Six Factors Leading to Med/Mal Claims

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Topics for today

- Patient Communication
- Team Communication
- Informed Consent
- EHR Documentation
- Follow-Up Systems
- Apology and Disclosure
MY, THAT IS A TYPO... SO YOU WERE EXPECTING THE COLLAGEN INJECTION IN YOUR LIPS, AND THE LIPOSUCTION ON YOUR HIPS ?..
The most common medical “procedure”?

- The face-to-face patient interaction
- 150,000-200,000 visits in an average career
Yet …

- Very limited training
- Limited supervision in early stages of career
- No specific oversight as there is with other procedures
Patient communication

- Single largest contributing factor to medical malpractice claims
- Simple correlation: patients tend not to sue doctors they can communicate with
- Involves the entire team – physicians, administration, clinical and non-clinical staff (80:20 rule)
Patient communication

In virtually all specialties, communication errors or barriers are the main factors resulting in medical malpractice claims, second only to errors of clinical judgment or technical error (actual malpractice)
In nearly 70% of all sentinel events, communication and teamwork issues are named as a root cause.
Why do patients sue?

- Caregiver attitude: 35%
- Lack of (or poor) communication: 35%
- Financial incentives: 10%
- Media play: 7.5%
- Jousting: 7.5%
- Unrealistic expectations: 5%
Where good communication leads

- Solid physician-patient and provider-patient communication skills lead to:
  - More engaged patients
  - Patients more involved in their plan of care
  - Willingness to ask questions related to treatment
  - Adherence to their care plan
  - Satisfaction with care provided
  - Lower costs
  - Increased trust and loyalty
all of which lead to better clinical outcomes and, as a result, fewer medical malpractice claims.
Patients are changing

- More prepared through research
- More medically savvy
- More challenging of medical opinions
- More “consumer” than patient
Build rapport/set the tone

- Be prepared
- Greet the patient
- Make eye contact
- Shake hands
- Introduce yourself (to everyone in the room)
- Use the patient’s (parent’s) name
- Learn everyone’s role
- Smile and be pleasant
- Make small talk
Build rapport/set the tone

- Attend to the patient’s comfort
- Acknowledge the wait, if any
- Convey knowledge of patient history
- Sit down (it makes a difference!)
- Maintain eye contact
- Explain need to enter information in EHR
“How long, on average, does a physician allow a patient to talk before interrupting?”

Beckman HB, Frankel RM-Ann Intern Med. 1984 Nov;101
Allow your patients to talk!

Beckman HB, Frankel RM - Ann Intern Med. 1984 Nov;101
“Never talk down to patients. I’ll be back to explain why when the big hand’s on the 12 and the little hand’s on the 2.”
Teamwork and communication between physicians and staff

- Nurses and other staff are best risk management tools in the medical office (also biggest exposure)
- Open dialogue/relationship between physicians and staff is often overlooked
Teamwork and communication between physicians and staff

- Physician’s perception of his/her approachability is often different than that of nursing and other staff
- Differing communication styles can result in roadblocks
  - Use “No pride” and “3 Ds” to break down barriers
“If you see me about to do something **dumb** … different … or dangerous … tell me!”
Quality of teamwork across 25 organizations: differences between physicians and nurses
When BOTH physicians and nurses rated quality of teamwork at a 4 or higher ...

Positive outcomes resulted:
- ICU discharge return rates were 5% (vs. 16% when either rating was below 4)
- Critical mortality rates were lower – chance of survival doubled
Fear can be deadly in medicine, too

Nearly 40 percent of nurses on a Safety Attitude Questionnaire said they would hesitate to speak up if they saw a physician making a mistake.
Signed vs. informed

60%

who read and sign your forms still don’t understand

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The cycle of informed consent

- Capacity
- Communication
- Comprehension
- Consent
Focusing on the form misses the point
The cycle of informed consent

- Capacity
- Consent
- Communication
- Comprehension
Diminishing capacity

• Presume capacity, but can’t ignore signs
• Do we just need help communicating?
• Is there an advance directive in place?
  – How can I help get one?
Language barriers

• Can we …
  – get a professional interpreter?
  – get forms in native language?
  – use certified, medically trained staff members?

Family members are not okay
The cycle of informed consent

- Capacity
- Consent
- Comprehension
- Communication
Communication cannot be delegated

... but a team approach is ok.
The conversation basics

- Diagnosis
- Purpose of procedure
- Nature of procedure
- Material risks
- Anticipated benefits
- Possible alternatives
- Risks of doing nothing
The conversation basics

- High severity
- High frequency
- Substantial risk
- Significant risk
- Reasonable patient
- Reasonable provider
- Material information

Material risks
- Diagnosis
- Purpose of procedure
- Nature of procedure
- Anticipated benefits
- Possible alternatives
- Risks of doing nothing
The conversation basics

- What is your patient worried about?
- What does he/she not understand?
- How does he/she see life after this procedure?
- What’s meaningful to his/her life?

- Diagnosis
- Purpose of procedure
- Nature of procedure
- Material risks
- Anticipated benefits
- Possible alternatives
- Risks of doing nothing
The cycle of informed consent

- Capacity
- Communication
- Consent
- Comprehension
back to work
better
minor
minimal
good as new
textbook
Teach back

- Tell me our plan in your own words.
- How would you describe our next steps to your family?
- Tell me how you will manage this at home.

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Teach back

- Takes only 1 extra minute of time
- 3X greater recall and comprehension
- One OR’s surgical cancel rate dropped from 8% to 0.8%

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The cycle of informed consent

Consent

Capacity

Communication

Comprehension
More than a signature

Giving *this* person the ability to make *this* decision on *this* day.
Informed consent …

**is not**
- a document
- a signature
- one moment

**is**
- an ongoing cycle
- a shared decision
- mutual expectations
- many moments
The consent form

- Summary of the conversation
- Readable at a 5th-grade level
- Native language
- Minimal text
- Signatures
- Dates and times
Form is never more than an extension of content.

Robert Creeley
The medical record

• Summary of the conversation
• Who was present
• Materials reviewed or given
• Patient’s decision
Can you dictate this in < 20 seconds?

**Bad Chart**

Consent form signed.

**Better Chart**

I discussed with the patient his prognosis and the indications for surgery. We discussed the risks, benefits, and alternatives including doing nothing. Mr. Jones was concerned about a bowel perforation, which we discussed at length. Questions were invited and answered. Mr. Jones wants to proceed.
Informed refusal
Competent persons can refuse medical treatment, even at the risk of death.

Chief Justice Rehnquist, U.S. Supreme Court
Seek to understand

I am curious...

I’m curious about your reasons for not going forward today.

Help me understand...

I would appreciate it if you could help me understand your thought process.

Seek to understand

Fears
• Unknowns, assumptions
Beliefs
• Cultural and/or religious
• Tolerable compromise?
Myths and Misinformation
• Can we combat with good information?
Financial Concerns

Social Determinants of Health \((life \ constraints)\)
• Can we do early/late/weekend hours?
• Draw labs at another location?
• Accommodate family members?
• Arrange for travel?

Parent refused to consent to immunization.

I discussed with the parent the indications for immunization and the probable consequences of declining. We discussed the parent’s reasons for choosing not to immunize and he was not swayed by my responses. 

In my professional judgment, this parent understands the nature and consequences of this decision and has made an informed refusal.
Documentation and Medical Malpractice

- Documentation remains in the top 6 issues leading to medical malpractice claims
- During implementation and early adoption of EHR there is an increased risk PT injury and Malpractice
- Ineffective documentation is a two-fold malpractice contributor
  - Clinically, poor documentation can lead to a patient injury
  - That same ineffective documentation doesn’t allow for proper defense
Documentation and Malpractice

- Quality documentation
  - Critical to defense
    - Malpractice cases are settled 2 – 5 years after the occurrence. Documentation refreshes your memory
  - Supports the care given and the decision making even when there was a negative outcome
Inadequate Documentation and Malpractice

- Increases the filing of claims
  - Attorney experts look for “red flags”
- Causes patient injury
  - Loss of communication, coordination and continuity
- Is the leading reason medically defensible malpractice cases are settled or lost at trial
“Red Flags”

- Medication/treatment ordered but not documented
- Lack of patient teaching or discharge planning
- Charting inconsistencies
- Lapses in time
- References to incident report
- Lack of informed consent
“Red Flags”

- Fail to monitor or fail to act when patient condition deteriorates
- Battles between health care providers
- Late entries that aren’t labeled as such or appear to be self-serving
- Fraudulent or improper alterations of the record
- Destruction of records or missing records
Elements of Quality Documentation

- Timely
- Legible
- Complete
- Accurate
- Objective
- Consistent
- Timely
Consistent Documentation

- Same way every time
- Same place every time
- Same flow every time
- Same tone every time

CONSISTENCY BREEDS ACCURACY!!!
Objective Documentation

- Document what you see, hear, smell, count, measure, perform … be specific
- Signs and symptoms should be factually described using your senses
- Use “quotes” for verbatim statements from patients/families
  - One of the most underutilized resources available to you
Avoid:

- Subjective statements (your assumptions or personal opinions)
- Generalizations, speculation and vague words
- Derogatory or discriminating remarks about the patient/family (Work-Comp PT, Peds PT example)
- Staffing problems
- Alleged negligence by co-worker or statements regarding prior treatments
Accurate Documentation

- Double check patient name/secondary ID
  - Verify all reports, results and documentation
- Reread your entries
- Use only acceptable abbreviations
- Correct appropriately
Advantages of ERH for Pt Care and Med/Mal

- No legibility issues
- Tickler systems (when properly used)
- Ability to leverage of data for increased quality (CRICO)
- Ability to quickly share large amounts of data
- Potential SIGNIFICANT error reduction capabilities
  - Computer Provider Order Entry (CPOE) has been shown to reduce medication error rates by as much as 55%
Advantages of ERH for Pt Care and Med/Mal

- Clinical Decision Support Systems (CDSS) can provide significant advances in;
  - Disease Management
  - Preventative Screening
  - Failure to Diagnose
  - Med Errors
- Only Works With Proper Use and Data Entry!!!!!!
Major EHR Pt Care + Med/Mal Concerns

- Check-Box Documentation
- Cut-And-Paste/Templated Material
- Lack of Free-Flow Text
- Loss of Pt. Personalization
- Data Overload-”Where’s the Beef?”
- Searching for Screens
- Work Around/Alert Fatigue
- One-Up/One-Down Errors
Check-Box Documentation

- Pre-filled data ripe for mistakes
- Repetition phenomenon allow you to “see” the proper box checked
- “Skimming” both questions and checked data is common
- BEWARE Default “Normal”
Cut and Paste/Templated Material

- VA Study shows 75% of charting contains templated material
- 82% of resident notes and 74% of attending physician notes included at least 20% copied and pasted material
- Inappropriate copied and pasted material and/or templated material calls into question the integrity of entire documentation
  - He/She issues
  - 28 week’s pregnant for 4 months?
  - Detailed description of ovaries and uterus in autopsy?
Cut and Paste/Templated Material

- 82 year old woman with normal testicular exam
- 56 year old below the knee amputee with pedal pulses equal bilaterally
- And on, and on
Lack of Free-Flow Text

- Only real opportunity to “tell your story”
- Shown to be extremely useful to quality patient care especially with critically ill patients (mainly from advantages in transitions of care)
- Room 201 looks just like 202 looks just like………
- In the outpatient setting 1pm looks like 2pm……
Loss of Patient Personalization

- Written or dictated documentation allowed for visualization of your patients
- EHR has removed our ability to connect with patients through documentation
- Free-flow text is the best method to contribute to personalization
- Photos also help
Data Overload/”Where’s the Beef?”

- Our EHR generates notes after you check little boxes on millions of pages of menus. The boxes are tiny & the menus are incredibly detailed, so it takes forever to find what you want, & it’s easy to miss something, or check something wrong. Then, the finished note is incredibly boring & fake, just line after line of mostly normal findings. I can't find the 'meat' in other providers’ notes. My eyes actually blur. I tell myself to read every word, but all the notes are 95% identical. I've missed important things...I think this system produces [pejorative]...You can't tell what actually happened at the visit, because all the notes look the same...”
Searching for Screens

- Spatial location is often lost in EHR
- Inability to quickly flip through the record inhibits use of information
- Routine failure to review/update history and physical and/or allergy list because they are not first in line
Work Arounds and Alert Fatigue

- Best example is “tickler systems” for follow up
- Plaintiff atty’s love to ask why an alert was ignored
- Difficulty and inefficiency promote work arounds
- February 9, 2009 *Archives of Internal Medicine*
  - Drs ignored 90% of drug interaction warnings
  - Over rode 77% of allergy alerts
One Up/One Down Errors

- Drop down boxes cause numerous errors via selection of the med/order/instruction found either one spot above or below the intended selection.
- Especially common with Look Alike/Sound Alike/Spelled Alike Medications:
  - Amlodipine
  - Amiloride
  - Chlorpromazine
  - Chlorpropamide
  - Penicillin
  - Penicillamine
Follow-Up Systems Errors

- One of the major focuses of plaintiff attorneys when pursuing service-lapse type claims
- In a study performed by one of the nation's largest malpractice insurance providers assessing risks leading to patient injury in the medical office setting, the single greatest concern was ineffective tracking for diagnostic tests/consults (follow-up systems)
Follow-Up Systems Errors

- Most frequent failure is loss after return of study results
- Most often seen with lab and radiology reports
- Unrelated to clinical practice-deals with office procedure
- Patient education/orientation on test results delivery methodology is necessary
Follow-Up Systems Errors

- Define then convey your policy on delivery of test results
- No news is “NO NEWS”
- Staff engagement and responsibility is imperative
- Right patient/right test verified multiple times during visit
Follow-Up Systems: Key Steps

# 1 – Timely Receipt of Results

# 2 – Timely Review

# 3 – Timely Notification

# 4 – Tracking No Shows and Cancels
Follow-Up Systems

# 1 – Timely Receipt of Results

CASE EXAMPLE:

- 57-year-old female sent for mammogram and then biopsy of a breast mass
- Mammogram is abnormal
- Result is mistakenly sent to wrong clinic
- Ordering physician never followed up
- Patient believed “no news is good news” and did not get the biopsy
Follow-Up Systems

CASE EXAMPLE:

- Teen boy has mole removed by family doctor
- Family doctor sends for pathology
- Patient returns 9 months later for something unrelated
- Pathology report finding malignant melanoma is neatly filed in the chart
Follow-Up Systems

# 3 – Timely Notification

CASE EXAMPLE:

- Family doctor asks M.A. to report to patient that pap smear was abnormal
- M.A. leaves a message
- Patient never calls back and never returns
- Patient dies from cervical cancer
- No documentation in Patient’s chart of doctor’s instructions or M.A.’s efforts to contact
Follow-Up Systems

# 4 – Tracking No Shows and Cancels

CASE EXAMPLE:
- 52-year-old man seen for rectal bleeding
- Colonoscopy finds adenocarcinoma
- Patient instructed to come back for follow up
- Patient travels internationally for work – cancels, reschedules, no-shows…
- Finally comes in 10 months later
- Claims he wasn’t told the severity of his condition and need for follow-up
Follow-Up Systems
# 4 – Tracking Missed and Canceled Appointments

No show or cancel without reschedule → Documentation to provider and in chart → Provider or designee reviews for decision

Determines no follow-up needed → Contact to patient with instructions

Document efforts and instructions
Follow-Up Systems

- Do you have a system for tracking ordered tests, imaging, and consultations?
- Do you have a system for tracking provider reviews?
- Do you have a back-up plan if the ordering provider is absent?
- Do you have a system for notifying patients of results?
- Do you have a system for tracking cancelations and no-shows?
- Is a provider making the decisions about how hard to push?
- Have you conveyed to the patient the significance?
- Are you documenting your efforts and instructions?
Apology and communication position statement

To err is human.

Mistakes are part of the human condition.

Health care providers, being human, make mistakes.

The way they approach their mistakes is what matters most.
“In the beginning, all I wanted were answers. If someone had just talked to me, none of this ever would have happened.”

Danielle Bellerose
Patients and families hire attorneys because of a lack of information and feelings of betrayal and mistrust.
“Full disclosure is the right thing to do. It is not an option; it is an ethical imperative.”

Lucian Leape
MMIC/UMIA position: Timely and meaningful communication between providers and patients is imperative when an adverse outcome occurs.
Apology and communication

- It’s the right thing to do
- It’s our moral and ethical obligation
- It’s our professional responsibility
- It’s a requirement of TJC
- Patients want and expect it
- Part of the healing process
Why

Apology and communication

- Preserves the patient relationship
- Improves patient satisfaction
- Increases trust in the physician and organization
- Results in a more positive emotional response
- Probably reduces patients seeking legal remedy

K. Mazor, Health Plan Members' Views about Disclosure of Medical Errors
Annals of Internal Medicine, March 16, 2004
Doing the right thing

Organizations are discovering the power of transparency
Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program

Allan Kachalia, MD, JD; Samuel R. Kaufman, MA; Richard Boothman, JD; Susan Anderson, MBA, MSN; Kathleen Welch, MS, MPH; Sanjay Saint, MD, MPH; and Mary A.M. Rogers, PhD

Background: Since 2001, the University of Michigan Health System (UMHS) has fully disclosed and offered compensation to patients for medical errors.

Objective: To compare liability claims and costs before and after implementation of the UMHS disclosure-with-offer program.


Setting: Public academic medical center and health system.

Patients: Inpatients and outpatients involved in claims made to UMHS.

Measurements: Number of new claims for compensation, number of claims compensated, time to claim resolution, and claims-related costs.

Results: After full implementation of a disclosure-with-offer program, the average monthly rate of new claims decreased from 7.03 to 4.52 per 100,000 patient encounters (rate ratio [RR], 0.64; 95% CI, 0.44 to 0.95). The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters (RR, 0.35 [CI, 0.22 to 0.58]). Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability (RR, 0.41 [CI, 0.26 to 0.66]), patient compensation (RR, 0.41 [CI, 0.26 to 0.67]), and non-compensation-related legal costs (RR, 0.39 [CI, 0.22 to 0.67]).

Limitations: The study design cannot establish causality. Malpractice claims generally declined in Michigan during the latter part of the study period. The findings might not apply to other health systems, given that UMHS has a closed staff model covered by a captive insurance company and often assumes legal responsibility.

Conclusion: The UMHS implemented a program of full disclosure of medical errors with offers of compensation without increasing its total claims and liability costs.

Primary Funding Source: Blue Cross Blue Shield of Michigan Foundation.


For author affiliations, see end of text.
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Deny and defend → disclosure and offer

“Implementation was followed by steady reduction in the number of claims and various other metrics, such as elapsed time for processing claims, defense costs, and average settlement amounts.”

Contact us

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