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NEWS & VIEWS

Reducing Physician Extender Liability

With the advent of managed care the use of physician extenders (PE) has grown considerably. PEs include nurse practitioners, nurse midwives, nurse anesthetists, anesthesia assistants, and physician assistants. However, as a result of the increased use of PEs, the frequency and severity of claims against physicians attributed to PEs has also steadily increased. Recent data from the Physician Insurers Association of America (PIAA) reveals that over 28 percent of claims against general and family practice physicians involve a PE.

Under expanding theories of tort liability, physicians are increasingly being held responsible for the acts of physician extenders in virtually all clinical settings. Although the practical benefits of utilizing PEs are numerous, myriad legal doctrines hold the physician responsible for the acts and omissions of such employees. Implementing effective risk management measures will help ensure that the benefit of using PEs in your practice is not at the expense of increased liability exposure and malpractice claim development.

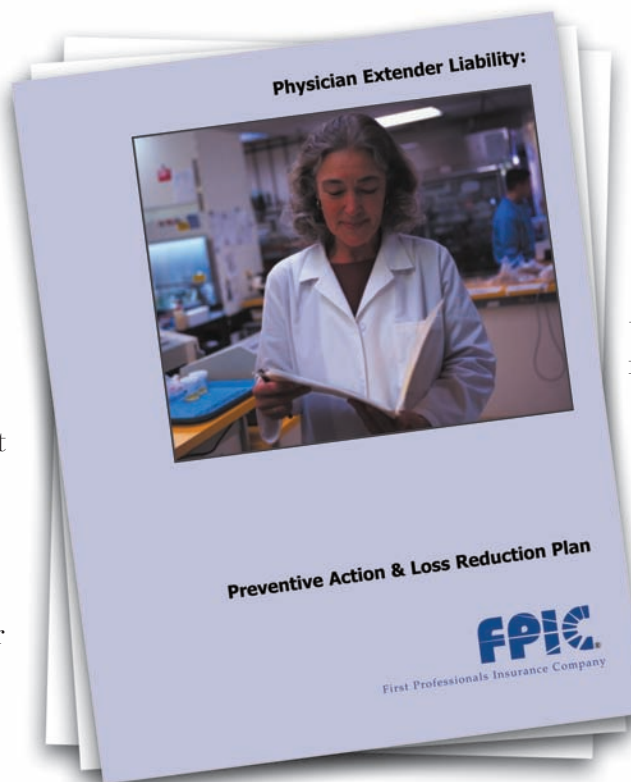
Physicians are held responsible for the actions of PEs under the theory of vicarious liability. Generally, it relates to direction and control of another's actions. The greater the degree of control or direction a physician has over a PE, the greater the degree of physician responsibility or liability. Vicarious liability encompasses situations where the physician may have acted appropriately but ultimately find

themselves responsible for the failures of another.

FPIC is committed to countering the increasing claims resulting from the use of PEs. To help reduce the claims exposure faced by physicians and the extenders they supervise, FPIC has developed a booklet "Physician Extender Liability: Preventive Action & Loss

Reduction Plan." The booklet details the responsibilities of the supervising physician and includes an analysis of physician extender closed claims. The booklets were recently mailed to all physician offices that have coverage for a PE.

In addition to the booklets, FPIC offers in-service presentations to clinical and administrative staff to



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assist in decreasing physician extender liability. Site assessments are also available to policyholders to assist in implementing the measures detailed in the booklet. If you would like to receive additional copies

or to schedule a consultation, contact the Risk Management Department at 800-741-3742, ext. 3016.



FPIC Receives Collier County Medical Society Endorsement

FPIC and the Board of Directors of the Collier County Medical Society have recently completed an endorsement program. Members in good standing with the medical society will now be eligible to receive a 5 percent program discount off the professional liability premium. This discount will be available to current insureds upon renewal after November 1. It can then only be combined with FPIC claims free discounts for even greater savings.

The Anatomy of a Trial

Editor's Note: This series of articles is based upon actual cases that FPIC has defended in the courtroom and illustrates FPIC's ongoing commitment to a strong defense of claims against our insureds.

Acute Myocardial Infarction

Case Facts

Consider the case of a 60 year-old female who presented to the Emergency Department with complaints of chest pain. An ECG was interpreted as non-specific ST-T wave abnormality and ischemia. A diagnosis was rendered of "chest pain - rule out angina." The insured, a cardiologist, was consulted and his impression was chest pain, possible angina, diabetes, and hypertensive cardiovascular disease. The patient was treated with aspirin, calcium blockers, nitroglycerine, and ACE inhibitors. During

a Cardiolyte stress test, the patient reached a heartbeat of 153 beats per minute, which was 96 percent predicted maximal heart rate. The patient had no chest pain, but the test was discontinued due to fatigue. Cardiac catheterization was recommended, but refused by the patient. However, there was no documentation made of the recommendation or of the patient's refusal. The patient continued to complain of mid-sternal chest pain and a second ECG was also abnormal. The patient was later found unresponsive, a code was called, but resuscitative efforts failed. Defense experts were critical of the



care, stating that the ECGs demonstrated T wave abnormality and that Troponin levels indicated progressing infarction which should have prompted intervention - primarily catheterization. Because of the lack of documentation, settlement of the claim was necessitated in the amount of \$350,000.

Risk Management Discussion

Errors in the diagnosis and treatment of acute myocardial infarction (AMI) continue to occur with alarming frequency and result in high morbidity and mortality. Malpractice claims stemming from problems in the diagnosis and treatment of AMI are not limited to cardiologists, and, in fact, are the most common claims against family physicians.

Acute myocardial infarction is ranked as the third most expensive and fourth most prevalent condition resulting in claims against physicians. A 10 year study encompassing over 142,000 AMI claims examined the contributing factors. Diagnostic error, particularly misinterpretation of electrocardiograms (ECGs), was alleged in the majority of cases and resulted in the greatest source of loss. Frequently, physicians confuse cardiac symptoms with other conditions and diseases, such as gastrointestinal or musculoskeletal problems. In the majority of cases, the patients were diagnosed with a gastric disorder, anxiety, or musculoskeletal pain and were treated with antacids, tranquilizers, antibiotics, or anti-inflammatory medications. The failure or delay in diagnosis was attributed to a failure or delay in ordering the appropriate evaluative study in 55 percent of the cases. In many of these cases, the physician failed to obtain a thorough history and did not investigate the patient's cardiac risk factors. Cardiac evaluation was not the primary focus in the evaluation. A myocardial infarction was never considered in nearly half of the cases.

Although, even with current technology, it is not possible to diagnose myocardial infarction with 100 percent accuracy, studies have indicated that failure to accurately interpret diagnostic studies, especially

ECGs; failure to obtain and evaluate the patient's history and risks; failure to recognize atypical presentation; and failure to promptly admit and treat patients have significantly contributed to errors in diagnosis and treatment of acute myocardial infarction.

Preventive Measures:

- Investigate and document all patient complaints related to chest pain or pressure. Avoid the temptation to disregard atypical presentations.
 - Obtain and Document a thorough patient history. Complete a cardiac profile to identify risk factors. Consider implementing a template to ensure consistent and thorough evaluation and documentation.
 - Review results of previous cardiac evaluative studies.
 - Discuss and document recommendations and rationale for subsequent diagnostic studies and treatment. Consider referral.
 - Avoid reliance on a single test result, especially if negative or equivocal. Maintain an index of suspicion until a preponderance of data rules out cardiac etiology.
 - Promptly report diagnostic results and their significance.
 - Evaluate, refer, or admit patients with symptoms until a cardiac etiology has been ruled out.
 - Consider an exercise tolerance test if clinical suspicion is present.
 - Implement and follow chest pain protocols created by the American College of Emergency Physicians or other organizations to establish a consistent approach to evaluation, management and documentation of chest pain.
 - Educate and inform patients of risk factors, diagnostic and evaluative processes, treatment alternatives, and the patient's response. Provide appropriate cautions related to lifestyle, activity, and warning signs.



Letters from Policyholders

Frederick Scheriff
Vice President of Claims
FPIC
600 N. Pine Island Road, Suite 250
Plantation, FL 33324

Dear Mr. Scheriff,

I have just recently completed a successful trial with excellent representation, sponsored by FPIC that deserves a letter of commendation.

The entire defense team that supported me and stood by me during this quite trying time is to be commended for an excellent performance.

Our lead defense attorney, Mr. Keith Puya both masterfully and meticulously assessed my defense, orchestrated an in-depth painstaking, arduous trial preparation and an emotionally and physically draining trial. He and his team compulsively and professionally dissected out the essence of the defense, analyzed and neutralized the plaintiff's attorney, and was most skillful at trial procedure, protocol and process. He demonstrated appropriate discretion for the plaintiff and the plaintiff's family

while eliciting the desired result in information gathering. He is to be commended for his excellent and facile use of legal procedures and protocol to a significantly positive end. His co-counsel, Michael Burt, was also very attentive, knowledgeable and showed a human interest in myself and the legal team. The team functioned in a coordinated and professional manner.

A highlight of our defensive team was Mr. Clive Smith*, who was indispensable with his trial analysis, witness analysis, and moment by moment interaction and advice during the defense and trial period.

This trial was like a pendulum that swung from one extreme to the other. Only with an excellent, talented, experienced defense team were we able to go from the jaws of defeat to a very successful and satisfying result. I commend you for your selection of your defense team and thank you for allowing them to assist me in my defense.

Sincerely
Dr. S
South Florida

* Clive Smith, FPIC Claims Manager

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