

Physician's Risk Advisory



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The Physician as Educator



Although lawsuits are an anomaly, they are a reality. The motivating factors behind a patient's decision to sue are generally well understood now. One recognized factor contributing to the filing of malpractice lawsuits is related to the patient's

expectations of both care and outcome (realistic or not). Unmet expectations are a source of anger and/or disappointment for all of us. For both clinical and liability reasons, we should influence our patient's expectations to the extent that we can. Clinically, a well informed patient is likely to be more compliant as they will tend to have a better grasp of the nature of their condition and what they - and you - can accomplish to achieve the desired outcome. From a liability standpoint, a patient who is conversant with the risks and possible outcomes attendant to their condition will have a more realistic set of expectations and, although their disappointment may not be lessened - they will be less prone to anger. Physicians who do a poor job of educating their patients run the risk of being judged by the unrealistic standards their patients pick up from other sources. There's a lot of information out there for patients to absorb; TV, the internet, well-meaning family and friends, plaintiff's attorneys, and so on. Much of it is credible - and much is misleading or just plain wrong. Where are your patients getting their information? The important thing to remember about "unrealistic expectations" is that an adequately informed patient rarely has them.

As you know, there is a tremendous amount of material available to practitioners to use to educate their patients; pamphlets, videos, CDs and DVDs are a few examples.

At the very least, these publications and media provide the patient with the kind of background information that they generally want and need to understand their situation. However, no matter how well prepared the materials are, they are only an adjunct to - and never a substitute for - direct one-on-one education from the physician. Having a rack of pamphlets accessible in the waiting area is just not nearly enough to satisfy the requirement to fully inform patients. Although we may hope our patients independently take advantage of this information, we should assume they don't. Many doctors delegate patient education to nurses or other staff. Selecting the right individual to educate a patient should be based upon their level of training and comprehension of the clinical details and implications of the illness or condition they are asked to address. For example, unlicensed staff should never be placed in a situation of having to explain the significance of any clinical condition to a patient. Medical Assistants are prohibited by law from giving clinical advice, so asking them to discuss clinical problems with patients may place them in a position of either attempting to answer the patient's questions or appearing to be uninformed. Unlicensed staff should be instructed to refer any clinical or treatment-related questions to a licensed provider.

Patient education is of value not only for the patient's protection, but the physician's as well. For example, if a physician unilaterally selects treatment "A" without educating the patient as to the various reasonable options available, then the doctor has *not* met the obligation of adequately informing the patient so that he or she can make an informed medical decision. However, if the doctor *actively* involves the patient and educates him or her about the reasonable treatment choices available - with recommendations, of course - then the liability risk is considerably reduced if the treatment isn't successful, as the patient has made an "informed choice," albeit with the physician's expert,

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but qualified guidance. In these situations, patients are less likely to file a lawsuit if things don't work out as expected because 1) they see themselves as the *primary* decision maker, 2) they are less likely to have been "surprised" by the outcome as it was (hopefully) covered during the discussion with their doctor and 3) this process of education – also known as "informed consent" – provided an opportunity for the patient to have the time to voice their fears and concerns with their selected expert and be properly educated as to what to expect down the road.

In addition to giving medical advice and direction to the patient, the physician is expected to review the foreseeable consequences for *not* following it. It's not enough to recommend that a patient have a follow-up mammogram or see a specialist. An explanation of the clinical implications for not doing so is expected and should always be well documented. Everyone's memory tends to fade overtime. That's why documentation plays such an important role in sorting out who said what to whom and when. As is almost always the case, the medical record becomes a crucial piece of evidence available if the patient's memory falters - or is just selective. Plaintiff's attorneys rely on the record in these situations as a major factor in determining whether or not to accept a case in the first place.

Case in point. A 68 year old diabetic presented to his medical group's walk-in clinic with a foot infection. His toes were slightly purple and he complained of tremors, pallor and nausea. Although preliminary tests indicated a possible bacterial infection, the treating physician diagnosed a viral infection, scheduled a follow-up appointment for the next day and sent the patient home.

The next day, at the patient's request, his wife called and cancelled the follow-up appointment. The patient's condition deteriorated and he went to an emergency department the next day. An x-ray revealed a piece of glass embedded in the foot and a blood culture was positive for MRSA. The patient was admitted, but IV antibiotic therapy was not sufficient to stop the infection and his leg was amputated below the knee.

At trial, the jury found the patient and his wife partially at fault for canceling the follow-up appointment. They also found the doctor negligent for not warning of the consequences of an untreated infection. In this situation a brochure would simply not have been enough. Doctors should take the initiative and track the patient down to deliver the appropriate "education" and then document it.

Informed Consent decision from the California 1st District Court of Appeal.

The parents of six year old Crystin Schiff, who had died after she was diagnosed with a brain tumor, brought a wrongful death action against the doctor with whom they had consulted concerning their child's treatment options. Mr. and Mrs. Schiff alleged that Dr. Michael Prados did not obtain their informed consent for their child's recommended treatment of aggressive radiation and chemotherapy and failed to advise them of the existence of an antineoplaston treatment that was offered by a doctor in Texas. The trial court granted the defendant's - Dr. Prados - motion for summary judgment (an assertion that the plaintiff has raised no genuine issue to be tried and requests the judge to summarily rule in favor of the defense) and entered judgment in favor of Dr. Prados.

The Schiff's appealed this ruling. Upon review, the 1st District Court of Appeal upheld the motion for summary judgment. The court held that the trial court judge did not err in granting summary judgment for the defendant.

A physician's duty to disclose extends only to available choices and the Court found that, for Dr. Prados to have suggested antineoplaston to the family, the drug would have had to have at least met the minimum requirement needed for an investigational drug's legality under California Health & Safety Code §109300, i.e., the manufacturer, Dr. Stanislaw Burzynski, must have submitted, and had accepted, a current and unrevoked investigational new drug application with the federal Food and Drug Administration permitting antineoplaston treatment (21 U.S.C. § 355(i)). Antineoplaston treatment did *not* satisfy this minimum requirement at that time. Consequently, the court held, as a matter of law, that a doctor cannot be held liable for failing to disclose a treatment option that cannot legally be administered in California. The court further held that, even if this treatment was available in Texas at the time, informing patients of treatment alternatives that are legally available in another state, but *not* in California, is beyond what the law expects of physicians.