



PRF NEWS

Volume 9, Number 2

Covering Practice and Risk Management Issues for Physicians

Breast Evaluation and Risk Management

BY R. JAMES BRENNER, MD, JD, FACR, FCLM

According to the Physicians Insurers Association of America, a consortium of physician owned liability carriers similar to PRF, pooled claims data indicates that delay in diagnosis of breast cancer became the most common reason that physicians were subject to medical malpractice lawsuits in 2000, with a follow-up study in 2006 showing the same results. As this aspect of healthcare is subject to a high public profile and expectations, certain strategies lend themselves to both good medical care and minimized legal exposure.

BREAST SCREENING INTERVAL

Breast evaluation should be seen in two contexts, screening and diagnosis. Screening for breast cancer involves regular clinical examination and periodic mammography. Specialty society recommendations for screening mammography differ somewhat, with ACOG suggesting yearly mammograms after age 50 but not specifying a screening interval for younger women. Although guidelines are not tantamount to representing the standard of care, they do serve as an influential basis for testimony should an allegation of delay in diagnosis arise. Thus, if a stage II cancer is diagnosed using a mammography interval period of two years, an aggrieved patient may contend that earlier screening would have resulted in an earlier stage of diagnosis and improved prognosis. Because many specialty societies recommend annual mammography for all women over 40, risk management considerations would favor this approach.

RESPONDING TO A NEW SIGN OR SYMPTOM

Regardless of prior screening results, the development of new clinical signs or symptoms referable to the breast should prompt a deliberate diagnostic evaluation and management plan. Distinguishing a dominant lump from the multiple lumps and bumps that define fibrocystic change is often difficult as

most cancers no longer present as fixed, retracted lesions. Although examining the breast over a short period of time to determine persistence of a focal lesion may be appropriate, physicians need to be aware that the law imposes a duty to refer for both imaging and clinical assessment (e.g., a surgical consultation and/or biopsy) where appropriate. In both cases, a deliberate strategy includes an established plan. Asking the patient to return "prn" for a specific breast problem invites delay in diagnosis when a cancer actually exists, and juries are often not partial to the physician who, in effect, is asking the patient to reconcile the clinical situation. A useful paradigm to consider when a breast problem is brought to clinical attention is that a "loop has been opened." The closure of that loop, either by appropriate referral or sufficient periodic assessment that validates a noninterventional approach, should be the desired goal.

DOCUMENTATION IS ESSENTIAL

The absence of chart notes permits speculation that proper care was not administered. Even when the physician prevails at trial, the adverse impact of litigation that might have been obviated by proper chart notes is not trivial. The medical record is permitted as evidence, not proof, of physician conduct in virtually all jurisdictions as an exception to the hearsay rule, to assist in resolving different mental recollections.

DIGITAL MAMMOGRAPHY

The emergence of new imaging technologies requires a re-assessment of what is expected of a "reasonable and prudent physician practicing under similar circumstances," the "classic" definition of standard of care. Digital mammography has been shown to be at least equivalent to film-screen conventional mammography and even better for dense breasts, although initial results are being examined more closely. Given the current inventory of

(continued on page 3)

Inside PRF News

Breast Evaluation and Risk Management

A local expert in breast imaging shares strategies for providing good medical care while minimizing legal exposure.

1

Avoiding Claims and Succeeding in Lawsuits

While an unfavorable result may be unavoidable, you can follow these techniques to minimize the risk of legal action and prevail if such action does take place.

2

Why Code Green

Code Green is good for the patient, the doctor and PRF—here's why.

4

Avoiding Claims and Succeeding in Lawsuits

BY JAMES M. GOODMAN, ESQ.

The vast majority of doctors win contested malpractice cases, but few enjoy the experience of a trial or arbitration. Unfortunately, there is no definitive way to avoid claims or prevail in lawsuits. There are, however, some things you can do to reduce your risks.



INTERESTED IN FINANCE COMMITTEE?

Recently PRF sent a memo to all insureds regarding the formation of a Finance Committee under the leadership of Damian Augustyn, MD, Treasurer and CFO. The Finance Committee is expected to meet quarterly, with the first meeting tentatively planned for September 2006. PRF's business meetings usually begin at 6:00 pm at the PRF offices on Van Ness Avenue. If you did not receive the memo and are interested in being considered for the Committee, please notify June Riley by phone at (415) 921-0498 or by e-mail at June@PRFrrg.com by July 31, 2006. ■

There are three critical points in the claims process when a patient experiences an unfavorable result following a medical encounter.

- ▶ Patient considers going to an attorney.
- ▶ Attorney decides whether to pursue a claim.
- ▶ Disposition of the claim.

PATIENT CONSIDERS GOING TO AN ATTORNEY

It is better if the process ends early—the question is whether the patient will consult with an attorney to see if there are grounds for a malpractice case. We have seen many instances where patients simply decide not to pursue a claim against the doctor, even in circumstances where there were serious problems with the quality of care. These decisions are usually based on an aversion to litigation or a strong personal relationship with the doctor.

Risk managers often tell doctors about the importance of good patient communication in avoiding lawsuits. It is important to understand that the good bedside manner must exist before a bad result occurs. It will do little good for an otherwise arrogant or inattentive physician to suddenly become Marcus Welby when his patient develops an unexpected complication. The patient will usually see through this and resent it.

Doctors receive a great deal

of advice about how to relate to their patients. They are told to listen carefully and give patients adequate time at appointments. These are useful, although the demands of a busy practice sometimes mean that a patient will feel rushed. It seems that the most important part of the relationship is the patient's understanding that the doctor truly cares about his or her well-being. There is little doubt that most doctors really do care about their patients, but patients do not always have that understanding. No one can tell you how to let your patients know you care. In most situations, it may not take more than a few seconds of your time to communicate a caring attitude. It is much easier for a patient to pursue litigation against a physician who is perceived as uncaring.

ATTORNEY CONSIDERS WHETHER TO PURSUE CLAIM

It would be rare for a doctor to talk a lawyer out of pursuing a case. This is, however, one of the points at which good record documentation becomes important in avoiding a claim. A well written chart can sometimes prevent a claim from getting started.

The record should contain timely and essential documentation of the information received and your decision-making process. This might include indications for surgery, informed con-

sent or treatment and diagnostic recommendations.

The timing of documentation is very important in relation to a bad result. While you will surely make record entries after an adverse outcome, it is what you have written beforehand that usually matters most. Entries made after a complication are viewed with suspicion, particularly if they attempt to document something important that happened much earlier and was not placed in the record at the time.

A well documented record can help an experienced plaintiff's lawyer or his medical consultant decide that a case is not worth pursuing. This is a good endpoint for a claim.

DISPOSITION OF THE CLAIM

Once the lawsuit or arbitration proceeding is initiated, the focus becomes trying to achieve a successful disposition. This would generally be viewed as a defense verdict or award or a dismissal or settlement on reasonable terms.

The unifying theme of almost every decision in the case should be how it will affect the ultimate outcome at trial or arbitration.

The question in most cases will be whether the doctor met the standard of care and/or caused the patient any appreciable harm. In trial, a jury is instructed as follows: "A physician is negligent if he fails to use the level of

(continued on page 3)

Breast Evaluation and Risk Management *(continued from page 1)*

only 10% of all mammography units in the country being digital, universal implementation of digital mammography is at least a decade away. Indeed, because the overall results between the two approaches are similar, the interpretation of the study is probably more important than the type of FDA certified mammography unit that is used and referral to any accredited facility is at present reasonable.

SCREENING ULTRASONOGRAPHY

Screening ultrasonography has been advocated for improved cancer detection, with several studies reporting encouraging results, especially in women with dense breasts by mammography. Based on these reports, the NCI is currently conducting a controlled clinical trial to determine the advisability of screening ultrasound. Because mammography reports indicate breast density (which itself is an independent risk factor), clinicians are often asked to consider this approach. However, given the lack of current validation, this procedure is not currently considered a standard of care.

BREAST MRI

Similarly, properly performed breast MRI has been demonstrated to increase sensitivity to breast cancer compared to mammography, although its cost is higher and its specificity lower than mammography. Several clinical trials have indicated a potential role in very high risk patients, i.e., those with a demonstrable genetic predisposition. As a result, some payers now permit reimbursement for screening MRI under specified conditions regarding family history.

BREAST CANCER RISK ASSESSMENT

Given the prevalence of breast cancer, all women should be considered to be “at risk.” When patients seek additional studies such as an MRI or a screening ultrasound, risk assessment may be indicated. Patient history has become a more important component of patient management as new indicators of risk are identified. Careful risk assessment may be conducted outside of a busy clinical practice by referral for genetic counseling. Depending on the results, accommodating patient preference should

include disclosure that many procedures will not be reimbursed. Furthermore, both MRI and screening ultrasound may incur both anxiety for nonspecific findings as well as many “false positive” interpretations. Though extensive discussions may not always be possible in a busy clinical practice, addressing these issues—perhaps with the assistance of nonphysician personnel—should satisfy most patients and serve as a basis for reasonable care in case such conduct is called into question.

DRUGS FOR BREAST CANCER PREVENTION

Regardless of what types of tests may be requested, reasonable assessment of risk is emerging as an issue germane to the primary care provider. Cancer prevention strategies, including surgical and hormonal (e.g., Tamoxifen, Raloxifene, and perhaps aromatase inhibitors in the near future), may need to be discussed with women at sufficient risk using, for example, a Gail, Klaus, or other model. These discussions not only address the medical issue, but they are a risk management tool to preempt

allegations that an aggrieved patient with breast cancer would have selected such a choice had it been offered.

DEFENSIBLE MEDICINE, NOT DEFENSIVE MEDICINE

Successful strategies in risk management are aimed at encouraging defensible medicine, rather than defensive medicine, the latter of which invites wasted resources. Diagnosis of breast cancer will not always be realized at a time satisfactory to a given woman, and most women will not succumb to breast cancer. When issues in management occur, there is often no right or wrong answer. Litigation outcomes will usually be resolved based on the standard of reasonableness, not outcome, because it is the conduct of the healthcare provider, not the end result, which is at issue in cases alleging malpractice. ■

Dr. Brenner is professor of Radiology and chief of Breast Imaging at UCSF.

Avoiding Claims and Succeeding in Lawsuits *(continued from page 2)*

skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in similar circumstances. This level of skill, knowledge, and care is sometimes referred to as the ‘standard of care.’ You must determine the level of skill, knowledge, and care that other reasonably careful physicians would use in similar circumstances based only on the testimony of the expert witnesses who have testified in this case.”

Arbitrators are supposed to use the same legal standard. The question of whether the standard

of care was met is determined from competing expert testimony, including that of the doctor on trial.

Every step in the management of a lawsuit should be undertaken with the end game in mind. It should direct everything from expert selection, whose deposition is taken, what questions are asked, and how you give testimony concerning your care. There may be technical issues, like the statute of limitations, which do not relate directly to the question of the standard of care. These defenses should only be pursued after due consid-

eration of whether they will harm the main defense in the case.

There are many procedural and substantive decisions that are made from the beginning to the end of a lawsuit. It is only by keeping focused on the issues that will ultimately decide the case that the correct approach can be employed throughout. It is frankly surprising how often participants will say or do things in the course of a case which are detrimental to their ultimate ability to prevail at trial.

The probability of getting a dismissal, favorable settlement or defense award are greatly enhanced

if every aspect of the case is undertaken with consideration of how it will appear at the time of arbitration or trial. ■

James M. Goodman, Esq. is a Partner at Hassard Bonnington, LLP.



PRF NEWS

Covering Practice and Risk Management Issues for Physicians

Volume 9, Number 2
July 2006

Stephen Scheifele, MD,
Executive Editor
Robert D. Nachtigall, MD,
Editor

PRF News is produced by
Knox Communications

Physicians Reimbursement
Fund, Inc.
711 Van Ness Avenue, Suite 430
San Francisco, CA 94102
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com

June Riley, MBA
Executive Director

Soad Kader
Director of Membership

DIRECTORS
George F. Lee, MD
Stephen Scheifele, MD
Damian Augustyn, MD
W. Gordon Peacock, MD
Michael Abel, MD
Andrew Sargeant, ACA, CFA
(Vermont Insurance Management)

Reuben A. Clay, Jr., MD
Chair of Patient Care and
Management Committee

Stephen Scheifele, MD
Chair of Risk Management &
Education Committee

W. Gordon Peacock, MD
Chair of Peer Review Committee

© 2006 Physicians Reimbursement
Fund, Inc.

Why Code Green

BY STEPHEN J. SCHEIFELE, M.D.

Code Green, the risk management program of PRF: *It's the right thing to do.*

IT'S GOOD FOR THE PATIENT

Code Green acknowledges the patient's complication and attempts to make him or her whole again. It's not an admission of wrongdoing but an act of compassion. It's the recognition that untoward events do happen, and when they do, the physician will be there advocating on their behalf to rectify the situation. It's good medicine!

IT'S GOOD FOR THE DOCTOR

Code Green maintains the doctor-patient relationship. It gives the physician the opportunity for disclosure, apology and to accept responsibility. It is not an admission of guilt or assumption of blame. The physician remains proactive in caring for the patient. Code Green payments are not reportable.

Code Green can reimburse lost wages, out of pocket expenses and the cost of additional uninsured medical treatments. If you have a patient who you feel may

qualify for Code Green, file a Management Report with PRF requesting Code Green. PRF will assist your interaction with the patient. Any Code Green pay-

averted is a significant savings. The average Code Green expense for most cases is \$3,500. The average cost of defending a claim is approximately \$42,000.

Any Code Green payments to the patient are made directly by the physician, which supports the doctor-patient relationship. PRF reimburses the physician for his or her effort.

ments to the patient are made directly by the physician, which supports the doctor-patient relationship. PRF reimburses the physician for his or her effort.

IT'S GOOD FOR PRF

Code Green prevents lawsuits. Patients initiate legal actions not for the adverse event but because they became angry as a result. Often this is due to the misperception of a lack of disclosure or compassion on the part of the physician. With the cost of defense increasing, every legal action

It's easy to understand why Code Green is the right thing to do.

If you have any questions about whether Code Green would be appropriate in a situation where the medical outcome was less favorable than you had anticipated, call June at the PRF office at (415) 921-0498. She will be pleased to offer advice and assistance. ■

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