Hospitalist Liability

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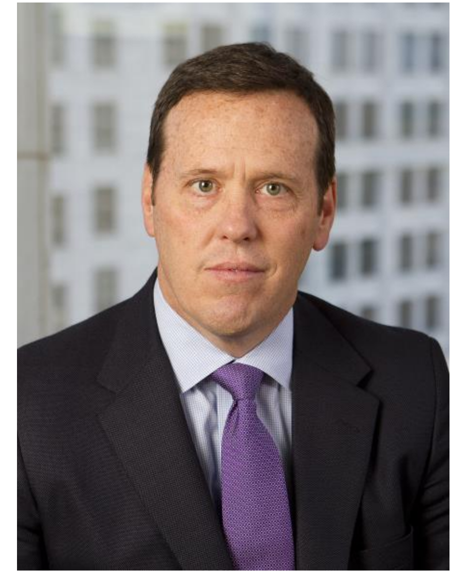
Today’s program

Today’s speaker is Daniel J. Huff, Esq. with Huff, Powell & Bailey, LLC.



For the past 24 years Dan has specialized in the defense of high damages lawsuits, primarily medical malpractice lawsuits and claims. He has represented defendants in more than 90 jury trials. He has defended and successfully tried cases for every specialty of medicine and numerous hospitals throughout Georgia. Dan’s trial record would be a proud career for any defense lawyer and remarkable because Dan has tried and won so many cases in so few years. In the past five years Dan has tried 30 medical malpractice cases in Georgia. Many of those cases have been against the best Plaintiffs’ attorneys in the state.

Huff Powell & Bailey is a trial law firm founded in July 2003 that is committed exclusively to complex civil litigation and specializes in the defense and trial of high risk cases with significant exposure. The lawyers of HPB have particular expertise defending medical malpractice cases against healthcare professionals and organizations and in defending product liability cases against automobile, medical device, and other product manufacturers.

For More Information about Dan and Huff, Powell & Bailey, LLC go to www.huffpowellbailey.com.

Objectives

At the end of this presentation you will know:

- The current medical malpractice environment for hospitalists
- The high risk situations where you are at risk to become a defendant
- The best ways to avoid becoming a defendant

Medical Malpractice

- There has been significant legislative medical malpractice reform at the state level.
- No meaningful federal reform is likely.
- Most state tort reform has been struck down by state supreme courts.
- The number of lawsuits are down, but severity of claims is up.
- Most medical malpractice cases involve hospital care.

Medical Malpractice

- "Jury of peers"
- Bad outcome
- Hired gun experts
- Overwhelming sympathy
- The defense wins 90% of the cases taken to trial

The Paradigm

- The patient is admitted to the hospital
- The patient has a bad outcome after admission or after discharge
- Allegations against hospitalists:
    - Monitoring issues
    - Communication issues
    - Discharge follow up issues

The Hospitalist and the PCP

- Why are hospitalists at greater risk for lawsuits?
  - Patients are sicker
  - There is no long-standing relationship with the patient or the patient's family
    - ➢ No patient loyalty
    - ➢ No familiarity with the patient's communication, personality, background or history

They Have Co – Defendants

The Goal of the Plaintiffs' Attorney

Strategy

"It is not enough to find out just what was done, but more important to determine why particular decisions were made and what alternatives existed. ***In addition, in every case where there are multiple defendants, it is the Plaintiff's objective to drive a wedge between the Defendants in an effort to have one suggest that another may have provided substandard care.***"

Brophy, *Medical Malpractice Depositions*, 2004

Suit Situations

- The direct admit
- The hand off
- The specialist – hospitalist joint venture
- Test results
- Nurse communication
- Discharge

The Direct Admit

- PCP calls about a patient with pneumonia who needs admission
  - 55 year old male smoker
  - Chest x-ray at the office
  - CBC shows elevated WBC
  - Productive cough and chest pain
- Hospitalist evaluated right away and admits to the floor with orders
- Arrests 4 hours later

The Hand Off

- Danger to the departing and the oncoming physician
  - Incomplete or inaccurate picture of the patient
  - Will not recognize significant changes
  - Will not anticipate what may happen
  - May change important treatment plans
- Enemy of the hand off is the lack of time

Specialists

- 45 year old patient admitted to Neurosurgery Service
  - CT and MRI: Large AVM and intracerebral hematoma
  - Patient developed headaches, nausea and blurry vision
  - There was confusion about which specialty was responsible for neurological monitoring
  - Unstable hematoma not timely diagnosed – herniation and death

Specialists

- 73 year old admitted for nausea and abdominal pain
  - Abdominal x-ray: bowel loop
  - Abdomen: distended
  - NG tube: foul smelling fluid
- Surgical consult obtained – no surgery
- 3 days later – patient dies from fecal aspiration

Test Results

- 62 year old post operative appendectomy patient has a low H&H 10 hours after surgery
- Surgeon was aware of low H&H immediately following surgery, attributed to blood loss and hemodilution
- Hospitalist believes surgeon will address, surgeon was not timely notified, patient experiences internal bleeding and death

Nurses

- Admission assessment by hospitalist:
  - Lungs clear to auscultation. Vital signs stable.
- 10 minutes later nursing assessment:
  - Coarse lung sounds, pulse 132, respirations 28.
- Patient arrests 50 minutes later

Discharge

- 73 year old patient admitted and discharged on Coumadin
- PCP was informed of admission but not about need for follow up INR and anticoagulation management when discharged.
- Coumadin never adjusted, cerebral hemorrhage 2 weeks later
- Failure to communicate

Lawsuit Avoidance

- Improve documentation of key events
  - Admission decision making
  - Communication with specialists
  - Responsibilities defined
  - Discharge plans and communication
  - Thought process

Lawsuit Avoidance

- Strive for clear hand offs
  - Real time, face to face
  - Organized
  - Make the time
- Email hand off?
- Delegated hand off?

Specialist Co-Management

- Does the hospitalist make suggestions or decisions?
- Define the separate and the overlapping responsibilities.
- Who is responsible for what tests?
- What happens if we disagree?
- Who will make the ultimate call?

Some Warning Signs

- You are doing things the other hospitalists are not doing
- You are doing things at night and on the weekends you don't do during the week
- You are being called to see ER patients that should be seen by specialists
- Specialists are not coming in

What questions do you have?

Thank You!

Disclaimer

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