to exonerate themselves by blaming the other physician involved.**

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Coordination of the Defense Among Defendants

- **When defendants try to exonerate themselves by shifting blame on someone else:**
  - The chances of winning go down dramatically
  - The amount of damages go up
- **While the doctor may get a smaller percentage of the fault, it is a smaller percentage of a larger award.**

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Coordination of the Defense Among Defendants

- **When the case is complex, expert reviews are conducted early so the pitfalls are known and worked out with the other attorneys before depositions.**
- **Once the complaint and medical records have been reviewed, liability may be very clear.**

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Coordination of the Defense Among Defendants

- **Coordination with the other defense attorneys can be a challenge.**
  - Identify the decision maker at the defense firm early on.
  - Speak directly with the senior attorney to work out complex cases.

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Coordination of the Defense Among Defendants

- **There are almost always multiple defendants.**
  - The key is to identify where multiple defendants have exposure.
- **Some participants are named as defendants to obtain their testimony and to get a full picture of what happened and narrow responsibility.**

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Coordination of the Defense Among Defendants

- **It is fairly uncommon to have multiple defendants who all have exposure.**
- **In cases with defendants of different specialties, responsibility may be unclear.**
  - They may be partners or may belong to the same organization.
  - If they work as a team, they should be defended as a team.

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The Role of the Subsequent Treating Physician

- **A non-party witness might be in a case because they were a subsequent treating physician to a patient who is now suing a previous provider.**
  - Constraints make it difficult for defense attorneys to discuss cases with subsequent treating physicians.
  - Many times, they are in a position to put aspects of the case in proper perspective.
  - These physicians can be seen as experts on the plaintiff as a result of their relationships.

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The Role of the Subsequent Treating Physician

- **Needed authorizations:**
  - Arons – authorization from the plaintiff for the defense attorney to speak with a treating physician about their involvement in the plaintiff's care.
  - HIPAA – authorization a result of federal law: fines are imposed if there is improper disclosure of protected health information.

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The Role of the Subsequent Treating Physician

- **It can be difficult to convince a subsequent treating physician to cooperate.**
- **The jury is more receptive to an eye witness.**
- **The subsequent treating physician's records and observations can clarify the facts from the positions being presented by plaintiff's counsel.**

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The Role of the Subsequent Treating Physician

- **Things to consider when scheduling a deposition:**
  - Witness availability
  - Whether their testimony is crucial to the case
- **Deposition transcript or video can be used at trial.**
  - It is generally accepted that physicians may be unavailable at the time of trial.

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The Deposition

- **How to prepare the defendant for a deposition:**
  - Ensure the defendant knows the sequence of events and understands the case from the defense perspective.
  - Explain the claims the plaintiff's attorney will present.
  - Make sure the defendant is clear about what actually happened.

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The Deposition

- **Most cases are not won at deposition.**
  - Cases develop over time as information and facts come to light.
  - Defendants can not convince the plaintiff's attorney to drop the case at the deposition.
  - The plaintiff's attorney will use those explanations to their benefit at trial.

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The Deposition

- **Lawyers will never tell a witness what to say.**
- **Key words during a deposition**
  - Try to avoid absolutes like: "never" and "always."
  - "Yes" and "No," may not answer the question completely.
    - It is better to say "that question really does not lend itself to a 'yes' or 'no' answer."

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The Deposition

- **Prepare a few days before the deposition.**
  - The amount of time needed to prepare varies from case to case, but it is minimally a few days to a week before the deposition.
  - Permit the defendant time to consider the important points in the case.

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The Deposition

- **Things to review before a deposition:**
  - The time frame of the physician-patient relationship, when the event occurred
  - The areas of concern and how they should be addressed
  - Different versions of potential questions he/she may be asked
    - Be consistent with responses.

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The Ideal Defendant

- **Understands this is not a personal conversation with the plaintiff's attorney**
- **Realizes that the answers given are being recorded by the court reporter for all time**
- **Recognizes that the response should be able to stand alone and not refer to other questions**

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The Ideal Defendant

- **Depositions differ from trial testimony.**
  - At deposition, all options are kept open for trial.
    - Responses are more expansive
  - For example: statistical risk
    - If you say your outcomes are better than practice standards, then that is the standard by which you will be judged.

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Alteration of the Medical Record

- **Altered records destroy the credibility of the defendant. E.g.:**
  - Different versions of the record are presented at deposition or trial.
    - Notes have been added to or deleted from the medical record.
- **Nothing should be added to the record after the last patient visit.**

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Demeanor

- **If the plaintiff's attorney is able to elicit an anger response from the defendant during the deposition, they will attempt to do the same at trial.**
  - An anger response will destroy the relationship between the defendant and the jury.
- **Curt, dismissive, or arrogant responses also hurt the defense of the case.**

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The Deposition: Misconceptions

- **Major misconceptions physicians have about malpractice cases:**
  - They can explain the case away.
  - The plaintiff's attorney knows more than he/she actually knows.
    - In their response, the defendant gives much more information than questions call for.
    - This leads to areas of questioning not anticipated by either party.

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The Medical Record

- **The medical record is a very important part of the deposition.**
- **Frequently, the plaintiff's attorney will ask the physician to tell them everything they remember about this case before going to the medical record.**

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The Medical Record

- **Defendant physicians should respond: "I have recently looked at the chart and I cannot really separate what I recall from what I have refreshed in my recollection of this case."**

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The Medical Record

- **The printed electronic health record presents differently from the computer screen or tablet the physician used in caring for the patient.**
- **It is important for a defendant physician to see and be familiar with the printed electronic health record prior to a deposition.**

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IN YOUR DEFENSE

The Use of Technology in the Courtroom

- **First establish a teacher-student relationship between the defendant and the jury.**
- **Graphics are used in court to explain complex cases to non-medical jurors.**

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The Use of Technology in the Courtroom

- **Graphics can include:**
  - Artist renderings
  - Laparoscopic photographs
  - Enlarged sections of a hospital record: progress notes, radiographic studies, pathology slides, etc.
- **An image is worth a thousand words.**

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The Use of Technology in the Courtroom

- **At the trial, the record that would have been printed several years ago at the time of the incident appears differently from the current print version of the same record.**
  - Software updates, which account for these differences, must be explained to the jury.

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The Use of Technology in the Courtroom

- **The jury is not going to see the same thing the defendant physician saw at the time of the treatment.**
  - Drop down boxes and input screens are difficult to replicate on paper.

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The Use of Technology in the Courtroom

- **Dictated notes and transcribed notes are a usual area of focus.**
- **Defendant physicians will have an opportunity to explain their documentation process.**

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Thank You.

Questions/Comments
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Visit the MLMIC Research Library at MLMIC.com

ELECTRONIC HEALTH RECORDS IN THE OFFICE PRACTICE - PART 1

Electronic Health Records in the Office Practice

Part 1

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1

EHR Documentation

- **Over many years, MLMIC has counselled policyholders about potential liability issues and patient safety concerns in the office practice.**
  - Over time, documentation methods have changed.
- **Implementation of the EHR has:**
  - resolved many issues, such as dating and timing of notes; and
  - given rise to new issues

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EHR Documentation

- **New issues have appeared as a result of EHRs.**
  - Inadequate system training for providers and staff members
  - Incomplete documentation
    - Reliance on templates
    - Infrequent use of narrative notes

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EHR Documentation

- **New issues have appeared as a result of EHRs.**
  - Auto-population
  - Inappropriate use of the copy and paste function
  - Management of data and documentation from other providers and locations

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EHR Documentation

- **EHR issues in the defense of malpractice cases**
  - The printed EHR:
    - Does not look like the computer screens used for documentation
    - Makes it difficult to follow a plan of care
    - Sterile representation of the care provided

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EHR Documentation

- **EHR issues in the defense of malpractice cases**
  - Upon receipt of a Summons & Complaint, physicians may go back to their notes.
    - Digital fingerprints are left by system users.
    - Every access and annotation made to the record is recorded and becomes a part of the plaintiff's case.

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EHR Documentation

- **Templates are a concern.**
  - All visits may appear the same due to the repetitive nature of templates.
  - A narrative note demonstrates the uniqueness of each visit.
  - Pertinent positive and/or negatives may be missed.

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EHR Documentation

- **Professional judgment can be shown with a narrative note.**
- **Document information about the clinical judgment and thought process used to evaluate the patient.**
  - In litigation, this record will demonstrate professionalism and skill.
  - It provides much more information than checking boxes.

8

EHR Implementation

- **Physicians should be involved in the system's implementation and understand the default settings.**
- **Ensure the appropriate amount of time is scheduled for different types of visits.**
  - For example: The default time settings for an office visit is ten minutes.
  - A plaintiff's attorney will check the system for default time settings to show that a ten minute annual exam contributed to a missed diagnosis.

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EHR Documentation

- **Problems may occur in an EHR with:**
  - Medication reconciliation
    - Must include prescriptions from other providers and sources.
  - Allergies
    - A patient can develop an allergy not previously recorded.
  - Immunizations
    - Provider is not made aware of an immunization given by another provider and administers it again.

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EHR Documentation

- **Problems may occur in an EHR with:**
  - Family and social history
    - Important to update and record cases of familial cancers
  - Management of documentation/reports from other sources
    - Specialists
    - Hospitals
    - Urgent Care Centers

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EHR Documentation Strategies

- **System prompts can guide a physician through the documentation process.**
- **Provide opportunities for patients to input information and complete forms electronically.**
  - Secure patient portals
  - Kiosks in the waiting area or exam room
- **All information provided by patients should be vetted prior to being incorporated into the system.**

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EHR Documentation Strategies

- **Immunization information can be obtained from state registries.**

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Information Overload

- **This is one of the main problems physicians have with EHRs.**
- **Some systems prompt the physician to enter information before moving on to the next item in the record.**
- **Default settings may supply expected data points to be acted on.**

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Information Overload

- **Information is being auto-populated into various parts of the EHR.**

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Information Overload

- **For physician offices and clinics that are part of large hospital systems:**
  - The care provided at any location of the healthcare system may be recorded in the EHR.
    - The information in the EHR is then accessible by all physicians in the system.
    - A physician may be accused of missing something that is noted in the vast amount of data.

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Customized EHR

- **There are consultants and professional firms available to assist with EHR customization.**
- **They may assist physician practices to make their EHR system more user-friendly and specific to how the practice operates.**
  - It is possible to hide or block important features when customizing is done independently.

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What Should Not be Documented

- **The tenets of documentation are the same whether on paper or in an EHR.**
- **Should not document:**
  - Physicians arguing or disagreeing over care to be rendered
  - Patient financial information
  - Personal ("post-it" type) notes about the patient
  - Anything that is disparaging regarding the patient

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EHR Documentation

- **Be mindful that whatever is written in the EHR could be looked at by someone else in the future.**

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Copy and Paste Function

- **Copy and paste can be a time saver.**
- **Allows historical information to be moved into the present, but there are liability risks.**
  - Ensure that:
    - You can identify the source of the information being copied and pasted.
    - The information that is copied is contemporaneous and accurate.

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Copy and Paste Function

- **Ensure staff and other providers are well-educated in the best uses of copy and paste.**
  - In litigation, errors which may be brought forward will call the entire record and care provided into question. (e.g., typographical errors)
- **Monitor the use of copy and paste in your practice.**
- **Current patient information that is copied and pasted can be problematic and must be accurate.**

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The Use of Addenda

- **This is generally not recommended unless valuable clinical information for the continuation of care must be documented.**
- **Do not want the documentation process to get in the way of rendering the best care for the patient.**
- **Sometimes addenda are necessary.**
  - EHR systems automatically date and time stamp all notes.

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The Use of Addenda

- **Addenda added days later can be problematic.**
- **Best practice: manually add the date and time when entering addenda.**
  - This demonstrates your understanding of the EHR timeline.
  - Include why the note was entered at the later time.
- **These practices provide context and clarity to the care rendered.**

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Metadata

- **Data about data**
- **Automatically generated by the EHR system**
- **Increased demand in litigation**
- **Plaintiffs' attorneys are requesting and carefully reviewing metadata.**
  - They are no longer just accepting paper printouts.

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Metadata

- **Provides an audit trail of the EHR**
  - Records who entered what information and when it was entered
  - Lists who looked at what in the record and for how long

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Electronic Communication with Patients

- **There are concerns when communication is done via traditional email.**
  - Free email systems are not encrypted.
    - Email used for patient communication should be encrypted.
  - Auto-population
    - Ensure the name or email address is correct before you send the message to avoid a HIPAA breach.

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Electronic Communication with Patients

- **There are concerns when communication is done via traditional email.**
  - Personal emails could potentially be read by someone other than the intended recipient.
  - Personal email may not be opened and read.

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Electronic Communication with Patients

- **The HIPAA Notice of Privacy Practice should specifically address email correspondence.**
  - If a patient consents to email correspondence, the preferred email address the practice may use must be specified.
  - If this is not properly documented, the practice may be held liable for a patient privacy violation if email is used without authorization.

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Patient Portals

- **Patient portal communication is preferred.**
  - Communication is encrypted.
  - There is an auto logout.
  - It gives you a date and time stamp that tells you when the message was read by the patient.
  - Information communicated via the portal is easily transferred to the EHR.
    - Physician-patient communication
    - Physician-physician communication

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Patient Portals

- **Structured data fields allow physicians to track patient data over time.**
- **For example: a patient's blood pressure readings may be presented over time in a graph and used during an office visit to demonstrate treatment success.**

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Patient Portals

- **Physician-patient communication is enhanced.**
- **Physician-patient communication is the cornerstone of the physician-patient relationship.**
- **For example: a patient over 50 gets a portal message to go for a colonoscopy. Metadata will record when that message was read by the patient.**

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Patient Portals

- **Patient portals are convenient.**
  - Patients are able to request:
    - An appointment
    - Prescription refill
    - Referral to another physician
- **Educate patients that the portal is for non-urgent communication and requests.**

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Patient Portals

- **Many patients may initially sign up for the patient portal, but if they are not using it, an alternative form of communication must be used.**
- **An alternate form of communication should be used for those patients who do not access the patient portal.**

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Patient Portals

- **The physician cannot rely solely on the patient portal for communication.**
- **Follow-up to ensure:**
  - The document was opened and reviewed by the patient.

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Patient Portals

- **If a patient portal communication is not opened or responded to by the patient within a pre-determined amount of time, staff must follow up with the patient.**
  - Recommend a phone call or letter be sent to the patient.
  - Document all communication in the EHR.

35

Patient Portals

- **It is important to have a back-up plan for communication when the patient:**
  - Cannot login
  - Forgets their password
  - Does not have access to or use computers/electronics

36

Patient Portals

- **A successful patient portal implementation begins with complete staff buy-in and enthusiasm.**
- **Consider using the portal as a marketing tool.**
  - For example: post a flyer in the office, offering the chance to win a gift card by submitting a patient portal message.

37

Patient Portals

- **Recommend patient portal use be addressed during office visits.**
- **Using kiosks or similar area that allows privacy:**
  - Office staff can address portal login and use when patients arrive for their appointment.
  - Encourage patients to check into the patient portal while waiting for their appointment to begin.

38

Patient Portals

- **While there are many benefits to the communication process, the patient portal system is not meant to replace a call to 911 for life threatening emergencies.**
  - It is designed for non-urgent communication and requests.
- **When there is a life-threatening emergency, patients must still call 911.**

39

Patient Portals

- **Patient portals have been shown to provide liability protection during a claim or lawsuit.**
- **Communication is encrypted and HIPAA compliant**
  - No threat to a privacy breach
- **Improves physician-patient communication**
  - Demonstrates physician is proactive and communicating with the patient
  - Establishes access to the physician

40

Patient Portals

- **Patient portals have been shown to provide liability protection during a claim or lawsuit.**
- **Audit system findings document physician-patient communication.**
  - It may clarify events during deposition.
  - For example: Patient may state they were not feeling well and told their physician. A focused audit of the portal system may refute such statements.

41

Curbside Consultations

- **These are informal conversations with colleagues about a particular patient.**
- **These conversations are sometimes, but not always, documented in the patient's record.**
- **These informal consultations are now often done via email and that information is going into the EHR.**

42

Curbside Consultations

- **Informal conversations with a colleague regarding a patient should not form the basis of a physician-patient relationship for a physician trying to assist a colleague without having formally seen the patient.**
- **With emails, there is now an electronic record of the conversation and opinion.**
- **A physician-patient relationship can be created for the consulting physician, depending upon the amount of medical information exchanged.**

43

Curbside Consultations

- **There is a greater potential for liability for the consulting physician when that physician:**
  - asks for additional information on the patient;
  - makes recommendations regarding care for the patient; or
  - requests to see the patient.

44

Thank You.

Questions/Comments
800-275-6564

45

ELECTRONIC HEALTH RECORDS IN THE OFFICE PRACTICE - PART 2

Electronic Health Records in the Office Practice

Part 2

Presented By:
Martin Kaiser, CPHQ
Salvatore Volpe, MD
Joshua Cohen, Esq.

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Clinical Decision Support Systems

- Use evidence-based medicine to provide guidance to a practitioner on either how to make the diagnosis or how to treat, in a given situation
- Information provided by the system is used to guide and not replace the practitioner.

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Clinical Decision Support Systems

- These systems may make recommends on certain immunizations and medications.
- Recommendations presented are only as good as the data provided by the physician.

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Clinical Decision Support Systems

- Problems can arise when the wrong information is entered and leads the physician down the wrong clinical decision making path.
- The physicians are the decision makers and must analyze all information provided to them from the system.
- Physicians also need to be aware of "alert fatigue" when using this technology.

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Clinical Decision Support Systems

- Must ensure clinical decision support systems are updated/current.
  - Templates will change as clinical practices are updated.
  - Plaintiffs' attorneys will request support templates for the time the care was rendered.
    - Retrieval or templates at a later date has proven to be problematic.

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Clinical Decision Support Systems

- The standard of care should always be what a reasonably prudent physician in the community would do under like conditions.
- Physicians should document the reason for their clinical decisions when they do not follow the support system recommendations.
  - Demonstrate your thinking process and clinical judgment.

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Office System Updates

- **Routine system updates can lead to errors that impact patient care.**
- **The system update may remove an item or function that is currently in use. (i.e., system customization)**
  - Verify with the vendor, in writing if possible, that all functionality will remain after an update.

7

Office System Updates

- **A system update can change the way the EHR will appear when printed.**
  - It is recommended that a log be maintained when system updates are performed.
  - In a court of law, this will explain why a record printed at one point in time could look different if it is printed after an update was done.

8

Office System Updates

- **If your system is being hosted by a vendor, it is recommended that you contact the vendor and have the vendor perform a completed system backup before the system is updated.**
- **If you are hosting the system in your office, it is recommended that you perform a complete system backup before the system is updated.**

9

Office System Updates

- **Prior to a scheduled update, you should consider having the staff print out two weeks worth of appointments and the clinical information associated with those appointments in the event that the upgrade leads to the system being down.**
  - This printed data will allow the office to function until the issue is resolved.
- **If your system is hosted by a vendor, it may be possible to roll back to the last backup.**

10

Office System Updates

- **Read the EHR vendor agreement before signing it.**
- **Know what will happen to your data if the vendor is no longer able to support your software.**
- **Ensure your vendor will maintain accurate patient records that can be accessed and reproduced for the amount of time required by law for every patient encounter.**

11

System Failure

- **If your EHR system fails or there is a functionality problem:**
  - Have a disaster recovery plan in place.
  - Review your contingency/disaster recovery plan.
  - Follow the steps that should be put into effect.
  - Revert to paper recordkeeping.
  - Ensure that there are adequate backups in place.
  - Do not panic.
  - When your system returns, be sure to scan all the paper records back into the EHR.
- **To protect confidentiality, know where your EHR data is stored.**

12

Interoperability

Interoperability is the ability of different information technology systems and software applications to communicate with each other, exchange data, and use the information that has been exchanged.

13

Interoperability

- **Different levels of interoperability:**
  - In the office, between the EHR and different medical devices
    - When imaging and technical information goes directly to the EHR.
  - Between two EHRs
    - During the exchange of information between two physicians
  - Direct mail
    - A standard way of sending information from one office to another.
- **Check with the equipment and EHR vendors to ensure interoperability.**

14

Interoperability

- **Concerns with system interoperability**
  - Medical technology is not very good at communicating with each other.
    - Information may not migrate to the EHR.
  - Sometimes medical devices do not communicate data to the EHR.

15

Interoperability

- **Concerns with system interoperability**
  - Information overload: when you get the information you need along with a lot more that is not relevant to the issue at hand.
  - Later, a physician may be held liable for other medical issues they are not taking care of, but should be aware of, from a review of all the information that was sent.

16

Interoperability

- **Physicians should work with their software and equipment vendors regarding the interoperability of their EHR system and the limitations that may exist.**

17

Computers in the Examination Room

- **Many patients find the computer a distraction.**
  - It takes the physician's attention away from the patient.
- **Ensure the computer work area is set up ergonomically.**
  - Position the computer so your back is not to the patient.

18

Computers in the Examination Room

- **Consider placing the computer on a cart.**
  - Allows you to stand
  - Allows eye contact with the patient while typing into the EHR
  - Can engage the patient more often and look down only as needed

19

Computers in the Examination Room

- **In litigation, patients complain that the physician:**
  - Was not listening to me or paying attention to me
  - Was too busy entering information into the system to pay any attention to me
- **Reassure the patient you are listening to them while you enter notes in the EHR.**
- **When introducing the EHR into the physician-patient relationship, consider using the "POISED" model.**

20

POISED Model

- **Prepare and review your records before seeing the patient.**
- **Orient and explain how the computer will be used during the examination.**
- **Information gathering is important, but allow time for a conversation with the patient.**
- **Share what you are looking at on the screen.**
- **Educate the patient and reinforce the plan of action.**
- **Debrief and assess the degree in which the patient understood your recommendations.**

21

Informed Consent and the Electronic Health Record

- **Informed consent is the discussion the physician has with the patient regarding the risks, benefits, and alternatives of the proposed procedure or treatment, including no treatment.**
- **Informed consent is not the form that is signed by the patient.**
- **Documenting the informed consent conversation is still largely done on paper and scanned into the EHR.**

22

Informed Consent and the Electronic Health Record

- **Some physicians are showing patients informational videos from the Internet instead of printed brochures.**
  - It is difficult to preserve the information from an Internet video in the EHR as part of the informed consent process.
  - It can become an issue in litigation as online material cannot be downloaded because it is copyright protected and therefore unable to be produced during a trial.

23

Informed Consent and the Electronic Health Record

- **Regardless of the technology used, it is still the responsibility of the physician to make sure the patient understands what procedure/treatment is being described, along with the associated consequences.**
- **For elective procedures, it is best to have the informed consent discussion with the patient in advance of the procedure and present them with a consent form during that conversation.**
  - This allows the patient more time to consider the procedure.

24

ELECTRONIC HEALTH RECORDS IN THE OFFICE PRACTICE - PART 2

Integrity of EHRs and Protected Health Information (PHI)

- **Concerns about remote access to EHRs**
  - Physical security of the device being used
    - (e.g., Is it a personal laptop or a public computer?)
  - Password security
    - Strong passwords should have at least eight characters, upper case, lower case, and wild card character.

25

Integrity of EHRs and PHI

- **Concerns about remote access to EHRs**
  - Access security
    - Multifactorial authentication
      - Concerns who you are, what you know and what you have. (For example: fingerprint, your password or a token which randomly generates access codes to the system.)
    - Virtual private networks (VPN)
      - Creates a secure connection between two locations.

26

Integrity of EHRs and PHI

- **Physical security**
  - Laptop or tablet is misplaced or stolen with saved passwords.
    - Information would be accessible by anyone in possession of the device.
  - Use of public, unsecure networks
    - The data that is transmitted can be seen by others.
  - Use of USB ports on office computers
    - Viruses can be introduced via USB ports.
    - USB ports can be shut down.

27

Integrity of EHRs and PHI

- **Ransomware viruses**
  - EHR system is breached by a hacker.
  - Hacker encrypts the patient data and the physician is locked out of the system unless they pay a ransom.
  - Law enforcement agencies have said to pay the ransom.
  - No guarantee you will get your data unencrypted after the ransom is paid.
- **Problem for any industry with a heavy reliance on technology.**

28

Integrity of EHRs and PHI

- **Prevention of ransomware viruses**
  - Have anti-malware software installed on your system.
  - Have firewalls installed on your system.
  - Restrict the staff's Internet access to websites only necessary to operate the practice.

29

Integrity of EHRs and PHI

- **WiFi security**
  - WiFi signals can be accessed from a distance, including from floors below and above your office.
  - Ensure the same level of security and protections with WiFi as in the system behind the firewall.
  - Provide WiFi access for patients and visitors that is separate from what is used by the practice.

30

System Attacks

- **Steps to take after a system attack**
  - Identify the nature of the attack.
  - Stop the attack.
  - Assess the damage.
  - Engage the appropriate IT staff to figure out how it happened, how the virus got in, what damages occurred and what you need to do to correct the vunerability.

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System Attacks

- **Must determine if there has also been a data breach (i.e., has the data been encrypted or stolen from the server?)**
  - Encrypted data may be lost if the hacker's server is shut down.
- **May need to restore data from backup files**
- **If there is a data breach, there are many federal (including HIPAA) and state law regulations that require reporting the attack to various authorities.**

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Strategies

- **Perform system backups on a regular basis, as frequently as possible.**
- **Have a disaster recovery plan.**
- **Perform due diligence on all hardware, software, and vendors.**
- **Ensure IT vendor is familiar with privacy and security.**

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Strategies

- **Key to protecting patient data is the vigilent prevention of hackers getting in your system.**
  - Educate staff.
  - Do not use USB ports for personal devices.
  - Change passwords on a regular basis.
  - Report anything suspicious to your system administrator.

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Thank You.

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FOLLOW-UP PROCEDURES IN THE OFFICE PRACTICE

Follow-Up Procedures in the Office Practice

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Follow-Up Procedures

- **The failure to follow up on the results of diagnostic tests or consultations may result in a delay in diagnosis or treatment.**
  - Potential liability exposure
  - Root cause of many professional liability claims

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Missed Patient Appointments

- **Office staff must ensure that the physician is aware of missed patient appointments.**
  - Electronic Health Record (EHR) systems can generate a daily report for the physician to review.
- **The provider must determine the next appropriate steps.**

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Missed Patient Appointments

- **It is also important to identify the reason for the missed appointment.**
  - Did the patient forget or is this a compliance issue?
  - Is there a language barrier?
  - Did the patient understand the importance of the appointment?
  - Is transportation an issue?
  - Is the patient unhappy with any care from any members of the staff?
  - Are insurance co-pays and cost an issue?

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Missed Patient Appointments

- **The physician will determine the importance of the missed appointment and how aggressive to be in terms of follow-up.**
  - Annual exam vs. follow-up of a chronic condition
  - Urgent vs. non-urgent visit
- **Policies and procedures must be developed for staff to initiate follow-up processes.**

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Missed Patient Appointments

- **Policy should be written to direct staff on the manner of patient follow-up:**
  - Phone call
  - Post card
  - Letter
  - Patient portal message
- **Method of follow-up must comply with your HIPAA notice of privacy practices.**

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Missed Patient Appointments

- **Documentation of all steps taken to follow up on a missed patient appointment is critical.**
  - Failure to document both the missed appointment and follow-up efforts make a lawsuit difficult to defend.
  - The liability for a missed patient appointment that results in a poor outcome may fall on the physician.

7

Missed Patient Appointments

- **Implement strategies to help patients remain compliant and keep scheduled appointments.**
  - Make confirming phone calls prior to all appointments.
  - Send a computer-generated email or text reminder of the appointment.
    - Require confirmation text or email back from patient.

8

Referrals for Consultations

- **A missed appointment for a specialty consultation can be legally problematic for the referring physician.**
- **The referring physician is the coordinator of the care.**
  - It is the responsibility of the referring physician to follow up on a consultation just as with any other request made of a patient.
  - Liability may exist if follow-up is not done.

9

Referrals for Consultations

- **Patient may self-refer to a specialist**
  - Not referred for care by another physician
- **In this scenario, it is important to establish a care coordination process:**
  - Discuss with the patient the communication of clinical findings.
  - Document the primary care physician named by the patient and to whom all records are sent.

10

Referrals for Consultations

- **The referring physician needs to impress upon the patient the rationale and importance of making and keeping that referral appointment.**
  - Improved understanding will increase the likelihood of the appointment being kept.

11

Referrals for Consultations

- **An EHR tracking or similar tickler system should be used to follow up on the results of consultations.**
  - Confirm the appointment with a consultant was kept by the patient by looking for a report of the findings.
- **Consider scheduling consultation appointments while the patient is still in the office.**
  - Many times the hardest part of this process is being able to schedule an appointment at the specialist office.

12

FOLLOW-UP PROCEDURES IN THE OFFICE PRACTICE

Referrals for Consultations

- **Document all discussions with the patient, as well as efforts made on their behalf to obtain the consultation.**
  - Calls from patients that they are unable to get an appointment with the consultant should be referred directly to the ordering physician.

13

The Medically Complex Patient

- **When the patient is seeing multiple physicians:**
  - Multiple physicians within the same specialty
  - Multiple physicians from different specialties
- **Accountability for care coordination by one physician is key.**

14

The Medically Complex Patient

- **The coordinating physician is responsible for overseeing the plan of care and managing the information in the medical record.**
  - May not be a primary care physician

15

The Medically Complex Patient

- **If a patient has more than one chronic health issue, the cardiologist or endocrinologist may be the designated coordinator of care.**
- **The specialist may see the patient on a more frequent basis than the primary care physician.**

16

The Medically Complex Patient

- **When the patient is seeing multiple physicians and consultants:**
  - The physician who orders the test is responsible for its follow-up.
  - Any physician who sees an abnormal result should respond to it as well.
  - Clarify this information for the patient as well.
  - Patients without guidance can feel angry, frustrated, etc.

17

The Medically Complex Patient

- **Plaintiffs' attorneys look to the primary care physician, not the patient, to be responsible because the physician has more knowledge of the patient's condition.**
- **A process for care coordination must be established and documented in the EHR for the patient who self-refers to the specialist.**

18

Follow-Up of Diagnostic Tests

- **Physicians can be held liable for patients who fail to undergo recommended tests.**
  - Document all steps taken to ensure patients undergo the recommended studies.

19

Follow-Up of Diagnostic Tests

- **Communication with the patient on the importance of the test is crucial.**
  - This discussion should include educating patients about the risks of not following the plan of care.
- **The practice should have a policy and procedure in place to address follow-up for missed diagnostic tests.**

20

Follow-Up of Diagnostic Tests

- **The physician must be made aware to ensure the level of follow-up is commensurate to the missed test.**
  - Utilize a tickler system or EHR tracking system.
  - Letters are proof of follow-up and can demonstrate the physician advised the patient multiple times of the importance of the test.
    - Shows you made reasonable efforts and that you are organized.

21

Follow-Up of Diagnostic Tests

- **Good documentation of all follow-up steps taken, as well as the patient's response or noncompliance, is the best defense against a claim or suit.**
- **Recommend one telephone call, two if needed, and a follow-up letter.**
  - Consider discharging the patient from the practice if consistently noncompliant.

22

Communicating Test Results

- **Problems resulting in litigation can occur when there is a failure to:**
  - notify a patient of a positive test result; and/or
  - act on test results
- **Upon ordering a test or lab work, physicians need to communicate to the patient that they will be hearing back from the office once those results are in.**

23

Communicating Test Results

- **Consider having the patient come to the office to review test results.**
  - Can:
    - Identify tests that were not performed.
    - Review inconsistencies in results.
  - Establishes closure and completeness of the physician evaluation.

24

FOLLOW-UP PROCEDURES IN THE OFFICE PRACTICE

Communicating Test Results

- **A policy and procedure should be developed to guide this process.**
- **Utilize EHR tracking systems to flag high risk patients and identify significant results.**
- **The physician will determine whether communication with the patient requires a discussion in person or a phone call.**
  - If you are unable reach the patient by telephone, send a letter with certificate of mailing.
  - Keep a copy in the patient's record.

25

Communicating Test Results

- **Plaintiff's counsel will review all test results in the medical record.**
  - Ensure all results were reviewed by the physician.
  - Look for documentation that the patient was advised of all results.
- **An abnormal test result that is not addressed is an area of potential liability for failing to meet a standard of care.**

26

Communicating Test Results

- **Physicians can be responsible for failing to review patient information from all providers in a comprehensive EHR.**
- **Encourage patients to be partners in their healthcare and to call the office for their test results.**
  - Patients should not rely upon "no news is good news."

27

Communicating Test Results

- **Office staff are integral to this communication process.**
- **Develop a policy and procedure for staff to:**
  - Monitor when test results come into the office.
  - Organize results for physician review.
  - Coordinate patient-physician discussions as directed by physician.
  - File/scan into EHR once communication is complete.

28

Patient Noncompliance

- **Noncompliance, be it a missed appointment or failure to follow the plan of care, is a concern as both may lead to patient injury.**
- **Reach out to the patient to identify the reason for the noncompliance.**

29

Patient Noncompliance

- **Many factors can be involved:**
  - Fear
  - Stigma
  - Costs
  - Understanding their diagnosis
  - Divorce or multiple family households

30

Patient Noncompliance

- **Understanding the reason for noncompliance will help determine the next steps.**

31

Patient Noncompliance

- **Reasonable efforts must be made to reach the noncompliant patient.**
  - Reasonableness is determined by each patient's condition and medical risk.
  - Extent of efforts to reach the patient is determined by the risks.
  - The physician has the ultimate responsibility because he/she has the knowledge and expertise to determine the impact of noncompliance.

32

Patient Noncompliance

- **Efforts to reach the patient may include:**
  - Telephone the patient with a request to call within a defined time and make and keep the next appointment.
  - Send a letter to the patient (certificate of mailing) if there is no response.
- **Document all efforts made to rectify this compliance issue.**

33

Patient Noncompliance

- **Consider discharging the patient from the practice.**
  - Determine how serious this noncompliance is to the health of the patient.
  - Identify if noncompliance is a pattern for this patient.
  - Examine the liability risks associated with the continued noncompliance of this patient.

34

Discharging a Patient From Your Practice

- **Discharge from practice should be done in writing.**
- **Consult with attorneys from Fager Amsler Keller & Schoppmann, LLP to determine whether discharge is appropriate.**

35

Discharging a Patient From Your Practice

- **There are certain situations where discharge may not be appropriate. The patient:**
  - requires urgent or emergent care;
  - requires of continuous care without a gap; or
  - is over 24 weeks pregnant
- **Discharge letter should indicate the patient is being discharged by all providers in the practice.**

36

FOLLOW-UP PROCEDURES IN THE OFFICE PRACTICE

Discharging a Patient From Your Practice

- **Discharge letter should include one of the following reasons:**
  - A serious disruption in the physician/patient relationship
  - Noncompliance with recommendations for care and treatment.
    - Urge the patient to follow up with another physician immediately.
  - Nonpayment for professional services that are duly rendered despite multiple attempts to arrange a plan for payment

37

Discharging a Patient From Your Practice

- **There should be a 30-day notification period from the date of the letter when the physician is only available for emergency care.**
  - The physician determines whether the patient has an emergency.
  - Provide more time depending on geographical area or specialty.
- **Ensure the patient has sufficient medication for at least 30 days.**

38

Discharging a Patient From Your Practice

- **Enclose an authorization for the transfer of medical records to another physician.**
- **Suggest the patient contact the medical society, hospital referral service, or insurer for a list of physicians.**

39

Discharging a Patient From Your Practice

- **Send the letter with a certificate of mailing.**
- **Do not use certified mail.**
- **Scan and maintain a copy of the letter and the certificate of mailing in the medical record.**
  - Both will aid in protecting you from charges of patient abandonment

40

Treating Patients with Limited Health Insurance

- **It has become very common for patients with limited health insurance or very high deductibles to forgo healthcare due to costs.**
- **Physicians should advise patients of the risks of not following/pursuing parts or all of a plan of care.**
- **Assist the patient in prioritizing their healthcare needs.**

41

Treating Patients with Limited Health Insurance

- **May need to adjust the care plan, change a medication to address cost issues.**
- **Explore other resources that may be available for financial assistance.**

42

Treating Patients with Limited Health Insurance

- **Discuss and document:**
  - All requests to have patient undergo the recommended test/procedure/consultation
  - A comprehensive informed refusal of care, including the risks of refusing care, the alternatives to the proposed test/procedure/treatment, including the risk of no treatment

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Treating Patients with Limited Health Insurance

- **If the patient remains adamant that they will not comply with the plan despite careful explanations and discussion, physicians should ask the patient to sign an Informed Refusal form.**
  - Sample forms are available from Fager Amsler Keller & Schoppmann, LLP.

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Thank You.

Questions/Comments
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HIGH EXPOSURE LIABILITY: A CASE STUDY ANALYSIS - PART 1

Case Study: Section I

On February 24, a 39-year-old male construction worker presented to a hospital ED at 12:15 p.m., complaining that he had passed out at work that morning and lost consciousness. He also reported numbness in both hands and that he had a similar episode the previous week.

At 1:10 p.m., he was evaluated by the emergency physician, who noted that this was the patient's second episode of syncope, with no associated fall or trauma. The patient had been experiencing intermittent episodes of light headedness, along with paresthesia of both hands, for the past two weeks. He was a smoker and had a family history of coronary artery disease. The cardiovascular exam was normal, and on neurologic exam, there were "no appreciable deficits." A syncope work-up was ordered, which included EKGs, cardiac enzymes, an echocardiogram, and a non-contrast CT of the head. The CT scan was unremarkable, and the lab tests and EKGs did not show evidence of an acute MI.

While in the ED, the patient requested that he be placed under the care of his father's attending cardiologist. The emergency physician's report, dictated at 1:29 p.m., indicated that the cardiologist was contacted, but he was in the catheterization lab and unavailable at the moment. The emergency physician did speak with the cardiologist's physician assistant (PA), and she was to see the patient in the ED, contact the attending cardiologist, and arrange an admission on his service.

At 3:15 p.m., the PA entered a progress note that the patient was to be admitted for monitoring and a cardiac work-up. She conducted a cursory exam, with a concentration on cardiac issues, and obtained an EKG. An echocardiogram was ordered. The PA noted that the brain CT scan had ruled out an acute bleed or infarct. Her diagnosis was syncope, rule out MI, rule out arrhythmia. She wrote that the patient was nauseous and ordered Zofran, Tylenol, and aspirin. The last line of her orders was "neurology consult." The patient was held in the ED, as an inpatient bed was not yet available.

Case Study: Section 2

At 3:55 p.m., while undergoing the echocardiogram, the patient vomited, became dizzy and diaphoretic, felt flushed, and complained of right facial and right arm numbness. The cardiologist in the lab, who was to interpret the results, documented the event and noted that a motor exam was non-focal. The patient was transferred back to the ED for further care, and the echocardiogram was to be completed at the bedside. The cardiologist wrote that he "gave report to the ED RN/MD," but did not specify who this person was. The echo nurse, who accompanied the patient, documented the name of the nurse who received the patient back in the ED.

Case Study: Section 2 (Cont.)

At 4:30 p.m., the PA entered a progress note that she was contacted by an ED nurse and advised that the patient had returned from the echo with complaints of vomiting and dizziness. Her plan consisted of continuing to monitor the patient, and she considered the possibility of a viral syndrome.

HIGH EXPOSURE LIABILITY: A CASE STUDY ANALYSIS - PART 1

High Exposure Liability
A Case Study Analysis

Part 1

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Introduction

- **Estimated 80% of serious medical errors involve miscommunication during the handoff of patients between medical providers**
- **Consequences of substandard handoffs may include:**
  - Delay in treatment
  - Adverse events

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Introduction

- **Consequences of substandard handoffs may include: (Cont.)**
  - Omission of care
  - Increased length of stay
  - Avoidable readmissions
  - Increased costs
  - Potential for patient harm

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Introduction

- **Diagnostic errors in the Emergency Department (ED)**
  - Account for 37% to 55% of ED cases in studies of closed claims
  - Gaps in patient information contributing to medical errors include:
    - Delayed radiology/lab reports
    - Missing medical histories
    - Missing records of abnormal vital signs
    - Information lost during staff shift changes

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Case Study Analysis

Case Study: Section 1

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History & Physical Examination by the Emergency Physician

- **An emergency physician's perspective:**
  - documented
  - Details of the patient's history were missing
  - Possible age bias in establishing a diagnosis
  - Lack of a re-evaluation in the ED
  - Transfer of responsibility from the ED to the admitting service was not made clear

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History & Physical Examination by the Emergency Physician

- **A neurologist's perspective:**
  - Patient had a sensory complaint and needed a sensory examination
  - Lack of documentation of a neurological examination
  - Neurology consultation should have been ordered, if available

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History & Physical Examination by the Emergency Physician

- An evaluation of the symptoms and the anatomical location that explained the symptoms was needed, then the etiology could be determined
- Patient was transferred to the cardiologist's service, but the ED had not determined that the problem was cardiac related
- Needed to get a detailed history from the patient, especially in light of the previous episode of syncope

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History & Physical Examination by the Emergency Physician

- **A defense attorney's perspective:**
  - Failure to document pertinent negative findings
  - Only a limited history was documented
  - No documented neurological examination
  - Jurors can accept that medicine may not be an exact science, but the physician's documentation must demonstrate their thought process in making decisions

9

Contacting the Private Attending Physician

- **An emergency physician's perspective:**
  - Cardiologist needed to work with the emergency physician to make the right medical decisions
  - Cardiologist was acting as the patient's primary care physician
  - Cardiology PA helped provide continued care of the patient
  - Responsibility for continued care of an admitted patient remaining in the ED depends on policies and protocols

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Initial Examination by the PA

- **A neurologist's perspective:**
  - Was the cardiology PA adequately trained to perform a neurologic examination?
  - Delayed the involvement of the correct specialist
- **An emergency physician's perspective:**
  - Neurologic presentation was never recognized
  - Unclear why the PA ordered a neurology consult

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Initial Examination by the PA

- No urgency to continue the evaluation since the patient appeared stable
- It was the patient's second syncopal event which should have raised the level of concern
- **A defense attorney's perspective:**
  - PA did not appreciate the urgency of the situation
  - Jury may be sympathetic to a PA placed in a difficult situation

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HIGH EXPOSURE LIABILITY: A CASE STUDY ANALYSIS - PART 1

Initial Examination by the PA

- Physicians utilizing PAs must have clear communication and monitoring
- If there is was problem involving a PA, the jury will ask the "what if" questions:
  - What if the attending physician was aware?
  - What if the attending physician had come to see the patient?
  - What if there was clearer communication between the physician and the PA?

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Case Study Analysis

Case Study: Section 2

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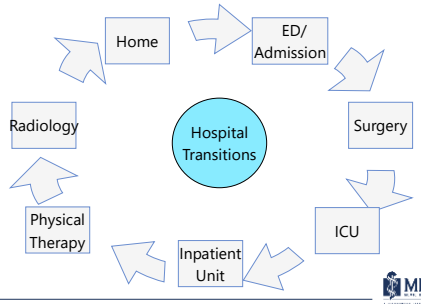
Transitions Within a Hospital Setting



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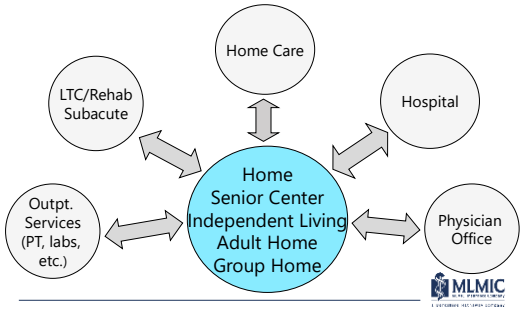
Transition Locations



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Return of the Patient from the Echo Lab

- **An emergency physician's perspective:**
  - Episode in the echo lab was unusual and clearly did not have a cardiac cause
  - Physician in the echo lab should have spoken directly to the emergency physician or attending cardiologist regarding the episode
  - Transitions of care can be difficult when admitted patients are waiting in the ED

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Return of the Patient from the Echo Lab

- **A neurologist's perspective:**
  - Episode in the echo lab was clearly a neurological event – the second within hours
  - Communication should be physician to physician, if possible
  - The information discussed should be documented in the medical record

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Follow-Up by the PA

- **An emergency physician's perspective:**
  - What was the evaluation of the patient upon his return to the ED?
  - Was the neurological exam normal or were there deficits?
- **A neurologist's perspective:**
  - It was clearly a neurological event, but not sure if the PA was aware of the details of what happened
  - An emergency neurology consult was needed

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Follow-Up by the PA

- **A defense attorney's perspective:**
  - PA was placed in a difficult position
  - Her documentation does not address the most significant issues involving the patient
  - No documentation to show if she was made aware of the event, or if she was aware, why she didn't communicate the information to the emergency physician or the cardiologist

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Use of Mid-Level Providers in the ED

- **An emergency physician's perspective:**
  - PAs working in the ED have colleagues available
  - When a PA comes to the ED from another service, it can be a more difficult situation
- **A defense attorney's perspective:**
  - PAs are usually sued because they were not properly supervised

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Use of Mid-Level Providers in the ED

- PAs are used as a vehicle to get to the attending physician
- When things go wrong, the plaintiff's attorney will suggest that things would have been different if the attending physician was present

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Inpatient Boarding in the ED

- **A defense attorney's perspective:**
  - The jury will not be concerned with whose care the patient was officially under
  - The jury's question will be, "Did this patient receive adequate care?"
  - Poor documentation results in poor communication
  - Want to be able to rely on what was documented in the medical record

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HIGH EXPOSURE LIABILITY: A CASE STUDY ANALYSIS - PART 1

Case Study: Section 3

At 5:00 p.m., the admitting cardiologist came to the ED and evaluated the patient. Although he did not document a progress note, he later recalled having performed a basic cardiac exam, interpreted the EKGs, and requested a neurological consultation since he did not feel there was a cardiac problem. The cardiologist also testified that he contacted the neurologist and provided him with all of the available information. He did not advise him on the timing of the consultation, as he felt the urgency would be determined by the neurologist. He claimed that he also contacted the neurologist from the ED, not just to consult, but to assume the care of the patient.

Case Study: Section 4

At 6:13 p.m., an ED nurse noted that the patient was awake, alert, oriented X3, and his speech was clear. The echo was completed at the bedside, and the patient complained of dizziness, nausea, and numbness of the right hand and arm. He remained in the ED, and at 9:05 p.m., another nurse's entry in the chart described him as lethargic with slurred speech.

At 9:35 p.m., a nurse's note described the patient as unresponsive, diaphoretic, pale, with right sided weakness. He was seen by a hospital intensivist for possible intubation, who sent him for a repeat CT scan of the head with contrast. He also had a CT scan of the chest, abdomen and pelvis to "rule out dissection," and they were unremarkable. The intensivist called the attending cardiologist and advised him that the patient's condition had deteriorated greatly and he was presently intubated in the ICU.

The cardiologist immediately contacted the neurologist and learned that the consult had not yet taken place and advised him to see the patient immediately. Sometime after that, he received a call from the neurologist saying that he had just seen the patient, who was being aggressively treated and evaluated for this acute change in mental status.

The next day, February 25, an MRI was performed which demonstrated a basilar artery occlusion and extensive acute posterior circulation infarction. The patient was transferred to a tertiary care facility, where he was pronounced brain dead on March 2nd.

On February 26, the cardiologist entered an addendum in the ED progress notes summarizing his involvement with the patient, as well as his desire to obtain a neurological consultation for the patient. He wrote that he informed the patient and family that the problem was non-cardiac, and he requested a neurology consultation. The note further stated that the neurologist agreed to care for the patient and that he no longer had "anything to offer in his care and management." The cardiologist later testified that he did not write a note during the ED visit because he concurred with the PA's notes.

Case Study: Section 4 (Cont.)

The neurologist claimed that he had no independent recollection of the patient or his interaction with the cardiologist. He was unable to produce the call logs from his answering service.

A lawsuit was initiated by the patient's family against the hospital, the emergency physician, the attending cardiologist, the PA, and the cardiologist in the echo lab, alleging wrongful death from the failure to timely diagnose and treat a basilar artery occlusion.

HIGH EXPOSURE LIABILITY: A CASE STUDY ANALYSIS - PART 1

High Exposure Liability
A Case Study Analysis

Part 2

Presented By:
Donald Pinals, MD
Michael Marin, MD
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Bill Vaslas, Esq.

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Case Study Analysis

Case Study: Section 3

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Evaluation by the Attending Cardiologist

- **An emergency physician's perspective:**
  - Progress notes did not show the cardiologist had turned over care to the neurologist
  - Patient continued to worsen over several hours with out anyone determining the underlying problem
  - Need definitive protocols for admitted patients held in the ED:
    - Who is responsible?
    - Who should be called?
    - Who writes the orders?
    - Who requests the follow-up lab tests?

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Evaluation by the Attending Cardiologist

- **A neurologist's perspective:**
  - Cardiologist did not appreciate the seriousness and potential for what might happen to the patient
  - Patient had two TIAs with no explanation
  - Cardiologist should have spoken to a neurologist, described the situation, and asked for advice

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Evaluation by the Attending Cardiologist

- **A defense attorney's perspective:**
  - The cardiologist should have prepared a progress note regarding his initial examination
  - A plaintiff's attorney would suggest that the cardiologist had obligation to apprise himself of what took place beforehand
  - A jury would want to know that the physician took every step to provide continuous care for the patient

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Transition of Care/Patient Handoff

- **A neurologist's perspective:**
  - Cardiologist needed to give the consulting neurologist clear information about the patient over the telephone
  - Neurologist was not given information by the cardiologist that suggested urgency
  - Documentation by the cardiologist would have helped his defense

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Transition of Care/Patient Handoff

- **A defense attorney's perspective:**
  - Cardiologist did not document this important step
  - Documentation of a handoff will prevent suggestions that there was no communication between providers
  - After a lawsuit is initiated, there is credibility in what was documented in the chart
  - Communicate with the family and document your discussion with them

7

Case Study Analysis

Case Study: Section 4

8

Inpatient Boarding in the ED

- **An emergency physician's perspective:**
  - This is a difficult situation in EDs
  - In this case, what would the emergency physician have done if he was the sole physician responsible for this patient? Would the management have been different?
- **A defense attorney's perspective:**
  - Jury can accept that a bed was unavailable, but not that the patient received substandard care because of it

9

Failure to Diagnose Basilar Artery Ischemia/Stroke

- **A neurologist's perspective:**
  - Giving tPA is a judgment call
  - Document the thought process that goes into the decision to give or not give tPA
- **An emergency physician's perspective:**
  - Possibility of giving tPA if a diagnosis of stroke is made
  - Need to determine:
    - When was the onset of symptoms?
    - What are the current symptoms?
    - What are the current deficits?

10

Defense and Causation

- **A neurologist's perspective:**
  - Case is not defensible
  - Sequence of events was typical for someone whose blood flow was shutting down in their vertebral-basilar system
  - Once a diagnosis is made, need to determine the treatment based on the patient's condition
- **An emergency physician's perspective:**
  - Case is not defensible
  - All providers had a role in the failure to diagnose

11

Defense and Causation

- **A defense attorney's perspective:**
  - Proximate cause defense: patient was never a candidate for tPA and nothing could have been done after the stroke
  - Prefer to try case on liability and departure issues
  - Difficult for jury to accept there was a departure in the standard of care, but recognize that it didn't cause harm or was not the substantial factor in causing an injury
  - Liability, but no causation, is a difficult defense

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Documentation

- **A defense attorney's perspective:**
  - Never alter a medical record
  - An addendum written in the record is acceptable if patient information is being added that the physician didn't have at the time
  - An addendum that is written to protect the physician or incriminate someone else will only benefit the plaintiff's attorney
  - Maintaining and retaining after-hour call logs can support the physician who has a good practice and accurate, truthful documentation

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Finger Pointing

- **From a defense attorney's perspective:**
  - Defendants will be cautioned that finger pointing is not an appropriate defense
  - Jury will conclude that someone did something wrong
  - Best defense is a unified defense

14

Preparing for Trial

- **From a defense attorney's perspective:**
  - Remain professional during the trial, even if the plaintiff's attorney is not!
  - Be prepared!
  - If the physician appears caring, well-informed and professional at trial, the jury will be more receptive to the defense that he/she did the right thing at the time of treatment

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Conclusion

- **Mixed expert opinions on the defense of the case**
- **Defendants refused to settle and case went to trial**
- **Case was later settled for a total of $1.5 million dollars**

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Thank You.

Questions/Comments
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Tip #15: Communication with Patients

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