MALPRACTICE RISKS FOR GASTROENTEROLOGY PA’S ARNP’S AND PHYSICIANS WORKING TOGETHER

ACG 2013
Andrew D. Feld, MD, JD, FACG
Group Health Cooperative, Univ. WA

Acknowledgement-Co Authors

- Richard E Moses DO JD
  - Gastroenterologist Colleague

- Lauren D Feld
  - Mount Sinai School Medicine, 3rd yr
Waiver

- This lecture is intended for educational purposes only, and should not be construed to provide specific legal advice
- For specific legal advice, please consult your health care attorney

Introduction

- Initial Instruction Request for Talk
  - Liability Risks For Gastroenterologists
- My Addition
  - Liability Risks for GI ARNP’s and PA’s
- My Initial Concern
  - Irritate ARNP/PA with part one
  - Irritate GI MDs with part two
  - No friends at All by end of lecture
  - BUT …Saved by legal principles/practice
Relevant Legal Principles & Practice

- Legal Principles
  - Vicarious Liability
  - Negligent hiring & credentialing
- Legal Practice By Plaintiff’s Attorney
  - Divide and Conquer
  - Develop Practitioner disputes
- So You are In a Symbiotic Relationship
- Thus rather than getting irritated realize I am Keeping you BOTH out of trouble

Overview of Liability Risk
Appears Low Risk To Date- May be Changing

<table>
<thead>
<tr>
<th>MD Liability Issues (Vicarious)</th>
<th>ARNP/PA Liability Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lack of Adequate Supervision</td>
<td>- Work Structure Precluding Adequate Supervision</td>
</tr>
<tr>
<td>- Untimely referral</td>
<td>- Lack of back up when requested</td>
</tr>
<tr>
<td>- Failure to Diagnose</td>
<td>- No Provision for Ongoing Training/CME</td>
</tr>
<tr>
<td>- Inadequate Examination</td>
<td>- Malpractice Insurance Issues</td>
</tr>
<tr>
<td>- Negligent Misrepresentation</td>
<td>- Billing Issues</td>
</tr>
</tbody>
</table>
Background: ARNPs And PAs in Gastroenterology

- Description of Education, Regulation, GI Practice
- Good overview article particular to GI

- Dorn, S Mid “Level Providers in Gastroenterology”
  *Am J Gastroenterol* 2010;105:246–251

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Non Physician Providers

Spencer Dorn 2010

Table 1. Defining characteristics of nurse practitioners and physician assistants

<table>
<thead>
<tr>
<th></th>
<th>Nurse practitioner (NP)</th>
<th>Physician assistant (PA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population size</strong></td>
<td>97,000</td>
<td>63,000</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Bachelor's degree in nursing plus 2- to 4-year graduate-level NP degree (master's or doctoral degree)</td>
<td>Bachelor's degree (most) plus an average of 26-month graduate-level PA degree (master's degree)</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Nursing model that emphasizes patient education, self-care, and health promotion</td>
<td>Biomedical model that emphasizes organ systems and disease processes</td>
</tr>
<tr>
<td><strong>Licensure</strong></td>
<td>State nursing boards</td>
<td>State medical boards</td>
</tr>
<tr>
<td><strong>Practice prerogatives</strong></td>
<td>Vary by state, although almost one-half of states have granted ability to practice independent of physician supervision</td>
<td>Works closely under supervising physician in a role of &quot;negotiated performance autonomy&quot;</td>
</tr>
</tbody>
</table>
PA Practice

- List of Regulatory Requirements by State
  www.aapa.orgform
  - Regulatory Authority and Licensure
  - Scope of Practice and Supervision
- Criteria for Licensure
  - Graduation From Accredited Program
  - PA National; Certifying Exam
- Team Concept: autonomy but not independent practice

ARNP Practice

- Reference/ Regulation
- State Board of Nursing Websites
Evolution of MD/NPP relationship

**From:**
1. “Aiding And Abetting the Unlawful Practice of Medicine” (old references discuss this!)
2. ER MD Article lament
3. Washington State RN Board Suit Against PA’s

**To:**
“Familiarity breeds respect”
working well collaboratively, good ratings

**But:** In the setting of a harmed patient, the plaintiff’s attorney will try to make the case for “inadequacy not platitudes”

Overview of Liability Risk
Appears Low Risk To Date- ? Changing data

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<td>Billing Issues</td>
</tr>
</tbody>
</table>
Supervision
What Does That Mean?

- Simple vs. complex patient
- Low vs. high risk patient
- Regular meetings
  - Hospital rounds?
  - Set time Office review?
- Conferences (practice, hospital)
  - Path, M&M
- CME

ACG Survey 2013 re GI NPP
414 responses- preliminary

- 76% respondents worked with ARNP/PA’s
- Breadth of GI Issues
- Supervision 95%
- Patient also seen by MD:
  - Always: 40%; half- 26%; ¼ 27%; never 6%
- Co Signing Notes
  - Daily: 62-51%; Weekly: 20-12%; N/A 15-34%
## ACG Survey 2013 re GI NPP
414 respondents - prelim

- **Training Prior to Seeing Patients**
  - 1-4wk: 29%; 5-12 wks: 37%; >12: 33%

- **Didactic Sessions**
  - Never: 38-53%; monthly: 20-10; weekly: 20-23%

- **Hours Annual CME**
  - 10-15hrs: 37%; 16-25hrs: 62

## Billing Issues

- Incident To
- Fraud and Abuse
- Hospital Charges
Don’t Forget Your Medical Assistants and Receptionists

- Vicarious Liability
  - Inappropriate Advice
  - Urgent Messages Not Transmitted
  - Inappropriate Wait Times
  - Open Access Screening
- Other

- Buppert C “Understanding Medical Assistant Practice Liability Issues DERMATOLOGY NURSING/August 2008/Vol. 20/No. 4

Claims-Actual Legal Case Examples
Moses & Feld Article- AJG 2007

- Lack of Adequate Supervision
- Untimely referral
- Failure to Diagnose
- Inadequate Examination
- Negligent Misrepresentation
Negligent Misrepresentation

- Fact Pattern
  - Anaphylactic medication reaction
  - Patient claim not aware not MD, not told by scheduling, not corrected when called MD
- Claim: Negligent Misrepresentation
  - “Patient is credibly unaware the treating provider is not a physician”


Untimely Referral/Failure to Diagnose MacDonald

- Fact Pattern:
  - Treated for GERD for months by GI PA
  - Re-presents w/ severe abd pain, constipation, given laxatives
  - Refused to leave clinic d/t severe pain; evolving MI w/ heart muscle loss
- Claim failure to diagnose and refer:
  - “misinterprets information, lacked skills”
  - “attempts to treat complicated beyond level of training, expertise”

  - Random review 10% insufficient
Inadequate Supervision

- Fact Pattern
  - Alleged sexual assault by GI PA
  - Claim: failure to exercise supervisory responsibility

Overview of Liability Risk
Appears Low Risk To Date

**MD Liability Issues (Vicarious)**
- Lack of Adequate Supervision
- Untimely referral
- Failure to Diagnose
- Inadequate Examination
- Negligent Misrepresentation

**ARNP/PA Liability Concerns**
- Work Structure Precluding Adequate Supervision
- Lack of back up when requested
- Lack of Training/CME
- Malpractice Insurance Issues
- Billing Issues
**ARNP/PA Outpt Hypothetical: Supervision**

- **Facts:**
  - ARNP asked to run IBD patient population of clinic after initial MD consultation.
  - Limited initial training by group. No CME, no local conferences.
  - Notes not routed to GI MD, nor regular review meetings
  - Complex IBD patient does badly, and sues.

- **Question:**
  1. Is IBD population management reasonably within scope of practice of NPP?
  2. Was there adequate supervision in this instance?

**IBD supervision hypothetical (continued)**

- **For Discussion - I cannot provide not “the answer”**
- **Q1:** My belief yes, can be within scope of practice with adequate ongoing education, careful support, especially with active IBD
  - NB: IBD one of the higher liability areas of GI
- **Q2:** Plaintiff attorney can make strong case for Inadequate supervision here
ARNP/PA Inpatient Hypotheticals

- Facts:
  - PA hired to work solely inpatient care, sees GIB and arranges procedures. Also does hospital rounds, and ongoing care. Speaks with on call GI doc daily. On call MDs always too busy to meet patients, sign or write notes, though PA puts discussed with Dr X in PA note.
  - Complicated hospital patient with pancreatitis does badly after several weeks of care, and sues.

- Question:
  - Is this within Scope of practice?
  - Was there Adequate supervision?

Inpatient Hypothetical
Continued

- Within Scope of Practice - Yes
  - Caveat: hospital patients high risk

- Adequate Supervision in this case -
  - Plaintiffs can make cogent case for no

- Again, this is Opinion - not fact, but
  - Throw tomatoes, but I am giving my best educated guess; and you should prefer to hear it now, think about/rather than hear it first at deposition/court
  - These are ACG Professional Issues Committee concerns, not just mine, so out there
  - Suggest you review with your own risk management attorney, malpractice carrier
Scope of Practice in Malpractice
Context

- Inpatient versus Outpatient
- Complex versus Straightforward patients
- Disease management
  - IBD Protocol Follow up versus Active Disease
  - Urgent Add On Patients

Other Potential Case Examples

- Hospital versus Clinic
- Limited versus Extensive Responsibility
- Simple versus Complex
- Urgent Add on
- Disease Management
- Hep C versus End Stage Liver Disease
- IBS, IBD, GERD, etc.
- Population Management
Summary

**MD Liability Issues (Vicarious)**
- Lack of Adequate Supervision
- Untimely referral
- Failure to Diagnose
- Inadequate Examination
- Negligent Misrepresentation

**ARNP/PA Liability Concerns**
- Work Structure Precluding Adequate Supervision
- Lack of back up when requested
- Lack of Training/CME
- Malpractice Insurance Issues
- Billing Issues

Summary Relevant Legal Principles & Practice

- **Legal Principles**
  - Vicarious Liability
  - Negligent hiring/credentialing

- **Legal Practice**
  - Divide and Conquer
  - Develop Practitioner disputes

- **So You are In a Symbiotic Relationship**
- Thus rather than getting irritated realize I am keeping you BOTH out of trouble
Preventive Advice

- **Gastro’s**
  - 1. Mutual respect
  - 2. Treat and Pay Well
  - 3. Patient Support
    - Esp high risk
  - 4. Provide CME and Backup

- **ARNP/PA’s**
  - Mutual Respect
  - Earn it
  - Stay up to date
    - Educate your doc
  - Alert GI MD to Needs
    - Hi risk patients
    - Areas of uncertainty
    - Unhappy patients

Thank you

- Hope this was helpful.
- Enjoy a satisfying and symbiotic relationship!
Stopping Anti-platelet Agents: Will You Cause a Stroke?

Glenn M. Eisen MD, MPH
The Oregon Clinic-West Hills GI
Clinical Professor of Medicine, OHSU

Thanks for staying....
Objective(s)

- Don’t cause a stroke
- Don’t cause a GI bleed

*Given theme of this session*....

Objective (s)

- Don’t cause a stroke
- Don’t cause a GI bleed

*Don’t get sued*....
Objectives

1. Understand the potential thromboembolic risks of stopping antiplatelet agents / anticoagulants in the elective peri-endoscopic setting
2. Learn the risks of continuing these medications in a patient undergoing endoscopy
3. Review literature/guidelines and best practice to inform clinical decision-making

Case presentations

Case #1 - 67 yr old female on clopidigrel/ASA for drug eluting stent (placed 11 months ago) presents for elective screening colonoscopy
Case #1

- Stop ASA and clopidogrel 7-10 days prior to colonoscopy
- Stop ASA
- Stop clopidogrel
- Defer colonoscopy
- Talk with her cardiologist
- Talk with your attorney

Case presentations

- Case #2- 78 yr old male with aortic valve, CHF, HTN and paroxysmal Afib on warfarin with recent progressive dysphagia. He undergoes a barium esophagogram suggesting achalasia.
Case #2

- Continue warfarin and proceed with dilation
- Stop warfarin 3-5 days prior to procedure
- Stop warfarin and use bridge therapy
- Consider botox injection
- Consider calcium channel blockade or other ineffective delay tactic
- Refer to surgeon

Prevalance of Antiplatelet and Anticoagulation Use

International, prospective cohort of >68k pts with vascular disease
- 70% take ASA monotherapy
- 18% dual antiplatelet
- 6% oral anticoagulation
- ¼ individuals > 40 develop atrial fibrillation

Bhatt et al JAMA 2006
Lloyd-Jones et al Circ 2004
Indications for Antiplatelet Therapy

- Atrial fibrillation
- Acute coronary syndrome
- Coronary revascularization
  - CABG
  - Percutaneous coronary intervention (PCI)
- Acute CVA/TIA
- Congestive heart failure
- Acute peripheral occlusion
- Secondary prevention
  - CVA/TIA
  - CAD/ACS
  - Peripheral arterial dz
- Mechanical valve

Stopping or Continuing Antiplatelet Agents-Balancing Risks

Bleeding versus thromboembolic event….can usually treat/stop bleeding while CVA/MI irreversible and devastating
# Bleeding Risk of Endoscopic Procedures

**Table**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Risk of bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk of bleeding (≤ 1%)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic esophagoscopy</td>
<td>0.3% (0/222)</td>
</tr>
<tr>
<td>Double-balloon esophagoscopy</td>
<td>6.7% (15/225)</td>
</tr>
<tr>
<td>Esophagoscopy</td>
<td>6.4% (13/204)</td>
</tr>
<tr>
<td>Bronchoscopic therapy</td>
<td>6.0% (2/33)</td>
</tr>
<tr>
<td>Acid aspiration without injection</td>
<td></td>
</tr>
<tr>
<td>Esophageal or jejunal biopsy</td>
<td>0.7% (1/141)</td>
</tr>
<tr>
<td>Nissen fundoplication</td>
<td></td>
</tr>
<tr>
<td>High risk of bleeding (&gt; 1%)</td>
<td></td>
</tr>
<tr>
<td>Esophagoscopy</td>
<td>2.0% (8/400)</td>
</tr>
<tr>
<td>Bronchoscopic therapy</td>
<td>2.0% (8/400)</td>
</tr>
<tr>
<td>Bronchoscopy and extraction</td>
<td>0.5% (2/416)</td>
</tr>
<tr>
<td>ERCP or sphincterotomy</td>
<td>1.0% (1/100)</td>
</tr>
<tr>
<td>Polypectomy</td>
<td>1.0% (1/100)</td>
</tr>
<tr>
<td>Laser resection and vaporization</td>
<td></td>
</tr>
<tr>
<td>Endoscopic retrograde pyelography</td>
<td>0.6% (4/672)</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>0.6% (4/672)</td>
</tr>
</tbody>
</table>

**Kwok et al AJG 2009**

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# Risk of GI Bleeding While on ASA/NSAIDs

Most cited paper 20 yrs old and retrospective series (Shiffman *GIE* 1994)

694 pts- 320 NSAIDs, 374 controls

Minor bleeding: 20/320 NSAIDs, 8/374 controls (p=.009)

Major bleeding : 2/320 v 2/374 (NS)

Conclusion- ASA/NSAIDs don’t increase bleeding risk for egd/bx, colonoscopy/bx, polypectomy, ERCP /sphx

*However, guidelines allow clinician to consider d/c for 5-7 days prior for high risk procedures*
Postpolypectomy bleeding on clopidogrel

No published prospective data
Recent retrospective case-control-142 patients (375 polypectomies) taking clopidogrel (cases) and 1243 patients (3226 polypectomies) not taking clopidogrel (controls)
Intraprocedural bleeding - 2.1% v 2.1%
Postprocedure (≤ 4 wks) higher but strongest risk factor was clopidogrel w/ASA 3.5%

Singh M et al GIE 2010

Postpolypectomy Bleeding Among Patients Continuing Thienopyridine Therapy During Colonoscopy

• Elective colonoscopies with polypectomy- 219 on clopidogrel or prasugrel, 297 controls
• Immediate PPB in 7.3% v. 4.7% (NS)
• 30 day follow up- 2.4% delayed bleeding v 0% (p=.01)
• Thienopyridine group older, more comorbidities and more polyps removed
• No major sequelae in either group and all delayed bleeding in ASA/thienopyridine users

Feagins et al CGH 2013
To clip or not to clip?

CEA- not cost effective for pts not on antiplatelet therapy but may be for polyps > 1 cm and on antiplatelet treatment (CGH 2013)

Meta- analysis: RR 4.66 for PPB in pts on clopidogrel (APT 2013)

Colon Polypectomy with Uninterrupted Anticoagulation

- Prospective RCT-single center
- 70 pts on warfarin (INR 2.3-2.5) randomized
- Cold snare v. conventional polypectomy for polyps ≤1 cm
- 0/35 v 5/35 delayed PPB (p=.027)
- 2/25 v 8/35 immediate PPB (p=.04) ? Endocut
- *Single center, limited # endoscopists-but perhaps consider in pts with high thromboembolic risks?*

Horiuchi et al GIE in press
Should you stop ASA after UGIB?

RCT of acute PUB on low dose ASA
After endoscopic rx; randomized to continued low dose ASA vs placebo+ PPI
Trend towards more bleeding in ASA group but $p > 0.05$;
All cause mortality higher in placebo group

Sung et al Ann Int Med 2010

Antithrombotic Endoscopy Society Guidelines on Endoscopy and Agents
Managing Anticoagulation- what do we really do?

- 2008 Board Review Course participants
- 2 hypothetical scenarios
  - how long to hold warfarin before and after elective polypectomy in patient with nonvalvular AF
  - How long to hold clopidogrel in patient with bare metal stent for same colonoscopy scenario


Managing Anticoagulation- what do we really do?

Scenario #1 - 67.3% didn’t follow ASGE guidelines
Scenario #2 - 52.4% didn’t follow ASGE guidelines

No major difference in responses if they were aware of guideline...or not
Procedure Risk for GI Bleeding

<table>
<thead>
<tr>
<th>High-risk procedures</th>
<th>Low-risk procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polypectomy</td>
<td>Diagnostic (EUS, colonoscopy, flexible sigmoidoscopy)</td>
</tr>
<tr>
<td>Bilary or pancreatic sphincterostomy</td>
<td>ERCP without sphincterostomy</td>
</tr>
<tr>
<td>Pneumatic or bougie dilation</td>
<td>EUS without FNA</td>
</tr>
<tr>
<td>PEG placement</td>
<td>Enteroscopy and diagnostic balloon-assisted enteroscopy</td>
</tr>
<tr>
<td>Therapeutic balloon-assisted enteroscopy</td>
<td>Capsule endoscopy</td>
</tr>
<tr>
<td>EUS with FNA</td>
<td>External stent deployment (without dilation)</td>
</tr>
<tr>
<td>Endoscopic hemoablation</td>
<td></td>
</tr>
<tr>
<td>Tumor ablation by any technique</td>
<td></td>
</tr>
<tr>
<td>Cytoplastomy</td>
<td></td>
</tr>
<tr>
<td>Treatment of varices</td>
<td></td>
</tr>
</tbody>
</table>

Anderson et al, GIE 2009

High-Risk vs. Low Risk Thromboembolic Conditions

<table>
<thead>
<tr>
<th>Higher-risk condition</th>
<th>Low-risk condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial fibrillation associated with valvular heart disease, prosthetic valves, active congestive heart failure, left ventricular ejection fraction ≤25%, history of a thromboembolic event, hypertension, diabetes mellitus, or age &gt; 75, Mechanical valve in the mitral position, Mechanical valve in any position and previous thromboembolic event, Recently (≤ 1) placed coronary stent, Acute coronary syndrome, Noninterventional precarious coronary intervention after myocardial infarction</td>
<td>Uncomplicated or paroxysmal nonvalvular atrial fibrillation, Bioprosthetic valve, Mechanical valve in the aortic position, Deep vein thrombosis</td>
</tr>
</tbody>
</table>

Anderson et al, GIE 2009
CHADS<sub>2</sub> Score - risk stratification for Afib

<table>
<thead>
<tr>
<th>Clinical parameters</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Age ≥75 years</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1</td>
</tr>
<tr>
<td>Secondary prevention in patients with previous ischemic stroke, transient ischemic attack</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHADS&lt;sub&gt;2&lt;/sub&gt; score</th>
<th>Stroke rate (per 100 patient-years without antithrombotic therapy)</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.9</td>
<td>1.2–3.0</td>
</tr>
<tr>
<td>1</td>
<td>2.8</td>
<td>2.0–3.8</td>
</tr>
<tr>
<td>2</td>
<td>4.0</td>
<td>3.1–5.1</td>
</tr>
<tr>
<td>3</td>
<td>5.9</td>
<td>4.6–7.3</td>
</tr>
<tr>
<td>4</td>
<td>8.5</td>
<td>6.3–11.1</td>
</tr>
<tr>
<td>5</td>
<td>12.5</td>
<td>8.2–17.5</td>
</tr>
<tr>
<td>6</td>
<td>18.2</td>
<td>10.5–27.4</td>
</tr>
</tbody>
</table>

Andersen et al Heart 2008

Conditions Associated with a High Risk of Thromboembolic Event

<table>
<thead>
<tr>
<th>Atrial fibrillation</th>
<th>Previous stroke/transient ischemic attack</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CHADS&lt;sub&gt;2&lt;/sub&gt; ≥ 3 (see Table 4)</td>
</tr>
<tr>
<td>Prosthetic valve</td>
<td>Associated valvular heart disease</td>
</tr>
<tr>
<td></td>
<td>Discontinuing anticoagulant in bioprosthetic valve &lt;3 months</td>
</tr>
<tr>
<td>Coronary disease and stents</td>
<td>Mechanical valve in mitral position</td>
</tr>
<tr>
<td></td>
<td>Mechanical valve with previous thromboembolic event</td>
</tr>
<tr>
<td></td>
<td>Recent acute coronary event &lt;4–6 weeks</td>
</tr>
</tbody>
</table>

Discontinuing dual antiplatelet therapy in Drug-eluting stent <1 year
Bare metal stent <1 month

DVITPE | Discontinuing anticoagulation in event <3 months
Recurrent DVITPE
Severe hypercoagulable state; active cancer; paroxysmal nocturnal hemoglobinuria; myeloproliferative syndrome
Cardiovascular Risks of Stopping Antiplatelet Agents

- Primary CV prophylaxis 0.7%/yr
- Secondary CV prophylaxis 1.5%/yr
- Bare metal coronary stents –first 30 days: 30% if stop ASA/clopidogrel, 4% clopidogrel only
- Drug eluting stents- first 30 days same as BMS, 1-6 months 3.3% both, 0.8% clopidogrel only, 6-12 months 0.7% both stopped
- Risk off AP agents never drops down to zero

Management of antithrombotic agents for elective endoscopy
Management of Anticoagulants

Low risk procedures- *No change in anticoagulation; may delay elective procedures if INR supratherapeutic*

High risk procedures- *stratify risk of thromboembolic event and adjust strategy accordingly*

Anderson et al, GIE 2009

Antithrombotic agents duration of action and reversal routes

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Specific agent(s)</th>
<th>Duration of action</th>
<th>Efficacious</th>
<th>Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiplatelet agents</td>
<td>Aspirin</td>
<td>10 days</td>
<td>NA</td>
<td>Transfuse platelets</td>
</tr>
<tr>
<td></td>
<td>NSAIDs</td>
<td>Years</td>
<td>NA</td>
<td>Transfuse platelets</td>
</tr>
<tr>
<td></td>
<td>Dipotassium</td>
<td>2.3 days</td>
<td>Hold</td>
<td>Transfuse platelets</td>
</tr>
<tr>
<td></td>
<td>Ticagrelor</td>
<td>≤7 days</td>
<td>Hold</td>
<td>Transfuse platelets - a desmopressin if overdose</td>
</tr>
<tr>
<td></td>
<td>GP IIb/IIIa Inhibitors (tirofiban, eptifibatide)</td>
<td>Years</td>
<td>NA</td>
<td>Transfuse platelets; in case of overdose, some agents can be removed with dialysis</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Warfarin</td>
<td>3-5 days</td>
<td>Hold</td>
<td>FFP + vitamin K, consider pentamine sulfate*</td>
</tr>
<tr>
<td></td>
<td>Unfractionated heparin</td>
<td>4-6 h</td>
<td>Hold</td>
<td>Hold or consider pentamine sulfate*</td>
</tr>
<tr>
<td></td>
<td>LMWH</td>
<td>12-24 h</td>
<td>Hold</td>
<td>Hold or consider pentamine sulfate*</td>
</tr>
</tbody>
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NA, Not applicable; NSAID, nonsteroidal anti-inflammatory drug; GP, glycoprotein; FFP, fresh frozen plasma; LMWH, low molecular weight heparin.
When to Restart Antiplatelet and Anticoagulant Agents

- Just as important as decision to stop agents
- I have reviewed more cases where issue was complication due to delay restarting agents
- Not evidence based - guideline based
- Warfarin within 24 hours
- Thienopyridine within 3-5 days
- Tailor towards bleeding/TE risk balance
- When in doubt discuss with prescribing MD

ACG/JACC White Paper
Practical approach to managing CV risk and bleeding complications

| Avoid cessation of all antiplatelet therapies after PCI with stent placement when possible |
| Avoid cessation of clopidgrel with first 30 days after PCI and either DES or BMS |
| Defer elective procedures up to 12 months |
| Perform endoscopic procedures 5-7 days after cessation of thienopyridine (continue ASA if possible) |
| Resume once hemostasis achieved; consider loading dose |
| Continue platelet directed therapy in procedures with low risk for bleeding |

Becker RC et al., AJG 2009
Warfarin/Novel Oral Anticoagulants
Site of Action

Novel Oral Anticoagulants

- Specifically target factor Xa or factor IIa (thrombin)
- 3 NOACs approved for stroke prevention in AF: rivaroxaban and apixaban, which target Xa and dabigatran which targets thrombin
Novel Oral Anticoagulants

• At least as effective as warfarin for stroke prevention in AF
• Doesn’t require monitoring like warfarin

• Shorter half lives than warfarin (9-17 vs >36 hrs)
  • BUT…rivaroxaban and dabigatran associated with more GIB than warfarin

Novel Oral Anticoagulants

• Predictable pharmacokinetics- provided nl renal and liver function
• Half life doubles for pts with Creatinine clearance < 30 ( from 13-27 hrs)
• Contraindicated in pts with CrCl < 15
Case Presentations

Case #1- 67 yr old female on clopidigrel/ASA for drug eluting stent (placed 11 months ago) presents for elective screening colonoscopy

Consider deferring for at least 1 month and discuss ongoing need for antiplatelet therapy with her cardiologist

Case Presentations

Case #2- 78 yr old male with aortic valve, CHF, Afib now with dysphagia and esophogram c/w achalasia

If pt interested in pneumatic dilation consider bridging therapy
Summary

1. Risks for bleeding as well as thrombotic events can be classified as high and low risk
2. The decision to stop, reverse or continue antiplatelet/anticoagulation agents should be based on the balance of these risks
3. Much is based on guidelines and expert opinion without level 1 evidence

Summary

4. ASA/NSAIDs don’t need to be stopped prior to procedures but decision can be individualized
5. Patients on dual antiplatelet therapy should likely continue ASA
6. Data for managing antiplatelet/anticoagulation for screening colons is evolving
7. All decisions should be discussed with patient as well as physician prescribing the antiplatelet/anticoagulant therapy
Relax..
How to Professionally and Personally Survive a Malpractice Suit
John Baillie, MB, ChB, FRCP, FACG
ACG Annual Meeting 2013

Dr Baillie has no conflicts on interest to declare relating to this talk
Surviving a Malpractice Suit

• When confronted by a law suit, the physician should immediately begin to build a personal support system, including the best counsel available.

• The sued physician should not expect support from co-defendants: your “friends,” other physicians, surgeons, radiologists, etc. will be looking out for their own interests and not yours! Their counsel will be trying to get them dropped from the case. You may well be on your own.
Surviving a Malpractice Suit

- Malpractice claims are common.
- On average, a U.S. gastroenterologist can expect to be threatened with a law suit every 5 years.
- The average delay before a suit is filed is 16 months; the litigation process takes an average of another 27 months to be resolved (i.e. 3.5-4 years from the time of the alleged error).

Surviving a Malpractice Suit

- **US Malpractice Statistics:**
  - Plaintiffs are successful in 21% of cases (almost 80% of cases coming to court are successfully defended).
  - 93% of cases are settled before coming to court.
  - The average settlement of an in-patient case is $363,000; for outpatient setting, it is $290,000.
  - Jury settlements are typically twice those of out-of-court ones.
Surviving a Malpractice Suit

• Threats, by patients or their families, of malpractice litigation should always be taken seriously.
• Identifying the source of their unhappiness and addressing it can head off a lawsuit (e.g. risk management can reduce or waive hospital fees; in most states, apologizing for an undesired outcome is OK).

Surviving a Malpractice Suit

• What precipitates a law suit?
• Unexpected results and complication without warning (surprises)
• Injuries perceived as “catastrophic,” esp. if patient primary provider in the home
• Relationship with physician is rocky, fleeting, or unsatisfying
• Other providers critical of care
Surviving a Malpractice Suit

• What precipitates a law suit?
  • Lack of empathy by physician and/or associated staff
  • Patient/family unable to get an adequate explanation of a bad outcome

Surviving a Malpractice Suit

• Common Responses to a Law Suit
  • Obsessive documentation
  • Ordering excessive tests/consultations
  • Stops doing procedures that may result in complications, even when indicated and competently performed
  • Avoids talking to colleagues
Surviving a Malpractice Suit

• Negative outcomes of a Law Suit
• Payments by insurers are reported to the National Practitioner Data Bank.
• In some states, payments must also be reported to the State Medical Board.
• A physician’s malpractice record may result in denial of credentials or licensure.
• Insurers may settle claims without the consent of the insured physician.

Surviving a Malpractice Suit

• Negative outcomes of a Law Suit
• A physician being sued may be shunned by colleagues and administrators.
• He or she will be instructed by counsel not to discuss the case with others, including colleagues.
• Embarrassment and feelings of guilt can lead to depression and a variety of maladaptive behaviors.
• Physicians being sued feel isolated and unfairly singled-out.
Surviving a Malpractice Suit

• Negative outcomes of a law suit
• Support systems are typically scarce or non-existent.
• Colleagues may lack sympathy, especially those who have not previously experienced allegations of malpractice.
• The hospital administration may take an adversarial stance rather than be supportive.

Surviving a Malpractice Suit

• Negative outcomes of a law suit
• Family and friends may lack understanding of the impact of a law suit and fail to provide needed support.
• Litigation stress can mimic PTSD and persist for years, even after successful resolution of the case.
• As litigation tends to proceed by fits and starts over months and sometime years, each period of activity may feel like repeated traumatization.
Surviving a Malpractice Suit

• Mitigating malpractice misery:
• Any claim or threat of a claim should be reported to the malpractice carrier (this is usually a condition of insurability).
• The defendant(s) should cooperate fully with Risk Management and defense counsel, and respond promptly to requests for information and opinions.

Surviving a Malpractice Suit

• Mitigating malpractice misery:
• Defendants should prepare for the fact that the litigation process will be a regular intrusion on both work and personal life.
• Where possible, heavy work schedules should be avoided, as data show that those dealing with one malpractice case are at increased risk for becoming the target of a second one.
Surviving a Malpractice Suit

• **Mitigating malpractice misery:**
  • Although it is the defense counsel’s job to “prep” his or her client for deposition and court testimony, hiring professional co-counsel to work with the insurer-designated attorney may be worthwhile, esp. if the attorney does not seem skilled or particularly interested in the case, or if the damages sought exceed insurance policy limits.

Surviving a Malpractice Suit

• **Mitigating malpractice misery:**
  • After a trial, the physician defendant should prepare for each possible outcome. Settlement of a case is not an admission of negligence, nor is the amount of the settlement proportional to the degree of culpability (if any) in the case.
  • You can never be sure what a jury will decide.
Surviving a Malpractice Suit

• Mitigating malpractice misery:
  • Knowing that physicians and their defense counsels want to avoid a payment that gets notified to the NPDB, malpractice cases are often settled before trial against a hospital or other employer or commercial entity. Often, this results in brinksmanship, with cases being settled after jury selection or even after the trial commences.

• Mitigating malpractice misery:
  • Sharing feelings with family and non-medical friends can often overcome misunderstanding (you are not a “bad doctor” because of the suit) and gain support and empathy.
  • Strong negative feelings that intrude on daily life should be discussed with a professional counselor. Privileged discussions can take place with counsel, spouses, clergy, mental health professionals, etc.
Surviving a Malpractice Suit

• Mitigating malpractice misery:
• After the case is concluded, a summary of the claim should be created, including the terms of judgment, settlement, or dismissal. This will be necessary when submitting requests in the future for credentialing and licensure. State medical boards typically request details of malpractice litigation within the previous 3-5 years when you apply for annual licensure.

Surviving a Malpractice Suit

• Mitigating malpractice misery:
• Hard as it is, after the event, try to view the malpractice suit as a learning experience. If asked, third parties, esp. your defense counsel, can point out behaviors or attitudes that led to the complaint, or which made it difficult to defend the malpractice allegation. This may require professional coaching (e.g. anger management), which is sometimes mandated by the court or by the State Medical Board.
Surviving a Malpractice Suit

• Mitigating malpractice misery:
• PREVENTION
  • Effective communication – listen to patients!
  • Get to know patients and their families / loved ones!
  • Establish realistic expectations and shared responsibility for outcomes (informed consent).
  • Provided specific - and preferably written - discharge instructions, including your phone number or one that will be answered by a covering physician.

Surviving a Malpractice Suit

• Mitigating malpractice misery:
• PREVENTION
  ➢ Create complete, legible and timely documentation
  ➢ Maintain CME and Board Certification requirements
  ➢ Participate in QI/QA programs
  ➢ Keep up with practice-specific journals