Medico-Legal Issues

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What is this about?

* A review of Australian data, including about EDs
* A review of some more recent USA information
* What makes us vulnerable
* Diagnostic errors
* Communication
* Strategies

The Medico-Legal Environment

* Recent Australian data not great
* AIHW report 2008-13 (excludes WA)
* 2012-13 about **$400,000,000** in payouts for medical negligence; closed claims
* Claim duration ~50% < 2 years; 72% < 3years
* ~$250,000,000 in public sector
* Not all data for individual states but NSW has 44% of payouts and 54% of claims >$100K (~31.5% of population)

Site of Claim

Public sector (about 93% of emergency medicine)

* ~50% of new claims arose in EDs; General Surgery or O&G context
* ED slightly ahead
* By Specialty … slightly different

Specialty of Claim - Public Sector

Specialty	Number	%
General Surgery	107	11.3
Emergency Medicine	92	9.7
Orthopaedics	70	7.4
#General Practice - Procedural	59	6.2
#General Practice – Non-procedural	52	5.5
*Obstetrics and Gynaecology	45	4.8
*Obstetrics alone	36	3.8
Psychiatry	26	2.7
Anaesthetics	23	2.4
*Gynaecology alone	21	2.2
Not known	204	21.6

Specialty – Private and Public

* When combine Private and Public claims 2008-13 → General Practice is the big winner!
* About 50% of cases doctor specialty not known
* But of rest GPs dominate…

Specialty	Number	%
General practice	493	11.7
General Surgery	166	3.9
Obstetrics and Gynaecology/ Gynae alone (41)	162	3.9
Orthopaedics	156	3.7
Emergency Medicine	102	2.4

What Did We Do Wrong?

* Alleged error uncategorised about 1/3 of time
* Of those categorised the top three are: -
* Procedure (24%) – complication thereof or wrong
* Diagnosis (17%) – incorrect; delayed
* Treatment (17%) – complication; wrong; delayed

NB This is different to usual view of ED practice

What Did We Do Wrong?

By specialty: -

* Emergency Medicine
  * Diagnosis problem 54%
  * Treatment issue 29%
* General practice
  * Diagnosis problem 37%
  * Treatment issue 7%
  * Procedure 7%
  * Medication 6%

What Did We Hurt?

Body function / structure affected for new claims in 2012-13

* Digestive / Metabolic / Endocrine 24%
* Neuromuscular / Movement 21%
* Mental / Nervous 12%
* Death 11%
* Cardiovascular / Haem / Respiratory 9%

Again, not typical of ED practice

Claim Resolution

* What happens to claims…

Mode of Finalisation	%
Discontinued	46.1
Settled – other (“out of court”)	39.7
Settled – court-based alternate process	7.2
Settled – mandated compulsory conference	3.3
Settled – state-based complaints process	1.2
Court decision	2.5

USA Experience

The Doctors' Company 2015; MedPro Group 2016; analysis of claims

Causes of claims: -

* Diagnosis (wrong; delayed; early discharge) 60%
* Treatment (incorrect; complications) 18%
* Improper performance of Rx (ETT; imaging; IV) 5%
* Medication (failure to order; complications) 5%

USA Experience

Contributing Factors

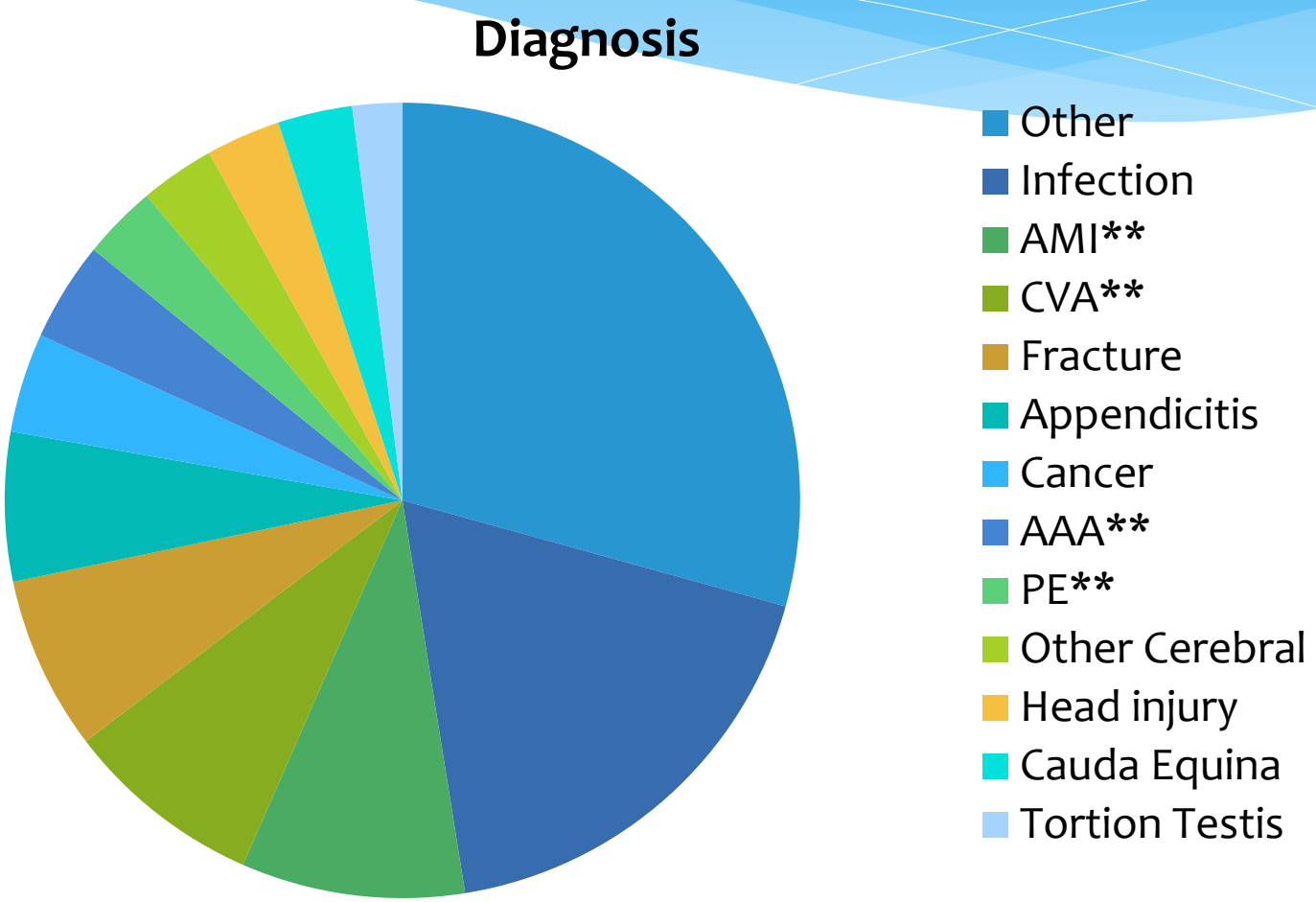
* Patient assessment (not address findings; not order tests; not consider available information)	52%
* Patient factors (obesity; compliance)	21%
* Communication among providers	17%
* Communication with patient / family, including discharge instructions	14%
* Documentation, including discharge letters / results	13%
* Workload; workflow	12%

Diagnostic Errors

Why….

* Don't access patient's record
* Inadequate assessment (cognitive bias; inadequate history and collateral history; inadequate consultation)
* Patient flow…"will take too long"
* Inadequate reassessment before discharge
* Failure to transmit test results to patient / doctor

Diagnostic Errors



Why We Get Sued

* Problems with EDs (and us)
  * Time critical; crowding
  * Multiple contemporaneous patients
  * "Just enough" information
  * 20% of your time is patient contact
  * Snapshot of illness
  * No prior relationship with patient – no trust
  * Someone else is always the "expert" (even their GP)

Litigation against ED doctors increasing

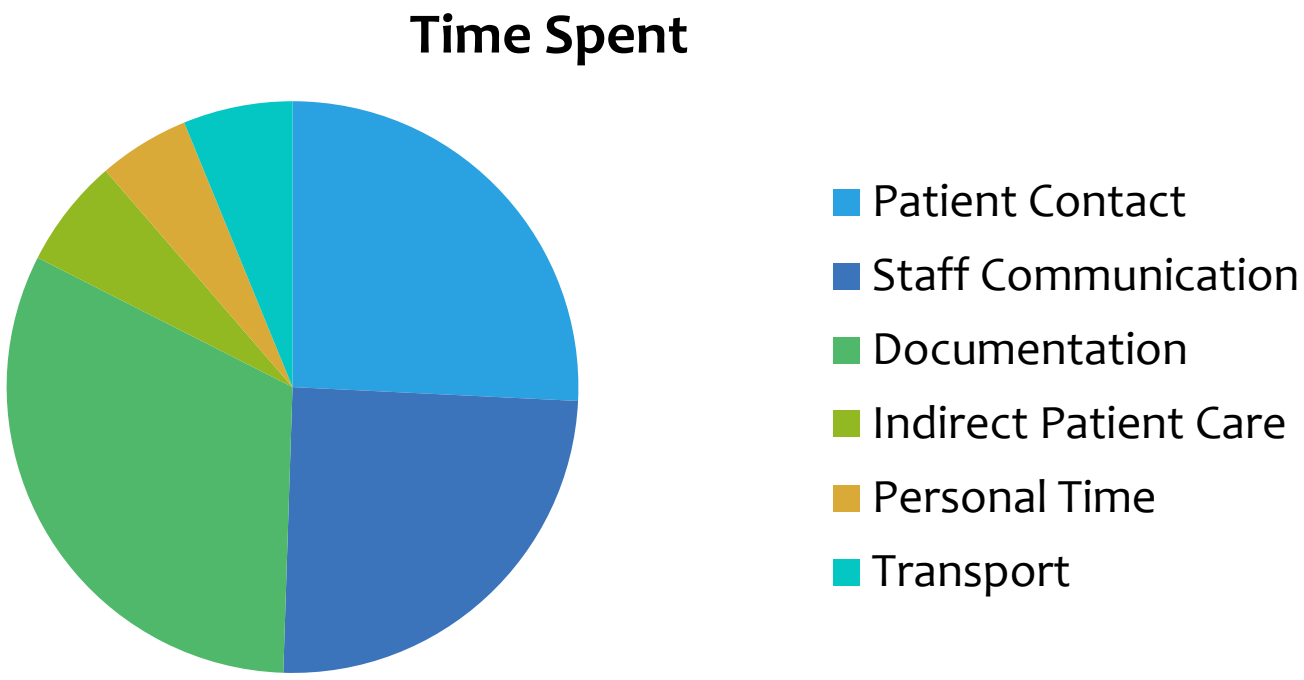
What do patients want?

* Short time to see a doctor
* Time with doctor*
* Information*
  * Reason for delays etc*
  * "The Plan"*
* "Nursing" care, especially analgesia
* Technical quality (not discriminating; presumed at time; use surrogate markers)

In summary, that they matter

* Communication

What We Do Instead



Communication

* Strongest predictor of patient satisfaction is their perception of the physician's behaviour.

"Patients don't care how much you know until they know how much you care"

Greg Henry MD

"Patients don't sue doctors they like"

Communication

* In over 80% of complaints poor communication is a factor; with patient, carers, other staff, consultants, patient's doctor…
* Includes the content, the tone, dealing with difficult patients

Dr Rob Walters

MIPS

Communication with Patient

* About 30 sec to establish trust / confidence
* Clothing; demeanour
* Say hello to everyone
* Don't presume relationships (spouse; daughter; friend)
* SIT DOWN
* Patients underestimate physician contact time by 50-100%
* Physicians overestimate it by a similar amount
* BUT if sit down, patients increase estimated time with doctor

→ Let patient talk (8 sec … 57 secs)

Communication with Patient

* Keep it simple
* 81% of encounters patients report medical jargon
* Average 4 per encounter
* 37% used when making recommendations
* 29% when giving health education
* Discharge advice - 3 things 3 times ?repeat back
* Use handouts. But… year 8 English

How Not to Get Sued

* Have the right diagnosis
  * Take enough time; examine the patient!
  * Ask advice
  * Follow up results
* Be friendly and helpful (at least, don't be a dick)
* Be professional – attire; demeanour; don't criticise GP; "consent"; confidentiality
* Communicate well – to everyone
* Manage expectations – waiting for…; what you think; what can be done; what the patient needs to do

How Not to Get Sued

* Listen at handover
* Document well (just enough)
* Keep cognitive load manageable; know when to retire!
* Precise discharge advice and documentation
* Ensure follow-up systems work
* Make department available
  * Phone follow up
  * Review clinic in ED
  * Or…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