

HIGH-RISK ISSUES ASSOCIATED WITH LAWSUITS— AND WHAT TO DO ABOUT THEM

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What are some of the riskiest areas associated with practicing medicine day-to-day? They may be more common place than you think, and some may be easier to guard against than you imagine.

To discover trends in professional liability, NORCAL Group relies on its extensive database of closed claims information. NORCAL Group also produces reports compiled from facts garnered during on-site risk assessments. Analyzing statistics from these two sources can give a credible picture of the types of situations and actions that most often lead to litigation for physicians, medical groups, and hospitals.

The Claims Perspective

NORCAL Group's closed-claims database can distinguish various nonclinical issues (that is, problems in processes or communication) that are associated with lawsuits. These associated issues have often complicated the defense of allegations made against doctors and healthcare facilities. Closed-claims data for all NORCAL Group companies' policyholders for the past two years (July 2009 through June 2011) show the top ten associated issues causing difficulties in claims were:

1. Problem with history, examination, or work-up.
2. Error associated with interpretation or communication of radiology results.
3. Communication problem between healthcare providers.
4. Comorbid issues (comorbidities complicated treatment of patients).
5. Informed consent issues.
6. Problem with medical records.
7. Failure to follow up on tests.
8. Vicarious liability.
9. Problem with a medical or surgical device.
10. Inadequate facility or equipment.

The Perspective from the Field

NORCAL Group companies sent Risk Management Specialists to perform on-site visits to identify risk issues in physicians' offices and hospitals. The Specialists produced reports that recommended strategies for reducing the specific risks found. In September 2011, NORCAL Group studied aggregate data from a subset of 175 risk assessments conducted in the last two years (between July 2009 and June 2011). The top 10 risk issues revealed in this study were linked to:

1. Handling of after-hours telephone calls (including documentation and communication with covering physicians).
2. Distribution of sample medications.
3. Reporting test and consult results to patients.
4. Use of therapeutic agreements with chronic pain patients.
5. Follow-up processes after hospital discharge.
6. Follow-up processes for return office visits.
7. Documentation of allergies.
8. Making corrections in medical records.
9. Legibility of documentation.
10. Authentication of medical record entries.

Looking for the Overlap

While the issues from the field are more specific than those on the closed-claims list, there is a revealing overlap. By looking at the lists closely, we can identify four main areas in which physicians are likely to significantly lower their risk levels if they implement effective risk management strategies. Those areas are:

1. Management of follow-up processes.
2. Generation of documentation.
3. Management of medications.
4. Communication with other healthcare providers.

The remainder of this article will offer tips to help you and your staff members evaluate and decrease your liability exposure related to these four key areas.

Management of Follow-up Processes

Follow-up systems are important because physicians have a responsibility to ensure that patients are informed about their conditions and get needed care. Here are some strategies for evaluating and honing your follow-up system.

- When patients are sent for testing, three areas of concern are: Did the patient comply with the recommendation for testing? Were test results received and reviewed by the ordering physician? Was the patient notified about the results? An appropriate follow-up system provides answers to these questions.
- Double-check your method for monitoring compliance with appointments. There should be some mechanism in place that requires licensed personnel in the practice to review all no-show appointments to determine which patients must be called and rescheduled.
- Don't make the patient solely responsible for making appointments for tests or for calling the office to obtain results; assist them.

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- Your follow-up system for diagnostic tests should include not only a method for confirming that you received the test results but also a process for ensuring that you reviewed the results. The review should be timely. A test result should never be filed until you (as the ordering physician) have personally reviewed, dated, and initialed it.
- Institute the policy of notifying *all* patients of all test results (rather than just reporting abnormals).

Generation of Documentation

The purpose of the medical record is to communicate internally and externally about a patient's health. In addition, in a medical malpractice lawsuit, the patient's record will be used as evidence.

- Each patient's chart should be an accurate account of the patient's history and complaints, physical findings, diagnostic tests, diagnoses, and medical care and treatment. Whether a record is paper-based or electronic, the documentation in it should show the patient's active problems, data analyzed to understand the problems, and plans for further investigating and handling of the problems.
- If you are handwriting medical record documentation, you should assess your entries to ensure that they are easy to read. If your notes are not clearly legible, you should consider methods to improve the notes, such as printing, dictation, or typing your notes into a computer-based medical record.
- If you choose to use dictation, you should read all the typed notes to make certain the transcriptionist has accurately recorded the information before you sign and date the notes.
- Allergy documentation is harder to miss if it is consolidated in a single area of the record. If the patient reports no allergies, the phrase "no known allergies" or the initials "NKA" should be written or typed in the area designated for documentation of allergies.
- After conducting an informed-consent discussion with a patient, ensure that there is confirmation of the consent process in the medical record, including a consent form signed by the patient and a description of the content of the informed-consent discussion in the progress or pre-procedure notes.
- Telephone contacts should be documented in the medical record, including calls taken after hours. Information from after-hours calls should be incorporated into the medical record as soon as possible.

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- If there is a mistake in the record, you should correct it by drawing a thin line through the inaccurate words. The original entry should still be readable. Then write the correction clearly and legibly nearby, and initial, date, and time it. Never erase, white-out, or otherwise obliterate any entry in the medical record. Electronic health records should not allow you to delete any previously entered material. Instead, they should have methods for correcting prior entries that preserve the original notes.
- Once you are notified about a potential liability claim, you should not change, add to, or in any way revise a medical record.

Management of Medications

The main medication management issues that have been discovered in office assessments have to do with distribution of sample drugs and establishment of pain management contracts. Some tips in these two areas follow:

- You may lower your liability risk if the sample medications in your office are well controlled. Sample medications should be locked in a cabinet or closet. Limit access to samples by designating specific staff to organize and maintain the sample closet. Do not allow pharmaceutical representatives or other unauthorized people access to the sample closet. Document all dispensed samples in the appropriate patient's medical record.
- When you give out samples, labeling them with specific information, including name and quantity of medication, name of manufacturer, physician name and address, patient name, date, and instructions for use, will reduce the risk that a patient will make a self-administration error. You can create label templates and fill in the appropriate information before applying a label to a sample box.
- When you are treating chronic pain patients with opioids, consider setting up written pain medication agreements with these patients. Such agreements can help you and the patient define and agree on appropriate behavior and hinder addicts from obtaining an unlimited supply of medication.

Communication with Other Healthcare Providers

Gaps in communication between treating physicians can cause problems that jeopardize a patient's well-being and provide the impetus for litigation. Here are some suggestions for remaining aware of a patient's situation when you are sharing that patient's care with a colleague.

- If you refer patients to other physicians, have some mechanism in place to see that your referral recommendations are carried out and that the patient was seen by the consultant (or another

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physician of the patient's choice). Your follow-up mechanism for referrals should also track your receipt and review of the consulting physician's report.

- Communicate in writing with the consultant about the specific consultation request you are making. Preparing a fact sheet with the patient's clinical information and your impression is an effective way to convey the significant details to another physician.
- After a patient is seen by a consultant, there must be a clear understanding about who will be responsible for what aspects of the patient's care and who will order further testing and consultations if these are necessary.
- If you are a consultant, communicate urgent or significant findings directly to the referring physician and be sure that you both know who will provide clinical follow-up. The communication should be done by phone and in writing.

Conclusion

Most of the risk management recommendations in this article are not expensive or hard to put in place. Most focus on setting up systems or protocols and then adhering to them. Taking some time to appraise and strengthen vulnerabilities in your practice or facility will help protect patients and may keep you from a malpractice suit or help you defend against one.

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