7. DEFENSIVE MOVES & STRATEGIES TO AVOID MEDICAL MALPRACTICE SUITS IN PRIMARY MEDICAL CARE AND SPECIALTY PRACTICE

Defensive Strategies Avert the Most Common Causes of Medical Malpractice Lawsuits in Primary Care & Specialty Practice.

Introduction

In reviewing statistics from various states in the US on who gets hit the most with medical malpractice suits, the findings are that it is usually the specialists in Ob-Gyn, orthopedic surgery, and also physicians who specialize in cosmetic procedures. Ironically, most of these medical malpractice lawsuits can be prevented if only the physician pays particular attention to these known situations which most often leads to litigation.

This chapter certainly does not list all the different types of lawsuits aimed at physicians-but the chapter lists the more common suits that take place in various hard hit primary care and medical/surgical specialties. These include Ob-Gyn, Surgery, imaging (x-ray and mammograms), orthopedic surgery, pathology/laboratory, and also the most common suit filed in gastrointestinal endoscopy, based on the ERCP procedure in which a prominent physician has written about his legal experiences with dozens of cases in which he has testified.

Defensive strategies and Preventive moves will be presented in these high risk areas.

“I understand, however, from the inquest that there were some objects which you failed to overlook” Sherlock Holmes-The Adventure of Black Peter.

THE MOST COMMON CAUSES OF MEDICAL MALPRACTICE LAWSUITS CAN BE AVERTED BY SIMPLE PREVENTIVE MOVES.
A. Preventable Ob-Gyn Errors In Primary Care Medicine:

For the past 15 years, according to national medical malpractice insurance statistics the most paid claims were those of Ob-Gyn treatment especially performed by the primary care/general internist/general practitioner/ family physician. While malpractice lawsuits against nurse practitioners are rare, nurse practitioners have been also been sued for pregnancy-related mishaps. **Lawsuits against primary care clinicians for pregnancy-related mishaps fall into five categories:**

1. Failure to diagnose pregnancy before initiating a therapy with potential for fetal damage.
2. Failure to get a standard test to diagnose an abnormality in the fetus.
3. Failure to inform a pregnant patient of the likelihood of fetal abnormality.
4. Failure to treat a maternal illness appropriately.
5. Failure to diagnose a maternal illness affecting the fetus.

**Examples:**

Insertion of IUD into Pregnant Patient

Preventive moves:

a. A pregnancy test, careful evaluation of regularity of menses for the past three months, and history-taking on the patient's sexual activity and use of contraception is always indicated prior to IUD insertion, or any therapy which could cause fetal injury. Some patients have menstration-like vaginal bleeding in the early stages of pregnancy.

b. A missed period in a patient with a history of irregular menses is almost as likely to be due to pregnancy as a missed period in a patient with regular menses.

**Failure to Test for Fetal Abnormality**

A 36-year-old woman claimed that if she had been properly advised by her family doctor she would have had an amniocentesis, it would have revealed that her fetus had Down's Syndrome, and she would have chosen an abortion. After a trial and appeal, the patient won the case against the physician.

Preventive moves:

a. If a clinician renders care to a patient who is pregnant, the clinician may be held liable for failure to diagnose fetal abnormalities.

b. Any clinician evaluating and managing pregnant patients must remain up-to-date on the standard of care for screening for fetal abnormalities.
c. If that is not possible, rather than provide primary care, refer pregnant patients to obstetricians, midwives or OB/GYN nurse practitioners.

*Failure to Inform Mother of Potential for Birth Defects*

A physician diagnosed a pregnant patient with rubella, but did not inform the woman of the probability that the baby would be born with birth defects. The baby was born with multiple systemic abnormalities, and cerebral palsy. The patient sought damages for past and future medical expenses and custodial care, and was successful in getting a judgment against the clinician.

*Preventive moves:*
- The availability of abortion makes it a virtual certainty that a clinician will be sued for wrongful birth and negligence if the clinician knew or should have known that fetal defects were probable, but failed to discuss the patient's options as soon as the probability of defects was known (or should have been known)

*Failure to Appropriately Treat Maternal Illness:*

A 27-year-old woman who had had one previous seizure was 24 weeks pregnant when she had a second seizure. The clinician ordered a loading dose of phenytoin and admitted the patient to the hospital, but the patient did not receive the first phenytoin dose until nearly an hour after admission. The patient and fetus were found dead three hours after the dosage, the result of a seizure that went unnoticed. The patient's survivors alleged that the phenytoin dosage was too little, too late, and that the hospital had not monitored the patient closely. The defendant clinician argued that a higher dosage would not have prevented the seizure.

*Preventive moves:*

a. Right medication, right dose, right route, right time right and timely consultant, and proper monitoring.

b. Damages, as well as emotional trauma, will be extraordinary when the injured patient was pregnant.

*Using the wrong antibiotic in pregnancy:*

Because fluoroquinolones have caused arthropathy in young animals, these drugs should be avoided in children and in women who are pregnant or nursing according to [Owens RC, Ambrose PG: Antimicrobial safety: focus on fluoroquinolones. Clin Infect Dis 41:S144, 2005]
The fluoroquinolones generally have mild gastrointestinal side effects (nausea, vomiting, or anorexia), central nervous system side effects (light-headedness, dizziness, somnolence, or insomnia), or rash occurring in fewer than 10% of treated patients. But Gemifloxacin use for more than 7 days may be associated with an increased risk of rash, particularly in women younger than 40 years. Sparfloxacin contains a halide at position 8 and is associated with significantly more photosensitivity reactions than the other fluoroquinolones. Sparfloxacin and grepafloxacin were withdrawn from the market because they were shown to prolong the QTc interval. But this adverse event has also been reported with levofloxacin and moxifloxacin. Risk factors include underlying cardiac disease, advanced age, hypokalemia, hypomagnesemia, and the concomitant use of other agents that may prolong the QTc interval, such as antiarrhythmics, macrolides, and certain antihistamines. Hyperglycemia or hypoglycemia has also been described [in less than 2% of patients] treated with fluoroquinolones. Given this finding, dose adjustment should be considered in elderly patients with type 2 diabetes. Tendinitis and tendon rupture also occur very rarely. Less common side effects include allergic interstitial nephritis, pseudomembranous colitis, and neutropenia.

Preventive moves:

- Avoid all fluoroquinolones in pregnancy.
- Also exposure to selective serotonin reuptake inhibitors (SSRIs) late in pregnancy has been associated with short-term complications in newborns including jitteriness, mild respiratory distress, excessively rapid respiration and admission to the neonatal ICU. Paroxetine (Paxil) use should be avoided, when possible, by pregnant women or women planning to become pregnant due to the potential risk of fetal heart defects, newborn persistent pulmonary hypertension and other negative effects, [the American College of Obstetricians and Gynecologists’ Obstetric Practice Committee issued 12/106].

Failure to Diagnose Gestational Diabetes

After a woman gave birth to a baby with macrosomia (a condition related to maternal hyperglycemia/diabetes), the woman filed suit against a nurse practitioner working at a city health clinic, who, she said, had told her she did not have high blood sugar because her urinalysis was normal. An obstetrician was associated with the clinic, but the nurse practitioner did not refer the patient to him. The case settled in favor of the patient.
Preventive moves:

- Know the standard of care--in this case a glucose challenge test for all pregnancies at 24 to 28 weeks' gestation.
- Refer pregnant patients to OB/GYN physicians, midwives or OB/GYN nurse practitioners.
- Supervising Physicians must make regular “records rounds” with nurse practitioners and physician assistants- because the “buck stops with the supervising physician”.

B. Additional preventable errors in women patients:

A major problem is the poor quality of vaginal/cervical specimens. In diagnosing cervical cancer, biopsies must be taken from a certain part of the cervix known as the "transformation zone,". But physicians and nurses fail to collect cells from the zone often enough to miss lesions 30% to 40% of the time. Even though it is usually apparent if the proper cells aren't present, the lab usually will make a diagnosis on any sample it gets.

Preventive moves:

- All labs as part of the official report must report the presence or absence of tissue from the "transformation zone"
- The gynecologist or other referring physician must have an office system in place that will adequately follow up on these reports and re do the test if appropriate. If not re-done the reasons for not repeating the test will be stated in the medical record of the patient.

C. Preventable errors in Surgery:

Clinical errors are reported almost as frequently and are associated with almost five times as many deaths, as medication errors according to initial data released by Doctor-Quality
Inc. Adverse clinical events are also nearly three times more likely to require additional treatment than drug-related errors.

According to the “Alert” newsletter from the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] which followed a similar 1998 message reporting on 15 “wrong-site” cases, 136 additional cases were reported in the subsequent 4 years. Most cases involve orthopedic or foot-related surgery - operating on the left knee instead of the right knee, for example. Of 126 cases analyzed by the JCAHO, 76 percent involved operating on the wrong body part, 13 percent involved surgery on the wrong patient and 11 percent involved the wrong surgical procedure.

✓ Preventive moves:

Since most cases involve a breakdown in communication between the surgical team and the patient and his family, surgical teams should take a “time-out” in the operating room to make sure they have the correct patient, procedure and surgery site. See MSMC procedure protocol.

Errors in surgery leading to liability payments published in the peer reviewed literature:

1. In a major study of all admissions (age > 13) of three surgical patient care centers at a single academic medical center between January 1, 1995, and December 6, 1999, were reviewed for significant surgical adverse events. The study group consisted of 130 patients with surgical adverse events resulting in total liabilities of $8.2 million. The incidence of adverse events per 1,000 admissions across three patient care centers was
similar, but indemnity payments per 1,000 admissions varied (cardiothoracic = $30 US dollars, women's health = $90 US dollars, trauma = $520 US dollars). Patient demographics were not predictive of high-risk subgroups for adverse events or litigation. *Morris JA Jr, et al, from the Section of Surgical Sciences, Vanderbilt University Medical Center, “Surgical adverse events, risk management, and malpractice outcome: morbidity and mortality review is not enough”. [Ann Surg. 2003 Jun;237(6):844-51; discussion 851-2]*.

In terms of medical outcome, 51 patients had permanent disability or death, accounting for 98% of the indemnity payments. In terms of legal outcome, 103 patients received no indemnity payments, 15 patients received indemnity payments, four suits remain open, and in eight cases charges were written off ($0.121 million).

Preventive moves.

Stricter monitoring and “systematizing” of the five categories of major causes which accounted for 75% of the these published surgical errors.

1. patient management, n = 104;
2. communication, n = 89;
3. administration, n = 33;
4. documentation, n = 32;
5. behavior, n = 23).

The current medical review process[in hospital medical review conferences] would have identified only104 of 390 systems failures (37%).

This study concluded

a. that there were no rational links between the tort system and the reduction of adverse events.

b. Sixty-three percent of contributing causes to adverse events were undetected by current medical review processes.

c. Adverse events occur at the interface between different systems or disciplines and result from multiple failures.
Indemnity costs per hospital day vary dramatically by patient care center (range $3.60-97.60 US dollars a day).

2. **Delayed Surgery is associated high mortality from acute abdomen in ICUs**
   
   [Critical Care Medicine, June 2006].

In medical intensive care units (ICUs), an excess mortality due to acute abdomen is primarily due to delays in surgical evaluation and intervention, according to researchers from the Mayo Clinic in Rochester, Minnesota. Peters et al [Crit Care Med 2002;30:1187-1190] retrospectively studied 77 ICU patients who were diagnosed with acute abdomen catastrophe. The most common diagnoses were

i. ischemic bowel,
ii. perforated ulcer,
iii. bowel obstruction and
iv. cholecystitis.

Mortality rates were higher among these patients than predicted by their APACHE III (Acute Physiology and Chronic Health Evaluation) scores when they were admitted to the ICU (63% versus 31%), the researchers report. Of the 26 patients who did not have surgery, none survived; of the 51 patients who did undergo surgery, 28 survived.

The factors that were associated with the increased mortality rate among these patients were

a. delays in surgical evaluation (p < 0.01),
b. delays in surgery (p < 0.03),
c. APACHE III scores (p < 0.01),
d. renal insufficiency (p < 0.01), and
e. ischemic bowel (p < 0.01).

- Preventive moves:

Since delayed surgery, according to this preport was more common among patients with altered mental state, few peritoneal signs, previous opioid analgesia, antibiotics and mechanical ventilation, there should be more focussed attention to patients with these characteristics. There should be less of a threshold to do a CT scan and earlier surgical consultation in these patients.
Preventable Anesthesia Morbidity & Mortality

***Proper Airway Management is the worst of the complications-especially if not immediately recognized: It is well known that if a patient is deprived of oxygen for 4-6 minutes they will experience brain death. Longer periods will lead to cardiac arrest.

A. Misplacement of the endotracheal tube. However, if a certain checking device is not present (such as in an office where surgery is performed) or not working, then an error may be made in assessing whether the tube is correctly placed.

B. Aspiration of gastric contents in a patient with a full stomach is a potential cause of mortality. All pregnant patients, very obese patients, trauma victims and patients with bowel obstruction have a full stomach. Precautions, through use of drugs to hasten onset of anesthesia and paralysis, along with pressure over the neck to prevent gastric contents from coming up the esophagus, will minimize the risk of aspiration.

C. Forgetting to reverse certain anesthetics "—i.e., their actions must be terminated with the use of antagonists. Patients who are deeply anesthetized or paralyzed will not breathe and may become hypoxic.

D. Conscious sedation. This sedation should produce only mental relaxation but not loss of consciousness. However, the margin between one effect and the other blurs and the same dose of drug in one patient may produce loss of consciousness in another patient.

E. Tension pneumothorax from excessive pressure in helping respiration. Unless the pneumothorax is recognized and treated by placing tube through the chest wall into the area just outside the lung itself, the patient may go on to die.

F. Allergic Reactions:
1. The drugs that produce allergy with the response of marked drop in blood pressure and wheezing leading to inability to ventilate, are generally drugs that are used incident to anesthesia, such as muscle relaxants (paralyzing agents), intravenous anesthetic drugs, and antibiotics.

2. Latex may also cause life-threatening allergic reactions. Latex containing gloves may lead to an allergic response when the surgeon puts his/her hands into the patient's body. These complications must be immediately recognized and dealt with.

G. Dantrolene must be stocked at all times to recognize an infrequent muscle condition called MH which may flare under anesthesia. However, if the office or facility does not stock dantrolene and is familiar with the signs of the disorder, there could be medical and litigation problems.

H. Not recognizing and quickly treating elevated Potassium which can occur after Succinylcholine administration.

I. A liposuction technique has been developed using large amounts of dilute local anesthetics injected under the skin. If the drug is absorbed rapidly or too high a concentration of drug is used, then toxicity may result which must be immediately recognized and treated.

J. Mechanical Problems with anesthetic machines:

A check-out list must be followed by every practitioner prior to using the machine. This check-out will detect most every problem with the machine.

D. Preventable imaging errors
Preventive moves:

In the private sector, the imaging community must take steps to better document the quality of the services it provides.

The clinical effectiveness of new forms of imaging technology should be investigated and proved before they are used widely.

It is good policy that General Electric, the largest manufacturer of imaging equipment in the United States, will sponsor clinical trials that will reach beyond earlier industry-sponsored trials.

These trials should focus more on the quality of the actual images to test the clinical effectiveness of new forms of technology such as new CT techniques to image the heart and breast.

Prevention of mammography errors

Recently trained radiologists were more likely to have false positives—or say there were suspicious lesions when none were present—than those with 15 years or more of experience. The radiologist's experience appeared to influence the false-positive rate. Radiologists in their 40s who completed medical school within the last 5 to 15 years were nearly four times more likely to have a higher false-positive rate than those in their 60s or 70s with more than 20 years since medical school graduation.

Women who were younger, premenopausal or taking hormone replacement therapy were more likely to get a false-positive result, as were women with a family history of breast
cancer or a previous biopsy. Agreement between different radiologists interpreting the same set of mammograms is known to be low. However, few studies have examined just how accurate the readings are for women in the general population who are being screened for breast cancer.

In this new study, Elmore et al [Journal of the National Cancer Institute 2002;94:1346-1347, 1373-1380] a comparison was made of the reading accuracy of 24 radiologists who interpreted 8,734 screening mammograms from 2,169 women.

The researchers' findings were that the interpretation of mammograms varied by radiologist. For example, one radiologist noted no suspicious masses on any of the films read, while another reported that 7.9% of the films contained a mass. Similarly, the proportion of calcifications and fibrocystic changes—other possibly suspicious or benign changes—detected on the films ranged from 0% to 21.3% and 1.6% to 27.8%, respectively. The false-positive rate for the radiologists ranged from 2.6% to 15.9%, the researchers note. However, after adjusting for patient, radiologist, and testing characteristics, this range narrowed to 3.5% to 7.9%.

✓ Preventive moves:

1. Since double reading of mammograms has been shown to cut down on false positives without boosting the rate of missed breast cancer cases. Although double reading has been implemented in 22 countries, but not yet in the US, Andersen's group points out that US "public policy needs both a focus on training and an immediate re-examination of double reading as national policy."
   It would therefore be prudent to implement double reading of all mammograms especially if the radiologist falls into the age group reported above.

2. In addition Sabel et al. found that a second opinion from a team of specialists after an initial diagnosis of breast cancer resulted in a significant change in the recommended surgical treatment in more than half of cases. Additionally, for 32 percent of the women, the change in recommendation was based not on disagreement about the radiology or pathology findings, but rather on interpretation of the standards for care endorsed by the National Comprehensive Cancer Network. Sabel also emphasizes that these results reinforce the importance of comprehensive breast cancer decision making and care by a multidisciplinary board of specialists in the treatment decisions for Breast cancer. [Sabel et al Cancer11/15/06]

✓ Preventive moves:

Have a system in place to prevent lapses in communication with patients and other providers.

Have a system in place for regular follow-through by the consultant neurologist—either through his assistants or by telephone ticklers on his desk.

E. Orthopedic medical malpractice: an attorney's perspective.
Orthopedic surgeons also have certain procedures and issues related to the physician-patient relationship that could potentially lead to a malpractice lawsuit. In this study, the author performed a randomized nationwide survey of medical malpractice attorneys to evoke their opinion on these issues. Klimo GF et al. Orthopedic medical malpractice: an attorney's perspective. Am J Orthop. 2000 Feb;29(2):93-7.

✓ Preventive moves:
Continuing education and physician awareness in formal courses should be initiated in the lumbar spine which was the most common anatomic area involved in orthopedic medical malpractice cases.
The author also found that a physician appearing rushed and uninterested is most likely to be the subject of a lawsuit where a poor physician-patient relationship was a contributing factor. Therefore the preventive move is most evident. Cultivate a good physician patient relationship even if you must take on less procedures to do this.
Educational and professional programs to increase the awareness and knowledge of orthopedic malpractice risks, and also to identify potentially preventable problems leading to malpractice litigation should be a regular feature of the orthopedic surgeon’s CME.

✓ F. Many errors in gastroenterology can be prevented by prudent patient selection, sedation, & proper indications for endoscopic procedures.
In addition the signed informed consent should include up-to-date information for the patient:

First with the advent of Medicare approval of screening colonoscopy for colorectal cancer [CRC] and the Katie Couric public colonoscopy seen in millions of homes the rates of Colonoscopic procedures have increased. The usual informed consent process and forms contains much of the warnings common to all such invasive procedures such as perforation, hemorrhage and even death. But I’ve noted in some cases that have come to litigation the absence of some important issues that the patient should also acknowledge by his signature to the informed consent statement.
THE MISSED CANCER RATE WITH SCREENING COLONOSCOPIES

One such omission in the informed consent form is the “missed rate” of cancers with colonoscopies—the gold standard of CRC diagnosis from which all other CRC screening and diagnostic procedures are compared. Patients should be informed that there is indeed a “miss rate” of CRC of 1-4% even with this gold standard procedure; [somewhat higher with Barium enema screening]- The reasons for this range from blind areas in the colon, mis-judgement that the scope has reached the cecum, poor preparation, and other interpretive errors. It is for that reason that the colonoscopy report should include

- a photographed cecum in each case for adequate documentation, as well as an
- appropriate description of preparation, &
- examination time [articles have also called attention to higher error rates in colonoscopies of less than 10 minutes], and that
- the patient must be informed that follow-up examination with a repeat colonoscopy or barium enema is necessary when the entire colon up to and including the cecum is not well visualized.

All this should be completely discussed and detailed in the informed consent statement signed by the patient prior to sedation and prior the procedure. [see Gastroenterology 2004, 127[2]:452; Am J GE 2002, 97[12]:3183, 2001, 96[12]:3457; Gastrointestinal Endoscopy 1997, 45[6]:451;].

POOR COLONOSCOPIC TECHNIQUE IS ALSO BLAMED FOR COLON CANCER MISSED RATES IN COLONOSCOPY

As noted above some patients who undergo colonoscopy that appeared to have cleared the colorectum of neoplasia return within a short interval (1–3 yr) with colorectal cancer. Although several a priori mechanisms mentioned above could account for this occurrence, wide variation in detection rates of adenomas and cancer at colonoscopy suggests that suboptimal colonoscopic technique is a significant contributor.

Optimal technique with white-light colonoscopy involves these factors which should be mentioned in the endoscopy report by the endoscopist-especially the time from insertion to completion should be carefully noted:

- taking adequate time for inspection during withdrawal (of at least 6-10 min at a minimum even in normal colons),
- interrogating the proximal sides of folds, flexures, and valves, clearing fluid and debris, and
- distending adequately.

Some adjunctive techniques are directed toward exposing more colonic mucosa during colonoscopy. Wide-angle colonoscopy appears to improve efficiency but does not eliminate miss rates. Colonoscopy in retroflexion was unsuccessful in reducing miss rates in one study, whereas cap-fitted colonoscopy was successful in reducing miss rates in one small study. Techniques to improve detection of flat lesions include pancolonic chromoendoscopy (CE). In two randomized controlled trials, CE improved adenoma detection, but CE does not appear to provide substantially greater yields than those obtained by the more sensitive white-light colonoscopists. Adenoma detection rates are
an important measure of the quality of colonoscopy and should be reported to endoscopists in quality improvement programs in colonoscopy. D. K. Rex, M.D. Maximizing Detection of Adenomas and Cancers During Colonoscopy Am J Gastroenterol 2006;101:2866–287

ERCP

Another area of common GI medical malpractice suits are with the ERCP procedure. An important medico-legal study by –Peter B. Cotton reports his analysis of his personal series [of his testimony] of 59 cases in which ERCP malpractice was alleged. Half of the cases involved post procedure pancreatitis; 16 suffered perforation after sphincterotomy (8 of which involved pre-cutting), and 10 had severe biliary infection.

In addition there were 2 esophageal perforations.

Fifteen of the patients died.

The most common allegation (54% of cases) was that the ERCP, or the therapeutic procedure, was not indicated. Disputes about the extent of the education and consent process were common.

Negligent performance was alleged in 19 cases. Inadequate postprocedure care was alleged in 5 cases, including 3 with a delayed diagnosis of perforation.

The final outcome was available in 40 cases. Sixteen were withdrawn, and 14 were settled. Of the 10 that came to trial, half were defense verdicts.


Preventive moves:

- Make certain that your invasive procedure informed consent statements signed by the patient are up-to-date-especially those for colonoscopy and ERCP.
- Ask your radiologist who is doing the initial or followup Ba enema for a “double reading” to decrease the “missed rate: e.g. 15% of the Ba enema errors were overlooked by the reader and was visible in retrospect-[see Radiology 1994, 192[2]:373
- In addition ERCP should be done only-
  1. for good indications,
  2. by trained endoscopists with standard techniques,
  3. with good documented patient informed consent
  4. and good communication before and after the procedure.
  5. Speculative ERCP, sphincterotomy, and pre-cuts are high-risk for patients and for practitioners and should thus be performed only in major tertiary care centers.
6. These preventive moves are echoed by Testoni PA in his article “Preventing post-ERCP pancreatitis: where are we?” JOP, 2003 Jan;4(1):22-32, in which he points out that Post-ERCP pancreatitis can be prevented by proper patient selection.

7. Patient-related risk factors are now well-known, so an increased risk of developing pancreatitis is predictable "a priori" in these subjects, independently of the type of endoscopic procedure performed—thus each patient should have a calculated risk factor on the chart and informed consent form.

8. When either diagnostic or therapeutic ERCP is indicated, these high-risk patients should be informed about their own specific risk of postprocedure pancreatitis.—[see chapter on informed consent].

9. Furthermore, since the risk of pancreatitis escalates when multiple risk factors occur in the same patient or some technique-related risk factor comes up during the procedure, diagnostic ERCP should be avoided in routine practice and

10. magnetic resonance cholangio-pancreatography [MRCP] should be substituted as the first diagnostic step.

G. Problems with Conscious sedation performed by interventional specialists—cardiologists, radiologists, gastroenterologists & others:

Conscious sedation involves intravenous sedative drugs that lower the level of consciousness, but don't put a patient completely under as with general anesthesia; patients can usually breathe on their own and recover more quickly. The most commonly recommended sedation drugs include fentanyl and Versed. A newer drug, propofol, is gaining popularity for colonoscopies and other procedures because it works quickly, deeply sedates patients and lets them recover faster. But while there are drugs that can be given to reverse the effects of Versed and fentanyl, there is no antidote to reverse propofol.

- These more powerful sedatives like propofol are more often being administered by medical professionals including gastroenterologists who aren't adequately trained in anesthesia and safety practices, increasing the risks of respiratory complications, cardiac arrest, brain damage and even death.

- The University Health System Consortium, which includes 95 of the nation's largest academic medical centers, reported at a recent meeting that there may be potentially 1,690 incidents a year nationwide related to
sedation -- ranging from an overdose of drugs to a procedure that is started before a patient is adequately sedated.

- In a survey of its members three years ago, the consortium found that 42% of hospitals don't require providers to have life-support training, even if a cardiac arrest team may not be available for more than five minutes.
- Only half of providers allowed to administer moderate sedation were trained in recognizing high-risk airways, or even basic airway management.

 Preventive moves:

The nonprofit Joint Commission on Accreditation of Healthcare Organizations has required for the past few years that hospitals have –

1. clear policies for administering moderate and deep sedation, and that

2. staffers have appropriate credentials to manage whatever level of sedation occurs. Still, in a survey two years ago, JCAHO found that 18% of hospitals weren't adhering to those standards. Sedative drugs, however, can be very tricky, even with the care of an anesthesiologist, "The journal Anesthesiology reported that more than 40% of malpractice claims associated with sedative use [even] monitored by an anesthesiologist involved death or brain damage. That rate is similar to general anesthesia claims -- and nearly half could have been prevented by better monitoring.

3. The JCAHO must improve its inspection systems of medical facilities.

4. Standardized monitoring by physicians should be the rule in all endoscopy suites.

ERRORS

For patients, and their physicians some of the most devastating medical mistakes can start in the lab, where studies show that 3% to 5% of the billions of specimens taken each year
are defective, be it a biopsy that doesn't extract the tumor cells, blood that isn't drawn correctly or a mix-up with another patient's sample.

- The error rate is significantly higher and more dangerous in common tests for many cancers, where a false positive may lead to an unnecessary hysterectomy or a false negative can miss a deadly skin cancer.
- Malpractice claims for pathology errors are the second-most costly to hospitals after neurology payouts.
- In a study of 335 pathology-related published malpractice claims, [also see appendix- Book II] 63% of these claims involved the false-negative diagnosis of cancer and 22% involved the false-positive diagnosis of cancer.
- Very often the private physician who had nothing to do with these lab errors is also named in the malpractice suit.
- For example clinicians refer to pathologists 300,000 fine needle aspirations annually in which a tiny needle is inserted into a growth to extract cells to rule out cancer. But 25% of the time the tests miss tumor cells.
- In one hospital main lab, blood samples are often unacceptable because phlebotomists (technicians who draw blood), nurses and other staffers incorrectly labeled blood tubes.

- At another Medical Center, out of more than 4.29 million blood specimens taken in the 26-month period there were about 16,000 errors. Most didn't cause harm, but about 12% were categorized as "critical," such as a requisition form with a specimen labeled with another patient's name or an unlabeled specimen.
- More infrequent but more dangerous to patients: "wrong blood in tube" mistakes, with one patient's name on another patient's blood. After automating some parts of its specimen processing and using an electronic error-reporting system there was a reduction in errors, especially mislabeled specimens.

- Preventive moves:

  1. Double reading of pathology reports to reduce errors because a second pathologist usually catches the mistake the first made should be mandatory in all Pathology labs.
2. A patient's current medication list should be verified at each medical encounter; each office visit

3. and also at times of transition in care setting like hospital admission or transfer to another short term or long term [LTMF] medical facility.

[A link to all the above information can be found at www.nap.edu/catalog/11623.html.]

IMPORTANT POINTS TO REMEMBER:

- The severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, appears to be predictive of payment to the plaintiff.
- The initiation of malpractice suits correlates poorly with the actual occurrence of adverse events (injuries resulting from medical treatment) and negligence.
To assess the ability of malpractice litigation to make accurate determinations, 51 malpractice suits were reviewed to identify factors that predict payment to plaintiffs.

Among these cases, 10 of 24 that they originally identified as involving no adverse event were settled for the plaintiffs (mean payment= $28,760), as were 6 of 13 cases classified as involving adverse events but no negligence (mean payment, $98,192) and 5 of 9 cases in which adverse events due to negligence were found in their assessment (mean payment= $66,944).

Seven of eight claims involving permanent disability were settled for the plaintiffs (mean payment= $201,250).

In a multivariate analysis, disability (permanent vs. temporary or none) was the only significant predictor of payment (P=0.03).

There was no association between the occurrence of an adverse event due to negligence (P = 0.32) or an adverse event of any type (P=0.79) and payment.

Thus the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff. [N Engl J Med. 1996 Dec 26;335(26):1963-7. “Relation between negligent adverse events and the outcomes of medical-malpractice litigation”].

![Chessboard](image)

✓ Preventive moves:

✓ Since the severity of the patient's disability was predictive of payment to the plaintiff, quickly identify and then pay particular attention to and give added supervision and monitoring of medical care to this particular patient group.

✓ In addition in this regard of missing a disease that will markedly increase a patient’s disability screening all adults for HIV is cost effective. A mathematical decision model study found that screening all adults for HIV with a same-day rapid test was cost effective when the prevalence of HIV in the community was as low as 0.20%.

✓ A routine, voluntary rapid HIV testing is recommended for all adults, except in settings where evidence shows that the prevalence of undiagnosed HIV infection is below 0.2%. This study entirely supports the shift from targeted screening based on patient risk factors to routine screening based on prevalence and incidence thresholds. The findings support recent CDC guidelines calling for routine HIV screening of all adults and adolescents. Reminiscent of successful screening programs for syphilis and tuberculosis—the cost-effectiveness question
will change from whether we should screen for HIV to when we should stop
[Annals of Internal Medicine [12/5/2006]]

For procedures in office, ambulatory care and also in-hospital to the following:

✓ USE A ROUTINE FORM SIMILAR TO THIS ONE SO THAT ONE DOES NOT HAVE TO REINVENT THE WHEEL FOR EACH INTERVENTION.
✓ NOTE THAT THIS FORM HAS A “TIMEOUT” TO ANSWER THESE THREE QUESTIONS

✓ IS THIS THE CORRECT PATIENT?
✓ IS THIS THE CORRECT PROCEDURE?
✓ IS THIS THE CORRECT SITE?
Summary and Conclusion

✓ The common denominator of avoiding most preventable causes of medical malpractice suits is good patient selection and good indications for the procedure as well as double checking the results of the imaging studies.

✓ In addition, "wrong-site" surgical cases can be prevented by taking a routine "timeout" in the OR prior to the first cut of the scalpel to double check on answering 3 questions-whether it is

1. the correct patient,
2. the correct procedure, and
3. the correct surgical site.
These simple steps performed routinely can avert huge malpractice claims and are certainly not difficult to do. Above all, good physician-patient relationships must be cultivated—not time rushed—even though "you take on less procedures and see less patients to accomplish this."

Doing so will save you a lot of grief.

J. PREVENTABLE HOSPITAL IN-PATIENT ERRORS APPLICABLE TO ALL SPECIALISTS:

- Studies show that diagnostic errors occur in 10% to 30% of cases, and generally stem from flaws in doctors' thinking, glitches in the health-care system, or some combination of both.
- While many diagnostic errors don't cause serious harm, errors that potentially could have changed a patient's outcome are found in 5% to 10% of all autopsies, [according to a 2002 study funded by the Agency for Healthcare Research and Quality.]
- Diagnostic errors are among the largest causes of paid malpractice claims at both Kaiser and the VA, [according the 11/29/06 WSJ] but studies show an industrywide problem.
- A study of 300 closed malpractice claims found that 59% involved diagnostic errors that harmed patients and 30% resulted in death. [Published October, 2006 in the Annals of Internal Medicine]

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<thead>
<tr>
<th>Dropping the Ball</th>
<th>From 11/29/06 WSJ</th>
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<td>Lack of follow up—Failure to follow patients after surgery misses recurrent colon cancer</td>
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<td>Failure to communicate test results—Bopsy report of cancer never communicated to patient who missed appointment</td>
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<td>Clinician sloppiness—Doctor known to commonly skip elements of physical misses gangrenous toes</td>
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<td>Failed oversight of care systems—Multiple X-rays not read in timely manner; films lost or misplaced</td>
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<td>Insufficient knowledge or skills—Missed diagnosis of complete heart block; misread electrocardiogram</td>
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<td>Faulty data gathering—Delayed diagnosis of abdominal aortic aneurysm; incomplete history questioning</td>
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<td>Faulty information processing—Missed cancer of pancreas in patient with radiating back pain, attributed to reflux</td>
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<td>Failure to verify diagnosis—Wrong diagnosis of osteoarthritis in patient found to have drug-induced lupus</td>
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<tr>
<td>Failure to gather new data—Missed colon cancer in patient with declining blood counts, attributed to gastritis</td>
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Sources: Department of Veterans Medical Affairs Center, Northport N.Y.; State University of New York, Stony Brook
PROACTIVE STRATEGIES

✓ Enlist the patient to be part of the solution. This or a similar note should be verbally reviewed, then given to your patient referred either to another specialist or to the hospital. An initialed copy should be placed in the file.

1 If you're scheduling surgery and can choose where it will be done, select a hospital in your area where the procedure is done frequently. Hopefully you’ll have privileges in that hospital. You [as well as your more sophisticated patients] know that patient outcomes are generally better in such hospitals.

2 Ask all health-care workers who attend you to wash their hands. Hand washing remains a critical way to prevent the spread of infections in hospitals, but studies show it is not done often enough, especially by physicians.

3 Tell your hospitalized patient to Ask questions. Know what drug and what dose you're being given -- and why -- before taking it. Never assume it's right just because a nurse tells you it's what the doctor ordered. Medication errors are the most common mistakes in hospitals.

4 Tell your hospitalized patient to make sure that everyone who gives you medications checks your hospital ID bracelet every time. Patient mix-ups are more common than supposed in hospitals.

5 Make sure any allergies are noted prominently in the chart and tell your hospitalized patient to mention them to everyone who attends him. Likewise, tell your hospitalized patient to make sure his chart notes every medication you are taking, including over-the-counter medicines and dietary supplements such as vitamins and herbs.

6 Tell your hospitalized patient to Try to have an advocate on hand 24 hours a day while you’re in the hospital-- a trusted friend or family member who can monitor the situation and actively seek help if there's a problem. Chasing down doctors or care or needed information can be nearly impossible when bed-bound, doped up or in pain. In some cases it might be advisable to hire a private-duty nurse overnight when staffing tends to be light and some studies show mistakes are more likely to occur.

7 Tell your hospitalized patient if he’s having surgery, to make sure the doctor marks the proper surgical site clearly -- and initials it, while you are alert. Wrong-site surgery is a highly publicized cause of error.
8 Tell your hospitalized patient to Ask the doctor, upon discharge, to **explain the treatment** he or she wants you to follow at home and write it down.

9 Tell your hospitalized patient that if in a teaching hospital and feel that the doctor isn't sufficiently knowledgeable or experienced, **ask that a more senior physician be consulted**. Ask that your request be documented in your medical chart.

That may be the chief resident or an attending physician. Don't worry about hurting an intern's feelings; your safety is more important. [SUMMARY from the 11/29/06 WSJ:

“In solving a problem of this sort, the grand thing is to be able to reason backwards. That is a very useful accomplishment, and a very easy one, but people do not practise it much. In the everyday affairs of life it is more useful to reason forward, and so the other comes to be neglected. There are fifty who can reason synthetically for one who can reason analytically”. Sherlock Holmes- *A Study in Scarlet*