Avoiding Malpractice and Practicing Safely in 2021

Carolyn Buppert, MSN, JD
Law Office of Carolyn Buppert
www.buppert.com
buppertcarolyn@gmail.com

Disclosures and disclaimer

- The speaker has no financial relationships to disclose
- Carolyn is admitted to practice law in Oregon and Maryland, but not in Texas. The content of this presentation is not legal advice to any individual. It is advice on how to avoid legal problems.

Objectives

1) Describe 3 situations where NPs were sued
2) Analyze ways to decrease the risk of malpractice
3) Discuss the malpractice considerations when providing services via telehealth

Elements of malpractice

1. Duty of care
2. Breach of the standard of care
   - What a reasonably prudent clinician of similar education would have done in similar situation
3. Injury
4. Injury was caused by the breach of standard of care

Missed diagnoses that have led to malpractice claims

- Cancer
- Acute MI
- Appendicitis
- Pulmonary embolism
- Meningitis

Big 4 red flag chief complaints

- Abdominal pain
- Chest pain
- Breast mass
- Headache – persistent and/or severe

NPs working in Gyn should know

- Abnormal Pap smears, not followed up, are a major risk

Why NPs are sued

- Missed diagnosis
- Lapsed follow-up (leading to missed diagnosis)

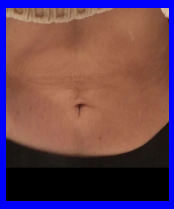
These are the same top 2 reasons why MDs are sued

Reasons for errors

- Failure to evaluate all possible diagnoses
- Breakdown in communication
- Failure to refer
- Failure to follow up

Case 1: Missed colon cancer

- 31-year-old woman w/ hx
  - tobacco
  - heavy caffeine
  - FH of colon ca
- C/o abdominal pain, anorexia, burning, cramping
- NP prescribed Zantac and f/u exam



Case 1: Missed colon cancer

- At f/u exam, patient c/o abdominal pain, increased stools
- NP changed med and ordered upper GI
  - Did not perform rectal exam
- 2 months later, patient c/o problems eating
- NP diagnosed gastritis; advised f/u in 6 months

Case 1: Missed colon cancer

- 6 months later, patient c/o stomach cramping, burning
- NP changed med and referred to GI
- Patient returned prior to GI appt c/o worsening pain and loose stools
- NP diagnosed nicotine addiction, gastritis, ulcer
- Patient went to ER; diagnosis Stage IV colon ca

Case 1: Missed colon cancer

- Patient died of cancer 2 years after diagnosis
- Jury awarded patient's family $4,690,000

Standard of care for abdominal complaints

- Colonoscopy, with this patient's symptoms and family history
- Perform a rectal exam when patient c/o abdominal pain
- Stool for occult blood

What we learn from this case

- Follow up in 6 months is too long for an acute illness
- FH of colon cancer necessitates enhanced evaluation
- Young people get colon cancer
- Don't defer the rectal exam

Case 2: Missed breast cancer

- 60-year-old woman evaluated for right breast mass
- MD referred her for mammogram, ultrasound
- Mammogram, performed the next day, showed fibroglandular densities but no specific evidence of malignancy

Case 2: Missed breast cancer

- Prior films were obtained
- Ultrasound showed no mass
- MD recommended clinical follow-up of the palpable mass
- MD testified that she informed the patient of the test results and told her it was important to get yearly mammograms
- Patient did not return for 4 years

Case 2: Missed breast cancer

- When patient returned, saw a nurse practitioner
- NP noted right nipple inverted, palpable density at 2 o'clock
- NP noted that the mass had been worked up 4 years earlier
- Patient reported that the mass had enlarged
- NP described the mass as slightly tender and diffuse, with no margins

Case 2: Missed breast cancer

- NP recommended dx mammo w/ F/U in 4 wks
- Dx mammo, performed the same day, suggested malignancy
- US the next day did not demonstrate any abnormality, but advised clinical correlation
- NP saw the patient again as planned in 4 weeks

Case 2: Missed breast cancer

- Records state the diagnostic mammogram and ultrasound showed no change from previously
- No record of physical examination at that visit
- No note that the NP discussed the abnormal mammogram report or presence of a persistent breast mass and nipple inversion with a physician
- No note that the NP referred the patient to a surgeon

Case 2: Missed breast cancer

- Patient went on to develop severe, persistent headache
  - Another clinician diagnosed a sinus infection
  - Antibiotics did not relieve the symptoms and the patient developed a drooping left eye
- On a visit to physician 10 months after last visit to NP, physician noted cervical lymphadenopathy on the right and the drooping left eye. Ordered a brain MRI, which revealed several areas of abnormality

Case 2: Missed breast cancer

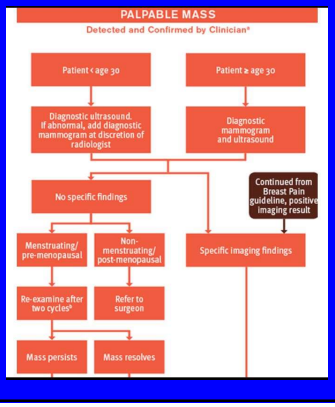
- Breast MRI noted significant axillary adenopathy and multiple breast abnormalities
- B/L breast biopsies and axillary lymph node biopsies were ordered as well as evaluation of the brain masses
- Cancer was found in both breasts and both axillae

Case 2: Missed breast cancer

- Patient diagnosed with stage IV metastatic breast cancer
  - Underwent palliative brain radiation was given anastrozole
  - Patient sued the MDs and NP for failure to diagnose breast cancer
  - Defendants argued the patient should have returned on a timely basis
  - Parties settled for $500K

Standard of care

- Neither the original examining MD nor the NP followed the standard of care for evaluation of breast mass.
- An algorithm for evaluation of breast mass
  - https://www.rmf.harvard.edu/Clinician-Resources/Guidelines-Algorithms/2019/BCA-palpable-mass



What we learn from this case

- Know the standard of care for the evaluations you provide
- A breast mass always deserves close follow up and further evaluation, until it is gone

Case 3: Consequences of practicing outside scope

- FNP working in ED in OK missed diagnosis of pulmonary embolism in a 19-year old. FNP was the only provider present at the time
- Patient died
- NP had never taken any courses in acute care or emergency medicine, yet hospital had granted her privileges
- Jury awarded family $6.1 million in damages
- https://www.medicalmalpracticelawyers.com/emergency-room-malpractice-2/6-1m-oklahoma-medical-malpractice-verdict-for-death-of-19-year-old-in-er/

Details

- Patient presented with SOB, chest pain, low O_2 sat, tachycardia and tachypnea. Meds: Oral contraceptives
- NP ordered chest CT and urine tox screen, which was positive for meth. Mother insisted on a 2nd screen, which was negative for meth.
- NP diagnosed meth use, cancelled chest CT, and admitted patient overnight
- 8 hours later NP ordered chest CT, not stat
- Results 2 hours later showed PE
- Patient transferred to another hospital, where treated with tPA, but she died within 2 hours of arrival

What we learn from this case

- Evaluate all possible diagnoses, in order of likelihood of dire outcome
- Stay within your lane: You must be qualified to perform competently at the level your position requires
  - If you don't have the education/training, you may be practicing unsafely and are in a bad defensive position, if sued
- Have a portfolio which documents your education, training and clinical performance

Case 4: Bad outcome where NP avoided liability

- Patient with history of admissions for mental health
- In an outpatient session, PMHNP directly asked patient about thoughts of suicide
- He admitted he was considering it by overdose, although he did not have the means yet

- NP insisted he let law enforcement take him to the hospital
- He went voluntarily to ER with police officer as escort
- In ER he insisted he was not suicidal. Psychologist evaluated. Discharged to outpatient care.
- 2 days later, he shot himself

- Court did not fault NP, nurses, physician or the psychologist at the hospital for discounting the patient's current suicide risk, based on their assessments
- They had followed hospital protocol for management of patients with suicide risk
- Once the patient was appropriately allowed to leave the hospital, his further actions were no longer under the hospital's control and the hospital was no longer responsible

Standard of care: Example screening for suicidal ideation

1. Why do you want to die?
2. Have you done anything in preparation for your death?
3. On a scale of 1–10, where would you rate your seriousness or wish to die?
4. Have you tried out any particular method or taken steps in rehearsal for suicide?

Weber et al. Psychiatric Emergencies: Assessing and Managing Suicidal Ideation at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5777328/

What we learn from this case

- When a clinician follows the standard of care, a bad outcome still can occur and patient can sue, but clinician likely will avoid liability
- Get comfortable with a suicide screening tool
- Have a protocol for evaluating and managing suicidal ideation

Case 5: Failure to manage perioperative anticoagulation

- 45-year-old woman visited NP for pre-op assessment
- H/o MVR, AVR, stroke, AF
- On Coumadin
- Scheduled for endometrial biopsy

Case 5: Failure to manage perioperative anticoagulation

- Surgeon's plan was to progress to uterine artery embolization if biopsy benign
- NP instructed patient to stop Coumadin 4 days prior to embolization, and speak to surgeon about Coumadin

Case 5: Failure to manage perioperative anticoagulation

- Surgeon instructed patient to continue Coumadin before and after biopsy
- Biopsy negative
- Patient stopped Coumadin 4 days before embolization
- Surgeon did not order replacement and instructed patient to resume Coumadin on d/c
- Shortly after d/c patient suffered embolic stroke

Case 5: Failure to manage perioperative anticoagulation

- Patient sued nurse practitioner
- Insurer settled on behalf of nurse practitioner

Standard of care

Communicate and coordinate care with other clinicians

What we learn from this case

- Agree on plan for anticoagulation or let the surgeon give all instructions re anticoagulation
- Document plan of care
- Based on history, consider pre and/or post-op bridge therapy with heparin

Case 6: Failure to perform red reflex test in infant

- Infant saw NP for well child visits, birth to 9 months
- Mother pointed out that one pupil larger
- Mother told NP child's eyes did not move in tandem
- NP: "These things aren't important"

Case 6: Failure to perform red reflex test in infant

- NP tested for red reflex at about 9 months; no light reflected; NP referred patient to ophthalmologist
- Dx: Retinoblastoma
- One eye removed 3 months later; the other eye removed 3 years later
- Parties settled for $2 million

Standard of care

- Perform red reflex exam at every well child visit until a child can read
- Exam is normal when reflections of 2 eyes viewed both individually and simultaneously are equivalent in color, intensity, and clarity and there are no opacities or white spots within the area of either or both red reflexes

What we learn from this case

- Know the appropriate screening for your population
- Perform the screening on schedule

Case 7: Failure to f/u on request for specialist evaluation

- 27-week gestation newborn admitted to NICU
  - Apgar 5 at 1 minute and 7 at 5 minutes
  - Wt. 740 gms
- Diagnoses
  - RDS, hypotension
  - apnea of prematurity
  - necrotizing enterocolitis

Additional diagnoses

Hyperbilirubinemia
Cholestasis
Anemia
Intraventricular hemorrhage
Inguinal hernia
Possible sepsis

Details

- On 49th day of life, neonatology team requested ophthalmology evaluation
- Ophthalmologist diagnosed retinopathy of prematurity, zone 1, stage 1+ bilaterally
- Planned f/u in 2 weeks
- NP noted plan of care and need for f/u
- Ophthalmologist never returned

Details

- Infant d/c'd on 119th day of life
- D/c instructions included ophthalmology appt
- Pt seen 25 days after d/c; diagnosed with b/l retinal detachment
- Infant blind
- Parents sued hospital, 2 neonatologists, 4 neonatal NPs, ophthalmologist
- Case settled for unknown amount

Standard of care

- Ophthalmologist examines eyes of premature newborns who weigh less than 3 lbs at birth starting at 4 weeks after delivery
- Repeat exams every 1-2 weeks until growth of blood vessels in the retina is complete
- NP's notes for 2 days following initial eye exam were deemed standard of care for neonatology charting, but in subsequent days of hospitalization, no further attention paid, in the notes, to the need for f/u exams

What we learn from this case

- Entire team may be held liable for lack of follow up
- Develop a plan, with the team, for follow up. Such as:
  - Everyone, every day, pays close attention to the problem list
  - Team leader for each patient, with back-up
  - Reminders built into electronic medical record

Considerations when providing E/M via telehealth

- Cases? Not yet
  - Standard of care: Same as for in-office visit
- Privacy concerns

HIPAA rules for security of hardware/software loosened temporarily in time of pandemic

Still need to safeguard patient's privacy

Get patient's consent for conducting telehealth visit when there may be others in the home

Rules for preventing mistakes

1. Know the red flag complaints.
   - For women's health - breast complaints, abdominal pain, abnormal Pap smear
   - For internal medicine - chest pain, abdominal pain, breast complaints
   - For peds - eye complaints or signs (according to the cases)
2. Rule out the worst diagnosis first
3. Know the risk factors that call for screening tests

Rules for preventing mistakes

4. Follow up diagnostic tests and referrals
   - Was it done?
   - Are results on record?
   - If abnormal, was the condition followed up to a diagnosis or rule out?
5. Revisit an unresolved problem until it is resolved

Rules for preventing mistakes

6. With every Rx, go through a SCRIPT analysis:
   - Side effects?
   - Contraindications?
   - Right medication?
   - Interactions?
   - Precautions?
   - Transmitted clearly?

Rules for preventing mistakes

7. Adopt systems and policies for assuring follow up
   - Tiered communications (telephone call, letter, certified letter). Tell the patient what to do, time frame, consequences of inaction
   - Tickler systems
   - Designated follow-up person vs. policy that all clinicians responsible for own F/U

Systems for preventing malpractice

1. Monthly chart audits answering:
   Is the problem list easily found and up-to-date?
   Has the clinician addressed in the most recent note the patient's complaint from the next to last visit?
   Are prescription refills logged on a refill record rather than buried in narrative text?

Systems for preventing malpractice

2. Practice adopts policies on:
   - Safe prescribing
     Proper indication, proper dose, proper route, discussed side effects and contraindications, transmitted legibly
   - Regular continuing education
   - Documentation standards
   - Patient failure to show

Policy: No shows

If a return visit or other follow-up is important, nurse practitioner or physician will call the patient and

- Advise the patient of the urgency of follow-up, and the worst-case scenario. Document the advice given.

Systems for preventing malpractice

3. Conditions of treatment:
   a. The individual has registered with the practice
   b. No treatment without chart
   c. If violate b., treat patient like a new patient; i.e., redo initial history
   d. No treatment without opportunity for follow-up

How to decrease your risk

- You can lower your risk for malpractice by
  - Implementing practice systems, policies on follow-up
  - Declining to work in a sloppy practice/facility
  - Declining to take on patient care unless you can provide all aspects of that care; i.e. full assessment, follow-up
  - Knowing the risks inherent in your population

How to decrease your risk

- Take on care only when you must, because you work there
  - Don't give advice unless the individual is a patient of yours
- Only practice within your scope
  - If an ANP, don't see children
  - If a primary care NP, don't manage major mental illness
- Get the highest level education/training you can, for your area of practice

Malpractice insurance

- Consider buying it, even if the employer offers coverage
- If purchasing your own policy, get an "occurrence" policy
  - covers acts occurring while policy was active
- If covered by employer who has a "claims made" policy, understand that you will need a "tail" policy after you leave that job
  - Tail coverage is expensive

Thank you for coming

Be careful out there

References

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