An Ode to the PALTC Clinician
James E. Lett, II, MD, CMD

We recently celebrated two days that are near and dear to my heart, but not to as many others as I would hope: the National Day of Recognition for Long-Term Care Physicians and Doctors’ Day. The initial intent of this piece was to seek your continuing support for the Foundation for PALTC Medicine. However, in the spirit of these two “holidays,” I feel the need not to ask you for anything, but to give to you today.

On behalf of the Foundation, I want to share with you our deepest appreciation for all that you give to the most vulnerable of our population every single day in communities, offices, and homes across this nation. You do it with far too little appreciation (much less acclaim), and you are vastly undercompensated. Yet you still minister, and do so exceptionally well. We continue on because in post-acute and long-term care (PALTC) we are powered by internal, not external, gain.

A vivid memory stays with me that only you, my colleagues in PALTC, can appreciate. When I was full-time medical director at a large geriatric facility and campus, I noted we had a Nurses Week to show well-earned appreciation for the amazing work of the nursing staff. I suggested we also celebrate Doctors’ Day. I was immediately shut down: “If we celebrate the doctors, we will have to celebrate therapists, social workers, certified nursing assistants, and everyone who performs medical services here.” And what would be the harm in that? I asked, but never received an answer.

For those of you whose Doctors’ Day, or your discipline’s special celebratory day, was ignored or forgotten, I thank you and celebrate you all, whatever the date on the calendar.

Like many of you in this field, I fell into it by accident and fell in love with it. I never reached anywhere close to the perfection in care I desired, but I never stopped trying to attain it. I find you all doing the same. For that, the Foundation and I salute you all: physicians, nurse practitioners, physician assistants, and all who put your healing touch on patients within — and without — PALTC.

I often search for the reason I love the PALTC continuum, as I suppose many of you also do. I am beginning to think it is because I never understood medicine, life, and death until I entered PALTC. I was then shaped by it and by the people, both caregivers and patients, within it. I initially thought I truly became a doctor when I made my first diagnosis. (I still remember the amazement of putting together the signs, symptoms, and physical findings from our lectures and medical books with a living being and actually making a diagnosis!) Then it was the first baby I delivered by myself that I felt defined my “arrival.” Then again, perhaps it was the first time I made a surgical incision into a living being.

As it turns out, none of these amazing events was my transformation into being a “real doctor.” It was only in long-term care that I had the epiphany that made my dream of being a physician a reality. It was the blinding, overwhelming understanding that despite all I had been taught in medical school and training, death is not the enemy of our craft. Suffering is the enemy, and it is to be fought at every point in care. You all understand that as well — this is the single truth that binds us. It allows us to ignore the artificial measures of mortality rates and inadequate quality indicators to care for the person within the patient. For this, the Foundation and I celebrate each day you practice as Doctors/ Nurse Practitioners/Physician Assistants/ Caregivers Day on your behalf.

I have attended PALTC patients who were lawyers, physicians, ballet dancers, substance abusers, convicted murderers, prison gang leaders, politicians, Holocaust survivors, and veterans of every American conflict since the Spanish-American War — including a Medal of Honor awardee from World War II. There also were two patients I so personally self-identified with that care decisions were made difficult, and, as a result, I nearly discharged myself from being their physician. They have all taught me to be mortal, humble, and, I believe, a better physician. You all, too, have made this journey down the PALTC Yellow Brick Road to becoming the clinician you want to become. It unites us all in a very special brotherhood and sisterhood.

To those of you who were humbled by and understood the depth of emotion in the words of Dr. Chuck Crecelius when he accepted the Foundation Medical Director of the Year Award at the annual meeting in Atlanta, and of Dr. David Smith when he received the Foundation’s William Dodd Founder’s Award for Distinguished Service at the same meeting, I salute you, whatever your role in PALTC.

My vision for the Foundation is to sustain you, the PALTC clinician; to increase the number of clinicians just like you in the workforce; to bring to our often vulnerable patients the gift of what you provide; and to make every day one of appreciation for the value you provide. The Foundation will certainly ask for support from each of you to meet these goals for our PALTC vision. But for today, we salute, appreciate, and thank all you caregivers and clinicians.

Dr. Lett has practiced in the PALTC continuum for more than three decades as a hands-on clinician and medical director. He has served AMDA in multiple capacities including president and committee member and is the current chair of the Foundation for PALTC Medicine.

8 Tips to Avoid Being Sued in the Nursing Home: Attorneys Offer Expert Insight on Improving Care and Avoiding Lawsuits
Randy Dotinga

LOS ANGELES — Don’t feel like you have to provide perfect care, but do make sure you’re responsible and responsive. And always — always! — be honest, even when you think you’re in trouble.

Attorneys who handle nursing home litigation offered these and other lessons to a receptive crowd at the annual meeting of the California Association of Long Term Care Medicine, which serves physicians, medical directors, nurses, pharmacists, administrators, and other professionals.

At issue: How can you protect yourself and your facility from getting sued for allegations of poor care? Here are some tips courtesy of three experienced attorneys.

1. Understand expectations about perfection.
“The standard of care does not require perfection,” said William C. Wilson, JD, a defense attorney based in San Diego and a regular columnist in Caring. In other words, the legal system understands that bad outcomes happen. According to Mr. Wilson, that means a facility may not be liable for a patient who falls multiple times so long as staff acted reasonably.

2. Always be responsive.
“When families want to talk and know what’s going on, it’s really hard for us when the physicians are not returning calls,” Mr. Wilson said. If family members call and never get a call back, he said, “it puts us [nursing facilities] in a tough spot.”

3. Keep appropriate staffing levels in mind.
Kimberly A. Valentine, JD, an attorney from Mission Viejo, CA, who represents patients and their families, said most of the cases she pursues involve inappropriate staffing. At issue, she said, is this: “What kind of environment are these people working in, and what kind of environment is the parent corporation creating?”

Nursing facilities can run into trouble if their staffing levels don’t meet legal requirements. This is an especially touchy issue in California, which mandated in July 2018 that skilled nursing facilities (SNFs) provide 3.5 hours of nursing care per patient per day, including 2.4 hours of care from certified nursing assistants (CNAs). According to Kaiser Health News, more than 50% of SNFs in the state requested waivers from the new rules.

However, Ms. Valentine cautioned that jurors in medical misconduct cases don’t focus on specific requirements. “They don’t care about the 3.5 hours,” she said. “They want to know if the care is bad.”

4. Consider the use of nurse practitioners and physician assistants.
More care facilities are embracing a “high-presence” model that keeps nurse

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practitioners (NPs) and physician assistants (PAs) on duty for extended periods of time, Mr. Wilson said. The presence of these medical professionals “really serves to undermine a patient’s claim that there’s a conscious disregard going on,” he said. “If you have really good, involved [practitioners] in your facilities, that’s a game changer.”

Ms. Valentine offered an important caveat: Make sure you and your staff members are familiar with regulations regarding what NPs and PAs can and can’t do, and make sure you have solid, legal clinical protocols or collaboration agreements. “I’m only likely to sue if they’re violating the regulations,” she said. “In the cases that I see, the NPs or PAs are working a lot on their own. They’re not physicians for a reason.”

5. Make sure orders don’t conflict.
“A lot of times you’ll see exposure [to lawsuits] when orders from the acute care hospital and the orders they received from the primary care physician are not in sync,” Mr. Wilson said. “It’s exposing the SNF. When you’ve got old and new orders, shouldn’t the registered nurse reconcile them?” Obviously, physician involvement when verifying orders on a new admission needs to be careful and robust.

Encourage your staff members to extensively document patient care, and don’t let anyone assume that minimal notes are enough.

Imagine, for example, that a patient refuses to be repositioned despite a wound on her heel. “It’s not enough that somebody is documenting that,” said defense attorney Laura K. Sitar, JD, of Irvine, CA. “I need to know what the CNA did to try to get past her refusals.”

Nurses, of course, may not remember a specific moment in a patient’s care. In those cases, Ms. Sitar said, “the nurse can tell me what her customary practice is.” But it is better for preventing or defending in a lawsuit to have documentation of every episode of refusals of care.

Ideally, Ms. Sitar said, staff members would have taken proactive measures to “get beyond the refusal.”

7. Don’t brush off disgruntled employees.
Ms. Sitar knows to watch for one thing in every nursing home negligence case:

“[I’m] only likely to sue if [the facility is] violating the regulations. In the cases that I see, the nurse practitioners or physician assistants are working a lot on their own. They’re not physicians for a reason.”

— Kimberly Valentine, JD

“Most of the time, I need to know what the nurse said. ‘The nurse can’t do anything about it,’ they’ll say. ‘The nurse can’t do anything about it,’” Ms. Valentine said. “But they can do something. They can give the patient a bowel bag. They can give the patient a chlorhexidine soap that’s going to help heal the wound. They have the power to do something.”

8. Never, ever, falsify documentation.
Two words should strike fear into the heart of anyone who thinks about falsifying documentation after the fact: audit trail.

Retroactive adjustment of patient documentation is “the worst thing you could do,” Ms. Sitar said. “I can’t fix it if you falsify the records.”

Documentation software typically allows users to determine what was changed in a patient’s medical record and when. But this doesn’t stop employees who are trying to erase the past. “Even in 2019, people are still changing the data,” Ms. Valentine said. “Plaintiffs’ counsel are starting to ask for [detailed audit information], and it’s hard to not give it up,” she said. “People don’t realize the level of detail that’s in there.”

Ms. Sitar added that one more thing will make documentation look suspicious: perfection. This is another indication that the legal system expects quality care, not perfect care.

Randy Dotinga is a San Diego-based freelance writer.

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