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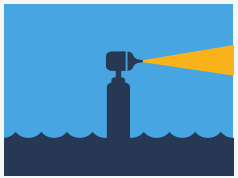
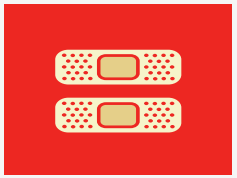
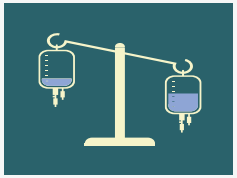
Malpractice Risks for Infectious Disease Specialists

37th Annual Conference
Infectious Disease Association of California





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Senior Patient Safety Risk Manager
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Vice President, Associate General Counsel
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Kathleen Stillwell, RN, MPA, MHSA, CPHRM
Senior Patient Safety Risk Manager

Kathleen Stillwell earned Master's Degrees in Public Administration and Health Services Administration. She is a registered nurse and Certified Professional Health Care Risk Manager (CPHRM). Ms. Stillwell is a nationally recognized expert in healthcare risk management with over 38 years of experience in clinical risk management, professional liability claims management, compliance, and high-risk underwriting. Her expertise includes hospitals, medical practices, and integrated healthcare organizations.

Ms. Stillwell serves on Chapman University, Leadership Council for Crean College of Health and Behavioral Sciences in Irvine, CA. She also serves on the University of California Riverside Advisory Board for Women in Leadership Program. Kathleen is a member of Brandman University Nurse Advisory Board, and a volunteer coach for physicians and nurses for the California Medical Association Care 4 Caregivers program. She has served as faculty for the American Society for Healthcare Risk Management and is published in the American Hospital Society Risk Management Handbook for Healthcare Organizations.

Kathleen has held numerous leadership positions with national and state risk management and quality organizations, including past Board Member for the American Society for Quality (ASQ), Healthcare Division, President of the CA State Patient Care Assessment Council, Board member for the California League of Nursing, adjunct faculty for Woodbury University and the University of San Francisco. She served on the Advisory Board of King International, Inc., and is a Charter Member of the Business Renaissance Institute.

Richard Cahill, Esq.
Vice President and Associate General Counsel

Richard Cahill received his undergraduate degree (summa cum laude) from UCLA in 1975 and his Juris Doctorate from Notre Dame Law School in 1978. He served as a deputy district attorney in California at the outset of his career and was subsequently appointed as counsel on the Central Legal Staff of the Nevada Supreme Court before entering private practice in southern California.

Mr. Cahill has specialized in various facets of health care litigation for more than 35 years, including the defense of hospital and physician professional liability claims, managed care contract disputes, network privileges issues and related business torts. His principal clients included Cigna Health Plans, Kaiser-Permanente and Tenet Healthcare Systems. He has completed in excess of 185 trials and binding arbitrations during his career with a combined win-rate of 92% and has been appointed as an arbitrator in more than 350 cases involving complex healthcare issues. Mr. Cahill is Vice President and Associate General Counsel with The Doctors Company and provides legal support to the Claims and Patient Safety Departments, oversees company appellate litigation, researches and submits original content for publication and lectures frequently around the country on topics related to the health care community. He has a preeminent rating with Martindale-Hubbell, the premiere peer-reviewed attorney rating service in the United States.

One moment can change a day,
one day can change a life,
and one life can change the world.

Buddha
563 BC - 480 BC

Objectives

After participating in this activity, I intend to:

- Recognize the top identified risks for my infectious disease practice
- Educate colleagues and staff about the types of claims and patient injuries found in the analysis of closed malpractice claims
- Implement three risk management strategies that may help reduce risk of patient injury and improve the quality of patient care

Infectious Disease Specialists Reduce Risks for Patients and Health Care

- Improve outcomes of patient care
- Reduce morbidity and mortality
- Reduce costs with impact on hospital length of stay
- Influence transitions of care to outpatient
- Infections prevention
- Antimicrobial stewardship programs
- Reduce cost of care

The Journal of Infectious Diseases, Volume 216, Issue suppl_5, 15 September 2017, Pages S588–S593, https://doi.org/10.1093/infdis/jix326

Responsibilities of Infectious Disease Specialist

- Perform physical exam
- Obtain medical history, medications, allergies
- Review patient's medical information: including records, lab, scans, X-rays
- Obtain additional studies as indicated: lab, cultures, body fluids
- Consider a differential diagnosis

Is Medical Malpractice Your Biggest Risk?

Why do patients sue?

- Dissatisfaction with care
- Lack of communication and rapport
- Provider attitude
- Feel they have been wronged
- Unrealistic expectations
- Anger

Your Top Risks

1. Documentation Issues
2. Cyber Attack
3. HIPAA Regulatory Compliance
4. Complaints to Medical Board
5. Negative Social Media Posts

Documentation: Your Silent Witness

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If It Was Not Documented, Was It Done?

- A legal document
- Supports continuity of patient care
- Rebuttal for complaints to state medical boards
- Primary witness to standard of care delivered
- Billing is based on documentation
- Most cited reason for nonpayment by third party

Metadata: The Electronic Footprint

Metadata is Forever

- Can destroy integrity of medical record
- Stores every key stroke, every space, every time
- Records password, time, date of every keystroke
- Cannot ever be erased
- Will be produced in malpractice claim, other litigation

Amending the Medical Record

- Late Entry
  - Information available but omitted from original entry
  - Includes current time and date
- Addendum
  - Follow medical records policy; usually later than 48-72 hours after visit
  - Indicate information was not available at time of original entry
  - Include current time and date and reason for addendum

Avoid Documentation Landmines

- Editorial comments about patients
- Medical record alterations
- Lengthy self-defensive entries explaining mishap
- Late entries
- Finger pointing
- Intentionally misstating what transpired

Documenting Difficult Issues

- Medication dependence/drug seeking behavior
- Inappropriate patient behavior
- Quote patient use of rude or profane language
- Termination of patient
- Medical errors
- Disclosure issues

What Not to Document

- Hearsay statements
- Unsubstantiated statements
- Events not impacting care
- References to legal action or incident reports

Copy and Paste Benefits and Pitfalls

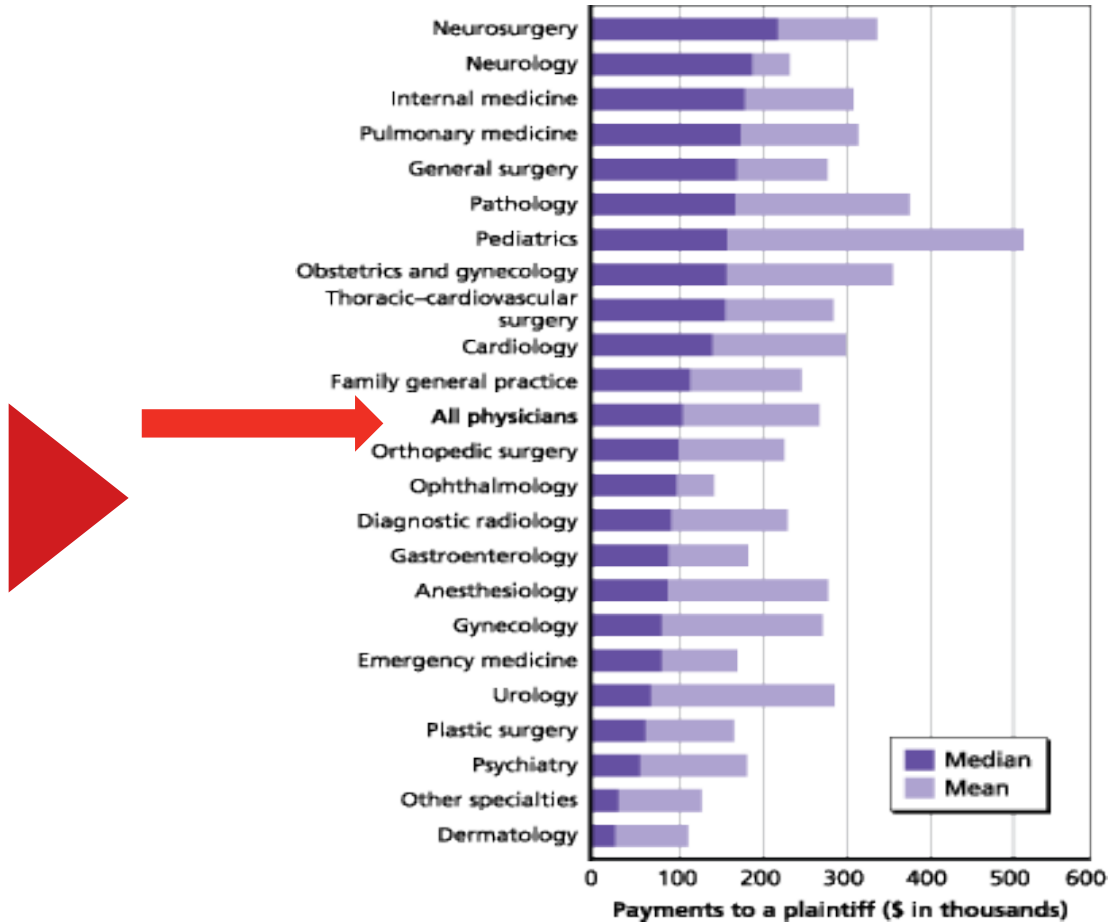
- Benefits
  - Reduces need to re-enter common information such as past medical/surgical history
- Pitfalls
  - Current day's information often not added to pasted information
  - Pasted information is often outdated
  - Pasted information is often not validated; may be erroneous

Remember to Document

- Your thought process
- Differential diagnosis
- Recommendations
- Patient response to treatment
- Patient education
- Aftercare and/or follow-up instructions

Infectious Disease Specialists and Malpractice Claims

Malpractice Claims By Physician Specialty



Infectious Disease Physicians do not have a category on the list!

https://www.rand.org/pubs/research_briefs/RB9610.html

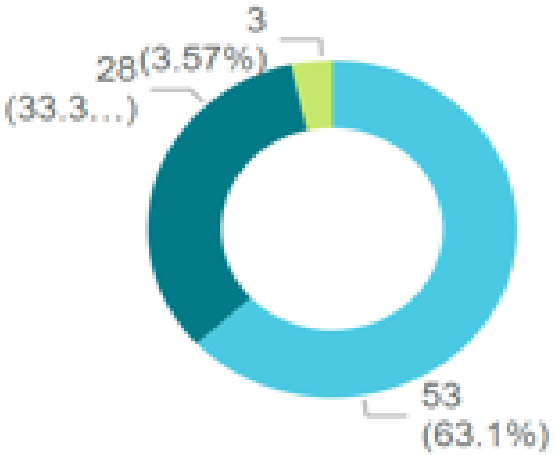
Closed Claim Data 2010-2020
Infectious Disease Specialists

84	91.67%	63%	33.8%
Case Count	% Cases Closed	Cases With Clinical High Severity %	Closed Cases With Indemnity Paid %

73% Hospital Based Claims
27% Ambulatory Based Claims

TDC Closed Claims 2010-2020
Candello Data 2023

Eighty-four Infectious Disease Claims: Severity



Claim Severity

- **High** 53 claims
- **Medium** 28 claims
- **Low** 3 claims

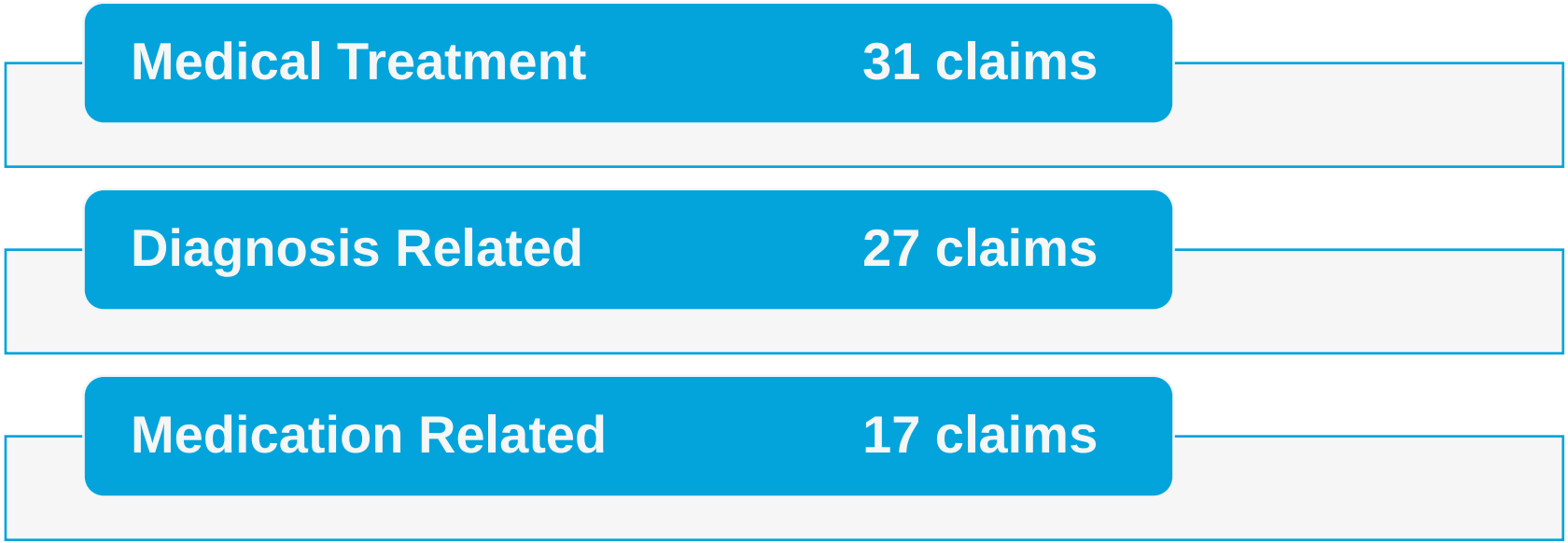
TDC Closed Claims 2010-2020
Candello Data 2023

Your Top Five Malpractice Risks

Allegations
1. Diagnosis-related: failure, delay, wrong
2. Improper management of treatment course
3. Improper management medical regime
4. Improper management of surgical patient
5. Delay in treatment or procedure

TDC Closed Claims 2010-2020
Candello Data 2023

Infectious Medicine Major Claims by Case Type
75 out of 84 Claims



TDC Closed Claims 2010-2020
Candello Data 2023

Additional Allegations Included

Failure to Monitor Patient Physiological Status

Failure to Treat

Wrong/Unnecessary Treatment

TDC Closed Claims 2010-2020
Candello Data 2023

Legal Issues
and Malpractice Claims

What is Medical Malpractice Negligence?

- Duty
- Breach
- Causation
- Damages

Other Theories of Liability

- Direct liability
- Agency
- Vicarious liability
- Respondent superior
- Collaboration and supervision
- Unprofessional conduct
- Negligent credentialing
- Negligence

Top Five Contributing Factors: Infectious Disease Specialists Closed Claims

1. Clinical Judgement – 51 Claims
2. Communication – 35 Claims
3. Behavior Related – 31 Claims
4. Documentation – 21 Claims
5. Clinical Systems – 15 Claims

TDC Closed Claims 2010-2020
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#1 Clinical Judgment – 51 Claims

- Patient assessment issues
- Selection and management of therapy
- Failure/Delay in obtaining consult/referral
- Patient monitoring
- Conditions affecting the caregiver

TDC Closed Claims 2010-2020
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#2 Communication – 35 Claims

- Communication between patient/family and providers
- Communication among providers
- Electronic communication exchange tools

TDC Closed Claims 2010-2020
Candello Data 2023

#3 Behavior Related – 31 Claims

- Patient factors
- Provider and employees

TDC Closed Claims 2010-2020
Candello Data 2023

#4 Documentation – 21 Claims

- Insufficient/lack of documentation
- Content related to decisions

TDC Closed Claims 2010-2020
Candello Data 2023

#5 Clinical Systems – 15 Claims

- Lack of/failure in patient follow up
- Lack/failure of in system for patient care
- Fail/delay to schedule test, consult, referral
- Failure/delay reporting findings/revised findings

Case Study #1
Failure to Diagnose

Day 1– ED 43 y/o Hispanic male, w/ Hx HTN, poorly-controlled diabetes w/neuropathy, Hx of IV drug use as teen. Pt c/o worsening back pain x 3 weeks, numbness/tingling in legs, fever, cough. Glucose 530, admitted to hospital. Noted to have bilat plantar ulcers. MRI spine no abnormality. "Elevated WBC, Echo: no endocarditis.

Day 3 – c/o back pain, irrigated/debrided foot ulcers.

Day 4 – ID consult, +MRSA bacteremia, source considered foot wounds. Cellulitis, Rx Vanco.

Day 9 – + blood culture despite Abx tx, Hospitalists ordered card consult, Echo normal, no cardiac issues. ID changed Abx to Daptomycin, pt w/rash, persistent back pain. Seen dial under supervision of hospitalists, ID.

Day 10 – Nuclear med WBC scan normal, ID added gentamicin, rash better 2 days later

Day 16 – 1st neg blood culture, plan IV Abx x 2 weeks, pt begin ambulating with c/o mid back pain, d/c home to f/u with PCP

One Week After Discharge

- Pt to ED; c/o L leg weakness, x3 days, now weakness both legs, cannot walk or move L leg, can minimally move R leg
- C/o numbness & burning pain upper back to bilat legs
- MRI: anterior epidural abscess T6-T9, compression of spinal cord, developing osteomyelitis
- Blood Cxs +MRSA. ID Rx daptomycin, cefepime
- Neurosurgeon called for decompressive laminotomy
- Pt paraplegic, wheelchair bound, incontinent of bowel/bladder, c/o depression

What Did the Experts Say?

Non-supportive and critical both sides

- Failure to repeat MRI for ongoing back pain
- Fail to order appropriate antibiotics
- Hospitalist met SOC as relied on Radiologist and ID
- Obvious epidural mass at T8, MRI misread
- ID doc fail to repeat MRI when pt had >2wks persistent pain + blood Cultures
- Hospitalist dismissed, case settled for radiologist and IDS

Case Study #2
Improper Treatment

Day 1 – Pt presents to ED: female 68 y/o, Hx of diabetes, HTN, and mildly decreased kidney function. Admitted for Abx tx L foot infection from spider bite. IDS consult requested. IDS dx osteomyelitis of 1st toe and cellulitis

Day 3 – Pt d/c home to have daily out pt IV Abx at IDS office. Vanco 2 mg qd (did not consult pharmacy) and weekly labs (CBC, CMP, ESR, CRP, Vanco trough levels). Pt not told to stop Motrin while taking Vanco.

Day 4 – RN (indept contractor at IDS practice) managed pt infusions. Pt's labs were to be drawn six days later no labs drawn.

Day 11 – One- week later pt came for IV Vanco, labs draw. RN said labs drawn before infusion; per chart labs drawn after Vanco infusion

Day 12 – Following day, Vanco level high 76.8 (double normal peak level), creatinine high 2.43 (normal 0.5-1.1) no one in IDS office noticed labs this day or over weekend. Lab did not call office to alert. Pt kept getting daily Vanco.

Day 14: Pt had Vanco-infusion

After infusion was completed, blood was soaking through back of patient's pants

- Pt sent to ED. Creatinine 4.82 (norm 0.5-1.1) Pt admitted w/ dx of GI bleed, acute renal failure (ARF), fluid overload
- IDS saw pt at hospital. Reviewed labs from 8/13, noted abnormalities, stopped Vanco. Diagnosed pt with Vanco-induced nephrotoxicity
- Pt had challenging, extended hospitalization, including cardiac arrest x2
- Residual permanent kidney damage, requiring lifetime dialysis
- Not eligible for transplant due to history of arrest and diabetes

What Did the Experts Say?

Non-supportive and critical both sides

- Failed to ensure labs were drawn, failed to note labs
- Pt already had renal dysfunction and required lower dose of Vanco
- IDS failed to consult with pharmacy on dosing of Vanco
- Labs should have been checked every 3 days to closely monitor for renal impairment
- Concern for dx of Osteomyelitis since MRI did not show disruption of bony cortex of toe
- Pt only had cellulitis and did not need Vanco infusion
- Failed to properly train and supervise RN
  - RN failed to follow prescribed weekly labs, failed to note labs, and failed to recognize their significance and notify IDS

What’s Next?

It's quite concerning for many of us, because obviously it's suggesting that for many years, we will not have the number of people necessary to manage infectious disease.

Dr. Carlos del Rio
IDSA President

https://vaccines.emory.edu/faculty/primary-faculty/delrio-carlos.html

Shortage of Infectious Disease Doctors

- United States is experiencing a dire shortage of infectious disease specialists according to the Infectious Diseases Society of America
- Currently, four of five U.S. counties do not have a single infectious disease physician
- In 2022 only 56% of adult and 49% of pediatric infectious disease training programs were filled
  - Most other specialties filled all or nearly all their programs

https://www.usnews.com/news/health-news/articles/2022-12-19/america-facing-shortage-of-infectious-disease-doctors

What Is On the Horizon?

- Telehealth can combat shortage of Infectious Disease Specialists (IDS)
- Hospitals are exploring ways to expand telehealth for IDS consults
- Telehealth has been proven to be an effective and efficient alternative to in-person ID care
- Will the 2023 Omnibus Appropriations bill direct funding to infectious disease?

https://go.beckershospitalreview.com/clinical/how-telehealth-can-help-combat-the-infectious-disease-

We make a living by what we get
and we make a life by what we give.

Sir Winston Churchill
1874 - 1965
Prime Minister, Statesman, Writer

Our Mission is to Advance, Protect, and Reward the Practice of Good Medicine.

We're Taking the Mal Out of Malpractice.

Thank you!

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Nothing ever goes away until

it has taught us what we need to know.

Pema Chodron
Tibetan Buddhist Nun, Author