Preventing Malpractice Lawsuits
Pediatric Emergency Medicine / Acute Care Pediatrics
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Closed Claims- Average Indemnity 1985-2011
• Neurology $331,886 1<sup>st</sup>
• Neurosurg $327,557 2<sup>nd</sup>
• Ob-Gyn $293,087 3<sup>rd</sup>
• Pediatrics $282,191 4<sup>th</sup>
• Emerg Med $245,250 9<sup>th</sup>
• Intern Med $223,980 14<sup>th</sup>
• Gen Surg $198,026 16<sup>th</sup>
• Ortho Surg $176,599 19<sup>th</sup>
• Fam Med $172,640 20<sup>th</sup>

Source: Physician Insurers Assn of America, 2012
Malpractice Risk and Awards
• 1991-2005- one insurance company
• Mean indemnity:
  Peds= $521,000    Highest of all
  All specialties= $275,000   EM= $180,000
• Awards > $1 million are rare (<1%)
• 7.4% all physicians sued annually
  – 3.1% pediatricians
  – 7.5% emergency medicine
  Jena AB, et al. NEJM, 2011

Malpractice Lawsuits
• 1/3 AAP members named
• ED= high risk
• 85% suits involve “off-hours”
• Most settle out of court
• 10% reach jury

High Risk Cases
Pediatric Emergency Medicine
• Meningitis
• Appendicitis
• Fractures
• Testicular torsion
High Risk Cases
Pediatric Emergency Medicine

• Wound complications
• Medication errors
• Myocarditis
• Dehydration

Why people sue

• Bad outcome
• Negligent care
• Poor communication

Why People Sue

• Monetary needs
• Anger/revenge
• Guilt/displaced blame
• “Save next patient”
• Relatives
• Greed
Lawsuits and the ED

• Long wait times
• Impersonal registration
• Brief contact with physician
• Rapport not established
• Distractions

Interruptions
Implications for safe, high quality care

5 ED Attendings, 8 nurses observed
• Physicians- 10 interruptions/hour
• Nurses- 12 interruptions/hour
  • Other people*, phone, pagers
  • Performed 1-8 other activity before return to original task


The Legal Process
Is it Malpractice?

• Bad outcome or bad practice?
• Was there a:
  – Duty to treat
  – Breach of duty
  – Injury related to this
• Role of an expert
Expert Witnesses

- Some organizations: ACOG, AAOS, ACEP
  - May review testimony if member has concerns
  - Rarely, will take action if expert provides false testimony

Standard of Care

What a reasonable practitioner, in that specialty, under those circumstances, would do
Statute of Limitations

- Most states (for adult patients): 2-3 years from time injury from negligence is or should have been discovered
- Extended for children
  - Developmental delays not obvious early on
  - Some states limit: 7-8 years after injury should have been discovered
  - Child may initiate lawsuit-age of majority

Statute of Limitations Case

- 18 year old boy sued NYC hospital for injuries suffered at birth
- Brachial plexus, Erb’s palsy, partial paralysis left arm
- Claimed he should have been delivered by OB experienced in shoulder dystocia, not residents
- Settled for $1 million

Selbst SM PEM Legal Briefs Ped Emerg Care 29(8), 2013

Preventing Malpractice Lawsuits

1. Practice good medicine
2. Communicate well
   (patients, staff, consultants)
3. Document the good care
**Practice Good Medicine**

- Act reasonably
- Consider mother’s concerns
- Observe if worrisome history, exam
- Focus on persistent vomiting, lethargy
- Arrange follow-up
- Look for improvement

**Practice Good Medicine**

- Follow policies and protocols
- Often sought by attorneys
- Make sure they are reasonable
- Defend deviation from guidelines
- Supervise trainees
  - Lack of supervision—medical errors


**Case Illustration**

- 16 year old “feeling terrible”
- 3 ED visits in 5 days
- DX flu, atypical pneumonia, stress
- Mother wants admission
- Mother escorted out of ED
- Admitted elsewhere with pneumonia
**Failure to Communicate**
- 70% lawsuits involve communication style, clinician attitude
  - Inadequately explained diagnosis, treatment
  - Failed to understand patient/family perspective
  - Discounted, devalued patient/family views
  - Patient felt rushed

*Beckman HB Arch Int Med 1994*

**Communication Skills**
- Patient satisfaction is key
- Consider professional training, role playing
- Patient advocate helps
- Triage and registration important

**Communications Skills ED Physician**
- Unhurried appearance
- Dress, posture, manners
- Demonstrate compassion
- Apologize for wait time
- Listen well
- Speak clearly, simply
- Hide your own anger
**Communication Skills**

• Tell family what to expect
• Keep family informed
• Don’t demean others
• Avoid joking, stray comments
• Calm angry families

**Communication - Interpreters**

• Use interpreter if needed
• Errors still occur
• Clinically significant errors more likely with ad hoc interpreters


**Communication - Interpreters**

• Case
  – Neonate brought to Rhode Island ED
  – In Triage, uncle (not fluent in English) demonstrated he tapped on baby’s chest
  – Asked if baby stopped breathing, said “no, no, I don’t know”
  – Resident documented hx “limited by language”
  – Discharged- apnea, death from RSV
  – Jury awarded $400,000

Selbst SM *PEM Legal Briefs Ped Emerg Care* 26(2), 2010
Case
• Mexican male with limited English using nail gun (seen in Oregon)
• C/O struck by piece of metal
• ED doc noted “struck by wood chip”
• Phone interpreter used, no speaker
• Dx corneal abrasion
• Vision loss from metal FB
• Jury award $350,000

Selbst SM PEM Legal Briefs Ped Emerg Care 19 (1), 2003

Communication with Patients
• 2 teaching hospitals in Michigan
• 4 domains studied
  – Diagnosis and cause
  – ED care
  – Post-ED care
  – Return instructions
• 78% deficient in 1 domain
• 51% deficient in 2 or more domains

Discharge Instructions
• When to see PCP
• When to immediately return to ED
• Review written instructions
• Obtain signature
Discharge Instructions

Only 60% of guardians for pediatric patients complied with discharge instructions to follow-up with a physician after leaving the ED


Discharge Instructions

- Verify comprehension
  - Have family paraphrase
- Tailor teaching to areas of confusion
  - Consider use of pictures

Samuels-Kalow ME, et al. Effective discharge communication in the ED *Ann Emerg Med* 60 (2); 2012


Discharge Instructions

- 844 audiotapes
- Verbal instructions often incomplete
- Minimal opportunities to ask questions, confirm understanding
- 34% told of symptoms that should prompt return

Vashi A, Rhodes KV. “Sign right here and you’re good to go”, … *Ann Emerg Med* 2011
Communication with ED Staff

- 65% sentinel events involve communication issues
  

- 24% cases of error/malpractice claims, inadequate handoff was leading contributor


Referral Note

- 5 month old
- To PCP on 1/15
- Temp 104.6
- Large head
- No source for fever
- Will not fix gaze
- R/O sepsis, R/O ↑ ICP

Triage 1130 on 1/16

- CC - fever, bulging fontanelle
- Crying, no relief
- Pus in both ears
- Lethargic, very sleepy

- T - 38.6
- P - 142
- RR - 64
- BP - 114 / 55
Resident Physician at 1235

- 4 days fever, screaming
- Poor fluid intake
- Large head from birth
- PE: conscious, tends to sleep
  - Neck supple
  - AF normal
  - Follows poorly

Assessment / Plan

- DX: Right OM
- Discharge to Home
- RX: oral antibiotics
- Change of shift
  - Child seen by resident only
  - Each Attending thought the other would precept

Outcome

- 1/18 0700 Cardiac arrest
- Retrospective note by ED physician
- Says colleague responsible
- Did not see patient
- Resident never precepted
- Worrisome chart found later
- PMD wrote long note 1/19
Lawsuit

• Who is responsible?
• How can this be prevented?
• What is an effective handoff?

Handoffs

• Call for standardized sign-out
  – Relevant medical, surgical history
  – Patient course, current condition
  – Studies obtained, pending
  – Suspected diagnosis
  – Anticipated disposition


Change of Shift

Teaching Points

• Dangerous time
• Communicate well with colleagues
• All involved have responsibility
• Reexamine the patients
• Avoid inflammatory documentation
Communication- Consultants

- Timely consultation is crucial- do not delay work-up (e.g. testicular torsion)
- Do not blindly accept advice
- Do not ignore advice
- Be clear on phone consultations
- PCP is advisor only
- Manage discordant radiology reads


Young man stabbed with “dragon dagger”

- Left lateral thigh wound
- In ED- hypotensive, lethargic
- IV fluids, blood ordered
- Wound sutured
- 2 hrs later, surgeon called
- Admit to ICU

Surgeon arrived 3 hours later
- Patient in cardiac arrest
- Severed iliac artery, DIC
- Death in OR

Lawsuit- defense verdict

Selbst SM PEM Legal Briefs Ped Emerg Care 27(2), 2011
**Teaching points**

- Hypotension must be explained—suspect more serious injury
- Good sign-out is essential
  - Surgeon not aware of shock on arrival
  - Not told of urgent need

**2 mo old boy fell, hit head**

- ED obtained head CT
- No fracture or bleed noted
- Discharged from ED
- Radiologist later noted:
  - Focal densities 4th ventrical, posterior skull
  - Recommends follow-up
- Parents and ED staff not notified