Medicolegal Risk Management

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Objectives

Describe appropriate safety measures to minimize medical (medicolegal) risk from systemic drugs.

Identify interactive skills with patients to minimize medicolegal risk in dermatology.
Important References


Shah VV, Kapp MB, Wolverton SE. Medical malpractice in dermatology-Part II: What to do once you have been served with a lawsuit. Am J Clin Dermatol 2016 (Dec);17(6):601-7.
General Approach

✓ Most points/principles from part I Q&A

✓ Part II Q&A that induce greatest fear in docs also covered

✓ Roughly 2/3 of Q&A from part I and roughly 1/2 of Q&A from part II covered in following slides

✓ Striving for heightened awareness, not memorization
Three states of relevance – speaker and attendees

✓ Washington  29.0 lawsuits/100K population  top quintile
✓ Oregon      28.6 lawsuits/100K population  4th quintile
✓ Indiana     20.7 lawsuits/100K population  3rd quintile

research.zippia.com/states-that-sue
Top 10 ways to reduce your risk of a malpractice lawsuit

Table 1 Part I

1. Establish strong physician-patient relationships
2. Obtain written informed consent (when standard of care)
3. Maintain your education
4. Maintain current patient health information
5. Maintain precise, comprehensive documentation
6. Hire (and train) qualified staff
7. Follow-up with patients
8. Request feedback
9. Be organized
10. Obtain suitable malpractice insurance

… great place to start, not intended to be comprehensive.
Wolverton Medicolegal Experience 1993-date

SJS cases
- Nutrition supplement
- Weight loss medication Rx
- Lamotrigine in child*
- TMP/SMX
- Law firm to adjudicate phenytoin role

Minocycline-induced DReSS

Isotretinoin cases
- IBD*
- Hyperlipidemia induced CVA

Fluoroquinolone/warfarin fatal hemorrhage*

Corticosteroid cases (systemic)
- Avascular necrosis/osteonecrosis
- IM CS and psoriasis flare
- IM CS and fat atrophy

Methotrexate (IM) and sepsis

Failure to diagnose melanoma*

Prison case of “deliberate indifference” in failing to prescribe amcinonide lotion*

“Plaintiff case” as examining physician and later expert witness liver transplantation during pregnancy due to carbamazepine
Wolverton personal lawsuit experience

I have twice been “served” with certified letter for a malpractice lawsuit

✓ “Homeless” lawyer “excessive” prednisone dose for bullous pemphigoid case

✓ Consultant/second opinion for MTX fibrosis → cirrhosis case (two visits)

... request for records “in no way involves action against you” yet**
What general precautions may help me avoid a malpractice lawsuit?

Important concepts

✓ Follow the suggestions in Table I from Part I (“Top 10 ways …”)
✓ It is very uncommon for patients to sue a clinician they like a lot!!
What is the overall risk for being named in a malpractice lawsuit in Dermatology?

Important concepts

✓ Jena* study in NEJM 40+K docs with 233+K claims in all 50 U.S. states
✓ Dermatology ranked 21st lowest of 24 specialties studies
✓ Mean payment all claims $274,887 with dermatology median $117,832

✓ PIAA self-report study 239+K claims, 2704 against dermatologists (1.1%)
✓ Most common were (a) inappropriate performance during procedures, and (b) diagnostic errors
✓ Melanoma (“failure to diagnose”) was most common diagnostic error

Is an “apology” an effective strategy to avoid a malpractice lawsuit?

Important concepts

✓ All but 13 states have “apology laws” (Oregon and Washington do have)
✓ AMA and ACP encourage disclosure of medical errors to patients → EFYTS
✓ 2015 Medscape Malpractice Report – 81% docs surveyed “disagree”
✓ Weak causal relationship between “apology” and subsequent lawsuit
✓ Components of reasonable “apology” (a) sincere apology without admission admission of guilt, (b) explanation of events in understandable way, and (c) writing off physician charges if possible (Bonus → “will stand by you”)

U.S. states without “apology laws”

- Alabama
- Alaska
- Arkansas
- Illinois
- Kentucky
- Kansas
- Mississippi
- Nevada
- New Mexico
- New York
- Pennsylvania
- Rhode Island
- Wisconsin
How can I better prepare my support staff to prevent a future malpractice against them and myself?

Important concepts

✓ Should be organized, hospitable, and competent in their area of work
✓ Should quickly “refer” to clinician any difficult patient encounters
✓ Provides written summary of encounter (at least with many EMR)
✓ Instruct staff to be courteous, empathetic, timely pt/family communications
✓ Avoid giving (or appearance thereof) medical advice or diagnosis
How can I improve my progress notes to protect me against a malpractice lawsuit?

Important concepts

✓ “Was not written, was not done”
✓ Problems or inconsistencies in medical record make/break the case
✓ Prepare notes in manner patient/family and attorney/jury to easily read
✓ Notes thorough, clear, concise regarding diagnosis and plan of care
✓ If possible, explain why you exclude certain diagnoses
✓ Some specialties incorporate Clinical Practice Guidelines into notes
✓ Dictating/detailing plans in front of patient has pros and cons
What general precautions should I take when using my electronic medical record (EMR)?

Important concepts

✓ Tremendous caution should be given to “copy and paste” function
✓ Due to potentially incorrect, outdated PHI circulated, ↑ medical errors
✓ Clinical decision support (CDS) systems for allergies, interactions
✓ Can be held liable CDS alerts that were ignored (VA ketoconazole shampoo)
✓ HIPAA related – password or computer theft, visit unprotected sites, etc.
✓ Report any security breaches immediately to patients, HIPAA, MP carrier
✓ Speak with EMR about possible encryption
What are the components of informed consent (IC) that I need to protect me from a future lawsuit?

Important concepts

Components of informed consent process
(1) Assessment of patient competence
(2) Patient education of management plan
(3) Specific explanation of risks, benefits, uncertainties, alternatives, including no treatment (drugs, procedures)
(4) Patient understanding verified
(5) Patient consent

… informed consent is the dialog/communication process not the signature
For which patients is a written IC required?

Important concepts

✓ Majority of IC is not written, largely under heading “express” consent
✓ Of systemic derm drugs, isotretinoin is only with **required** written IC
✓ **Surgical** procedures virtually always require written IC
✓ **Clinical trials** (always) all types, plus photographs (ideally) written IC
✓ No clinician would ever be faulted for creating own IC form for systemic Rx

… see *dapsone IC appendix* in my latest book CDDT 3e as example
In a general sense, which risks need to be discussed during the IC process for standard treatment?

Important concepts

✓ (Virtually) everyone agrees that IC does **not** require discussing every risk
✓ Most agree that **common** and (potentially) **serious** risks need to be discussed
✓ There is **no** consensus which risks are common/serious available
✓ Roughly even split on states “reasonable **physician**” or ”reasonable **patient”

... “confession” of SW **not** knowing or “caring” which is IN standard
Is an error (such as ‘failure to diagnose”) by itself considered medical negligence?

Important concepts

Four components of negligence
(1) Duty
(2) Breach of duty
(3) Proximate cause
(4) Damages

✓ “Breach of duty” = failure to act within a reasonable standard of care
✓ “Error” = act/assertion/belief intentionally deviates from what is … right
✓ “Act of error” does not necessarily = medical negligence
Is an error (such as ‘failure to diagnose’)) by itself considered medical negligence? Part 2

Important concepts = supplemental thoughts

✓ Fear of legal repercussions can increase likelihood concealment of an error
✓ Result of above jeopardize a patient’s medical well being
✓ An error can occur even if standard of care followed
✓ In one study 31% of malpractice claims were “failure to diagnose”

Practicing physicians “should” focus on the following (plus “Top 10 list”)
(1) Providing optimal care for their patients
(2) Thorough documentation of diagnosis and follow-up efforts
(3) Open communication with providers to reduce the chances if error
How can I minimize my litigation risk during cosmetic procedures?

Important concepts

Choose your patients “wisely”
(1) Avoid patients with high-risk medical conditions
(2) Avoid patients with psychiatric conditions
(3) Avoid patient with prior legal proceedings (… how do you find out?)

In advance (#3 below “after procedure”) clarify with each patient
(1) Explain realistic expectations for procedure results
(2) Thoroughly counsel patients for risks, benefits, alternatives in IC process
(3) If error or AE occur, promptly notify patient (and why not also MP carrier)
What type of liability do dermatologists face when using telemedicine?

Important concepts

✓ See part I, table 3 that follows
✓ Risks include breach of patient confidentiality
✓ Discuss wisdom of being involved in telemedicine with legal counsel
✓ Discuss wisdom of being involved in telemedicine with malpractice carrier
What should I do **once served** with a notice letter or complaint?

**Important concepts**

✓ **DO NOT** call or **write** the patient (plaintiff)
✓ **DO NOT** **alter** the medical **record** (written or electronic)
✓ **DO** notify your malpractice **carrier**
✓ Locate the patient’s “chart” and **keep** in a **secure** area
✓ Only **discuss** issues related to claim with **lawyer** or malpractice **carrier**
What are my obligations once I have been formally served?

Important concepts

✓ In part II of articles many points relate to preparing for deposition/trial
✓ I would re-emphasize DO notify your malpractice carrier PROMPTLY
Will a malpractice lawsuit bankrupt me?

Important concepts

✓ Rarely do physicians pay out of pocket directly
✓ In these uncommon situations, most cases less than $100K out of pocket
✓ Should expect increase in malpractice premiums well below above $$ amt.
✓ Policy limits act as functional cap for damages limit
Did saying “I’m sorry” help or hurt me?

Important concepts

✓ Refer to part I of paper “important concepts” for apology law section
✓ In part II of paper, question becomes if given did the “apology” help/hinder
✓ Many state statutes limit protection to expressions of sympathy
✓ Wise to consult legal counsel and/or malpractice carrier before “apology”

… SW experience FTDx melanoma transplant pt; surprising outcome!
When is it reasonable to “settle” versus when should the clinician insist on going to trial (“fight”)

Important concepts

✓ Malpractice policies may or may not require clinician consent to “settling”
✓ In general “settling” a case is largely a business decision (probability issues)
✓ AMA study found 5% to 10% of cases ever reach a court
✓ Of these cases going to court, 1% (of original total) jury rule against doc
✓ Part II of SW article gives several circumstances for which “settling” wise
Is there a way to avoid being listed on the National Practitioner Data Bank (NPDB)

Important concepts

✓ Simplest concept is **no payment** by clinician or carrier = **not** on NPDB
✓ If “settle” thus there is a **payment** to plaintiff = **listed** on NPDB
✓ Can **not** have NPDB entry **deleted**
✓ Definitely can list your own **rebuttal** up to 4000 words on NPDB
✓ In rebuttal can **describe** your “story”, thought process, role in pt care, etc.

NPDB entry does **not**

(1) Affect a clinician’s **ability to practice** in any way
(2) Make clinician an **incompetent** practitioner
Many, many thanks!