Top Ten Ways to Guarantee a Lawsuit

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Objectives

Participants should be able to:

1. Name at least three ways to “guarantee a lawsuit”
2. Identify best practices to reduce medical errors associated with lawsuits
3. Describe documentation strategies to improve defensibility
4. List the four components of an effective patient complaint process
Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed in this activity should not be used by clinicians without evaluation of patient conditions and possible contraindications on dangers in use, review of any applicable manufacturer’s product information, and comparison with recommendations of other authorities.

Not a guarantee that using information provided will prevent a claim against you or your practice.
ABOUT CURI

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Top Ten Ways To Guarantee A Lawsuit*

1. Don’t care whether patients like you
2. Assume each patient needs just a few minutes
3. Trust the patient to follow through on referrals
4. Diagnose over the phone
5. Don’t say anything if something goes wrong
6. Don’t worry about keeping detailed records
7. Don’t take time to document informed consent discussions
8. “Fix” records quickly when something goes wrong
9. Don’t bother to track test results
10. Don’t check the medical record when ordering medication

*Source: “10 Ways to Guarantee a Lawsuit,” Medical Economics
Case Scenario

• Our patient, John, seen in PCP Dr. Smith office to establish care; recently moved into area for work.

• Medical assistant (MA) calls for patient before he completes all intake forms. MA records no allergies or medications in EMR.

• John reports to Dr. Smith persistent hip pain, prior athlete, history of knee and ankle injuries. He is referred to Orthopedics (Ortho).

• Ortho PA speaks with Dr. Smith’s MA, reporting that patient received a preop chest x-ray and there is a nodule that needs follow-up.

• MA asks PA to fax copy of report; MA writes note on “post-it.” Fax sent to another office location in error. Receptionist cleans front desk and removes the “post-it.”

• Ortho PA documents call with MA about x-ray results in consult note that’s pushed electronically and received by PCP office. Dr. Smith never reviews the note. Unclear if John was ever informed.
What Went Wrong?
Poor Communication

• Effective communication in a physician office cannot be stressed enough and is imperative to patient safety
• Communication breakdowns are factors in most malpractice cases
• Effective and complete communication involves Patient, Provider and Staff
• Medical record is the most used means of communicating
Communication

- Will determine the perception of “quality”
- Can be in the form of non-verbal communication
- Sets the tone...especially by the front staff
- Comes into play with billing, telephone calls, prescription refills, etc.

What non-verbal messages are you sending?
Observe and listen to your patient. Make eye contact, Be aware of facial gestures and tone.
Perception of Care

…each patient needs just a few minutes

• Patients are often interrupted before they finish their first statement
• Patients feel more “heard” when doctors ask open ended questions
• When patients are given more opportunity to speak, they perceive the visit to be higher quality even if the overall length of appointment remains the same.
• First impressions count!

Consider your last 3 office visits. Who spoke more? Did you talk about psychosocial issues? Did you or the patient laugh, smile, frown? Did you touch the door handle while the patient was still speaking?
Medication Review

Institute of Medicine (IOM) estimates half of medication errors & one fifth of adverse medical events are preventable with proper medication reconciliation.

**Medication Reconciliation**

- Review of all prescriptions, over-the-counter medications, herbal supplements
- Performed at each visit and when new medications are prescribed
- Discrepancies discussed with the provider
- Provides educational opportunity
Test Tracking System

• Diagnostic test results tracking system
  - Ensure tests are performed
  - Results are sent back for review
  - Patient is notified
  - Compliments Appointment tracking process
• Failure of a tracking system leads to increased risk for delayed or missed diagnosis, resulting in bad outcomes and lawsuit
Case Scenario

• John calls Dr. Smith’s office, reports being anxious about surgery and missing time from new job; unable to sleep. Stated that he had taken Ativan in the past.

• APRN issued prescription. No education given as patient indicated he had taken in the past; no documented assessment or telephone note.

• John underwent Ortho surgery; course complicated by wound infection and persistent pain for months. Consult notes sent to Dr. Smith.

• John seen in the office complaining of urinary pain several months after surgery. Urine specimen collected; Dr. Smith prescribes Bactrim. John states he has upcoming appointment with orthopedist but is going to run out of pain medication, oxycodone, before. He further states he has tried to reach orthopedist with no success.

• Dr. Smith provides prescription of oxycodone. Does not know APRN issued benzodiazepine; did not check prescription monitoring site.
What Went Wrong?
APP Supervision

- Advanced Practice Providers (APPs) are valuable members of healthcare team
- Regulated by Medical board and/or nursing board
- Stay current on state specific regulations
- Collaborative practice agreement that defines scope of practice and quality review process for supervision

- Sample Supervision Process
  - Monthly for first six months (new arrangement)
  - Every six months (ongoing)
  - Ongoing availability of consultation (via in-person or telecommunications system)
  - Documented action plan and follow up
No Pain Assessment

• Complete a pain assessment when prescribing pain medication
  - Initially
  - Renewals
  - Documented
• Refer to CDC guidance on prescribing for chronic pain
• As public perception about opioid epidemic is shifting, jury verdicts are increasingly unpredictable
State Prescription Drug Monitoring Program (PDMP)

• Register to access state-specific PDMP,

• Check PDMP
  - Initially
  - Anytime prescribing any controlled drugs
  - For suspected abuse and diversion
  - Prescription history
Case Scenario

• Mary, John’s wife, goes to pharmacy. Pharmacist says Bactrim hasn’t been filled as patient listed as having a Sulfa allergy in pharmacy profile.

• Mary calls the office irate, speaks to the office manager. Office manager apologizes, listens to her frustrations over the complications and pain since surgery. APRN changes antibiotic, and office manager does not inform Dr. Smith.

• Over the weekend, Mary finds John unresponsive; he is transported by EMS to hospital and treated for overdose. Toxicology screen positive for marijuana, benzodiazepine and opiates. ER physician informs he should not have been taking this combination. John is angry.

• John does not return for follow-up appointment. Office does not contact him.
Case Scenario

• 18 months later, office receives request for records from an attorney’s office. Dr. Smith reviews record and sees ER discharge summary. Updates notes on last office visit to include education about opioids.

• Dr. Smith doesn’t remember the visit well but usually educates patients about opioid risks and thinks that this was done at the time but not documented.

• A malpractice claim is brought for delay of diagnosis of lung cancer against orthopedist and PCP.
What Went Wrong?
Unresolved Complaints

- Patient complaints provide a valuable source of information to identify communication and process breakdowns
- Unresolved complaints can contribute to malpractice lawsuits and medical board complaints
- Missed opportunities to fix problems before escalating out of control
- A comprehensive patient complaint process/policy:
  - Takes all patient complaints seriously
  - Reviews all facts and circumstances
  - Provides education and awareness to staff and providers
  - Provides notification timely to the patient of resolution
Communication can be challenging!
It is important to understand your patients...
No Action for Missed Appointment

• Whose responsibility is it to keep up with appointments?
  • Patient to schedule
  • Provider to ensure appointment is scheduled and patient understands need for follow up and risk of not following up
    − Best practice is a process for documenting and provider reviewing no shows, cancelations and reschedule appointments (if outside appropriate time frame for follow up)
    − Provider inform staff of next steps
    − Communicate and educate patient on next steps and importance of complying (via visits and phone calls)
Curiosity & Quick Fixes

• Altering records can look very suspicious to a jury in a malpractice case

• Use caution in accessing records without a just reason (curiosity is not a reason)

• Plaintiff attorneys can request an audit report that will reveal
  - Who accessed the record
  - What documents were viewed/changed
  - Amount of time spent in the record
Top Ten Ways : Case Issues

1. Don’t care whether patients like you
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Action Items

1. Take time to revisit the support systems that your EHR offers:
   - Test tracking – is it activated? Are the work flows (task lists) actually worked or are the lists too arduous? What could be done to adjust the demands and assure compliance? Secure input from the staff responsible when updating and improving the process.
   - No-shows – as stated above. The EHRs can produce a no-show report. Are those reports reviewed and worked? If you have a patient who is mid-treatment and no shows without a reschedule, would anyone know that? Would the patient be contacted? The treating provider be notified?

2. Managing patient complaints:
   - Who does that in your office? Is there anyone? or Is it left to whomever receives the complaint?
   - Do you offer Service Recovery training?
   - There are a limited number of individuals who really have a talent for Service Recovery; seek out those individuals in your office and support them. Managing patient complaints is difficult.

These are just a few suggestions but make time to revisit the points made in this presentation and truly assess your policies, procedures, training and engagement of your office Team to optimize the care you offer to your patients.
Highlighted Educational Resources

As a supplement, Curi members can access the following guidance tools for:

• Advanced Practice Providers
• Chronic Pain
• Documentation
• Medication Management
• Patient Complaints and Demands
• Tests, Appointments, and Referral Tracking
References


Thank you!
Contact Information

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