June 2005

Newsletter of Physicians Reimbursement Fund, Inc.

PRF NEWS

Volume 8, Number 2

Covering Practice and Risk Management Issues for Physicians

What It's Like to Be Sued: One Insured's Experience

Editor's Note: PRF News recently spoke with a PRF Insured who had gone through the process of being sued. The Insured agreed to share their experience if they could remain anonymous. The following article contains excerpts of the interview.

PRF News: *What can one expect if they're a named defendant in a medical malpractice lawsuit?*

Insured: First of all, it's a long process. In my case it was about five years. There are some cases that take as long as nine years.

Once you've received a subpoena that you're being sued, you need to re-contact your insurance carrier and then an attorney will be assigned to you. Shortly thereafter, you'll meet with your attorney to discuss what happened and how other doctors would have acted in a similar situation. And then things proceed to the discovery process, with depositions of plaintiffs, defendants, nurses and physicians—so the plaintiff's attorneys can decide if they're going to continue with the suit. Then there can be quite a time lag after those depositions. If they choose to go forward, they will depose experts. So there is a release of the names of the experts to both sides shortly before the deposition of those experts. A demand for settlement from the plaintiff can occur subsequent to the depositions, and then trial or arbitration takes place if a settlement is not reached.

In my case it took two years from the event before I was deposed, and then it took three years until arbitration, which took approximately two weeks and was held in an arbitration center in downtown San Francisco. I was present during all the proceedings. Although I had to wait a matter of weeks for the decision to come back, the outcome was great! I won.

PRF News: *What was the process like for you personally and how did it affect you professionally?*

Insured: While I won the case, it was a lot of heartache to get there. It was agonizing. You're not prepared in medical school to be sued. I always thought that you'd have to do something wrong to be sued. And now I know that that's not the case. If you have a bad outcome, you're at risk for being sued. It tears apart the core of the physician/patient relationship.

There was a bad outcome in my case and I actually continued to be very communicative with the patient and family. Unfortunately, you can get sued even if you are communicative and try to help them understand what happened in a bad situation. So now I don't trust people as much as I did before—I can't! I realized that I needed to talk it out, but unfortunately you can't just talk to whomever you want because a plaintiff can use that against you in trial if you talk to people around you, so you have to talk only to those who are protected—your spouse, those physicians or attorneys who are involved with defending you, or a psychiatric or psychological counselor.

PRF News: *What kind of help did PRF give you?*

Insured: We have some very experienced physicians who were able to review the case early on in the process and let me know what they thought. They were incredibly supportive and they reassured me that I'd done everything I medically could do. That really encour-

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aged me to fight the allegations. They also provided excellent attorneys for me. I had an attorney who was very compassionate and was able to work with me the whole time as well. And they also provided experts that were outstanding. This was a bad outcome, so it was traumatic for me, not only from the standpoint of being sued, but also because the outcome was not something that I wanted, either. So in that regard, PRF provided not only defense, but also expert advice to me as far as giving me the understanding of the fact that you can get sued and not be a bad doctor, which is contrary to what you tend to think when you come out of residency.

PRF News: *What advice do you have for others?*

Insured: Most of the time you're going to know about an event that had a bad outcome and I'd encourage people to notify their carrier within a week of the event so you can at least put forward some kind of record of your care and treatment. It helps you remember what you did.

If you can view medicine as a ministry as opposed to just a job, it can help because it means you aren't really expecting positive feedback all the time. Some things are beyond your control, and that has to be accepted. So I think you have to basically give yourself a break.

I think we would all be better off if we could somehow, as a profession, prepare our young people coming out of training to realize that not all bad outcomes are their fault. Sure, there are risk factors that increase your chances of being sued, like being non-communicative or not helping the patient get through their anger. I've read this over and over again. But it's a fact that there's one lawsuit every seven years for each physician in this country, so we have to just accept that. ■

"I'd encourage people to notify their carrier within a week of the event so you can at least put forward some kind of record of your care and treatment. It helps you remember what you did."

CHANGE OF ADDRESS

PRF has moved from the Medical Society building on Sutter Street to a new office space on Van Ness Avenue, at the corner of Turk. The new address is:

Physicians Reimbursement Fund, Inc.
A Risk Retention Group
711 Van Ness Avenue
Suite 430
San Francisco, CA 94102

Phone and fax numbers remain the same. ■

If You Are Named in a Lawsuit, PRF Will Provide the Following Coverage and Services As Needed:

- PRF will assign expert legal counsel to represent you.
- PRF will pay the full cost of defense. Coverage for the cost of defense, which often exceeds the cost of a settlement, judgment or award, is in addition to your policy limits of $1,000,000 per occurrence/ $3,000,000 per policy period.
- Your assigned counsel, the Chair of the Patient Care and Management Committee, PRF Board members and PRF staff are available to you during the life of the case to answer any questions or address any of your concerns. It is of utmost importance to PRF that its Insureds feel financially and emotionally supported during this trying time.
- It is PRF policy that at a strategic time in your case (prior to mediation, arbitration, or trial, or any event in the case that may be of special concern), PRF will meet with the named Insured and assigned counsel to thoroughly review the case and strategize in order to achieve the outcome most favorable to the Insured.
- PRF will always consult with the Insured to determine how the Insured wants to handle the case, i.e. vigorously defend the case or negotiate a settlement. This is a choice unique to each Insured and each case. A preference to settle does not necessarily imply any wrongdoing or malpractice on the part of the physician Insured.
- PRF will not negotiate or pay a settlement without the advice and consent of the named Insured. ■

The Use of Sedation in Palliative Care

BY HENRY REX GREENE, M.D.

Hospitalized, terminally ill patients who suffer uncontrolled pain, dyspnea, seizures, agitated delirium, or even intractable nausea and vomiting can present a terrible and wrenching clinical dilemma for patients, staff, and family members. What is not widely appreciated is the availability of a therapeutic modality known as palliative sedation (PS). Unfortunately, the appropriate role of PS has been obscured in the debate over physician-assisted suicide. The important distinction is that palliative sedation follows very specific indications and is neither physician-assisted suicide nor a vehicle for euthanasia.

Palliative sedation is simply light anesthesia, maintained as needed to control symptoms, using barbiturates, midazolam (Versed), or occasionally propofol (Diprivan). Its use in palliative care is no different than controlled sedation of ventilator patients. It is not intended to end life, although most patients die once started on PS. Studies indicate that dying patients live equally long with or without PS, averaging 1.3 days—and a few survive the episode. Ethically, PS falls under the doctrine of double effect, i.e., the desired result (symptom control) may carry the risk of an undesired outcome (death), but death is not the intended outcome.

Like any other intervention that carries the risk of death, PS should be covered by hospital policy and procedures, with a written protocol for its administration. Policy should require the exhaustion of lesser remedies, informed consent, family conferences, spiritual counseling—and psychological support if indicated. A DNR order is required, and second opinions may be warranted. At times PS must be given on an emergency basis, but it should never be done for reasons other than uncontrollable symptoms in dying patients. Nutrition and hydration are addressed separately, but not routinely stopped. Pain medication is continued as it is uncertain whether patients treated with PS experience pain.

Hospitals' ethics committees and palliative care programs are excellent resources for navigating the complexities of end-of-life care and should be involved in all cases that require PS. The goal in caring for dying patients who cannot be at home or hospice is to prevent symptoms from becoming intractable whenever possible. In practice, PS should be required as infrequently as possible, but still be available for those patients and families who would otherwise suffer needlessly. ■

"Like any other intervention that carries the risk of death, PS should be covered by hospital policy and procedures, with a written protocol for its administration."

Although it may superficially resemble physician assisted suicide, PS is different. In Oregon, 208 cases of physician assisted suicide have been reported during the past six years. Nearly 80 percent were cancer patients, but none of them had intractable symptoms or significant disability attributed to their cancer. They felt hopeless, helpless and were concerned about what lay in the future. In short, they showed signs of depression, which is common in seriously ill patients. Neither "terminal anguish" nor other manifestations of psychic distress are indications for PS.

Dr. Greene is the medical director of the Dorothy E. Schneider Cancer Center and director of palliative care at Mills-Peninsula Health Services. Board-certified in Internal Medicine, Hematology and Oncology, he was a clinical professor of medicine at USC-Keck School of Medicine until he moved to Northern California two years ago. He is a long-time consultant to the California Medical Association Council on Ethical Affairs.

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June 2005

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PRF News is produced by Knox Communications

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Informed Consent Revisited

BY STEPHEN J. SCHEIFELE, M.D.

The legal term "battery"— objectionable physical contact or bodily harm without permission—is not one we're accustomed to hearing in the context of the doctor-patient relationship. Yet in order to circumvent limits imposed by MICRA legislation, plaintiff's attorneys are attempting to use battery as a cause of action in cases where there may have been deficiencies in informed consent. The claim is that if consent does not exist, a medical procedure can be considered to be a form of battery.

A recent case highlights this issue: A patient died following complications after undergoing an angioplasty. The family argued that the patient had only consented to an angiogram and successfully claimed that the angioplasty constituted battery. In this case the claim of battery was easier to prove than claiming a lack of informed consent.

A claim of battery may occur in the following circumstances:

- The patient is not competent to give consent.
- The person providing consent does not have the authority to do so.
- A signed consent is not obtained or is lost.
- The physician proceeds after the patient verbally withdraws consent.
- Consent is given for a specific physician, but another substitutes.

Physicians can help protect themselves from consent disputes by:

- Documenting informed consent when the discussion occurs ***before*** the day of surgery.
- Postponing the procedure if the patient is not clearly competent.
- Obtaining and documenting informed consent personally.
- Involving a spouse or other close family member in the consent process.

Finally, remember that informed consent is a two-step process: a discussion with the patient AND the documentation of that discussion. This is especially important when the planned procedure may lead to other interventions. Consent must be obtained for all aspects of the procedure and any additional procedures that may become necessary. ■

> ***"Consent must be obtained for all aspects of the procedure and any additional procedures that may become necessary."***

Dr. Scheifele is a board member and chair of the Risk Management & Education Committee of PRF.