

Risk Rx



The Physician's Best Defense Against Malpractice

Alan G. Williams, JD
President of Physicians
MedicaLegal Prevention,
LLC

When questioned regarding the most important challenges facing physicians today, one third of responding physicians cited medical malpractice insurance/claims, according to a study published in the *New England Journal of Medicine*. Unfortunately, malpractice is a topic never far from physicians' and healthcare providers' thoughts. However, studies show that, subsequent to an adverse medical incident, physicians and healthcare providers are the ones who have the most control over whether a malpractice claim is ever filed. Believe it or not, it truly isn't the lawyers, the risk managers or the insurance companies who determine whether a physician or healthcare provider is sued. A study published in the *American Journal of Medicine* concluded that physicians who were rated in the bottom third of patient satisfaction surveys had a 110% increased risk of having a malpractice claim filed against them compared to physicians rated in the top third. Another study published in the *Journal of the American Medical Association* found that physicians who never had a malpractice claim filed against them: laughed and used more humor, asked patients their opinions, encouraged patients to talk and interact, educated patients regarding expectations, and spent on average over three minutes longer per visit, compared with physicians who previously had multiple malpractice claims filed against them.

Considering that a Harvard study reported that less than three percent (<3%) of hospitalized patients who suffered injuries or death directly

attributable to medical negligence actually filed malpractice claims, something other than the quality of medical care rendered can be the determining factor whether a patient files a malpractice claim. Researchers at Harvard, M.I.T., and the University of Michigan have concluded that when physicians and healthcare providers fail to adequately communicate with their patients subsequent to a complication or adverse medical incident (e.g., failing to explain exactly what happened and why it happened), patients often file malpractice claims simply to determine if any medical negligence occurred; however, once the discovery process of the lawsuit reveals there was in fact no medical negligence, the patients tend to drop the case. Such research supports the theory that the manner in which physicians and healthcare providers communicate and interact with patients is the single greatest determinant of whether a patient files a malpractice claim, even in cases where the physician or healthcare provider may have rendered substandard care.



Studies published in the *Archives of Internal Medicine*, the *New England Journal of Medicine*, and the *Journal of the American Medical Association* have found that patients typically file medical

malpractice claims subsequent to a complication or adverse medical incident because they felt their physician or healthcare provider:

- ◆ deserted them
- ◆ ignored their views and concerns
- ◆ did not timely communicate important information
- ◆ did not provide answers regarding what actually happened

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Prevent a Lawsuit, Before It Happens

With this information and these studies as a factual background, it is important to note what small but vital steps physicians and healthcare providers can take to reduce the chances of being sued, even in cases where there is a question whether proper care was rendered. Consider some of the following suggestions as a means to reduce the chances of incurring a malpractice claim:

- **Sit down:** Patients believe a physician or healthcare provider who sits during a portion of the visit has spent more time with the patient, compared to those who stand throughout the visit, despite the fact that time spent was exactly the same.
- **Listen to your patient:** On average, physicians and healthcare providers interrupt a patient just 17 seconds into the patient's description of her complaints, according to a study published in JAMA. Interrupting a patient so soon communicates that you do not value her and that you are not interested in hearing what she has to say.
- **Face the patient:** Rotate your body to fully engage the patient when speaking with her, as studies show that when physicians or healthcare providers face more than 45 degrees away from a patient the patient has a negative impression of the visit.
- **Look at the patient:** Studies show that when speaking to a patient, she must be looking at you 80% of the time and you must be looking at her 90% of the time for her to fully comprehend what

you are saying. Other studies show that only one in six American adults understand rudimentary medical discussions (i.e., most Americans don't know a "negative" test result is good, that "malignancy" means cancerous, etc.).

- **Review the chart before entering the room:** When two people meet for the first time, each judges the other within the first ten seconds and that judgment will most likely be permanent; don't let the first impression the patient has of you be the top of your head as you walk into the room hurriedly skimming the chart.
- **The Physical Examination:** From the patient's perspective, the P/E is the most awkward and potentially embarrassing aspect of receiving medical care. Do all you can to ensure as much privacy and dignity as possible when performing what could become an intensely negative and degrading patient experience, one that convinces her to file a malpractice claim if she subsequently experiences an adverse medical incident.

It's Still the Golden Rule: Do Unto Others

Some studies indicate that as few as 17% of all malpractice claims actually involve injuries caused by negligent medical treatment. If this percentage is even close to accurate, physicians and healthcare providers must realize that their relationship with the patient is the single most effective tool to preventing malpractice claims from being filed. If a patient does not want to sue her physician or healthcare provider—despite the quality of care she received—she won't.

Physicians and healthcare providers must attempt to ensure open, positive relationships with their patients, not only to provide the best medical care they can, but to reduce the chances of turning those patients into medical malpractice plaintiffs.

Alan G. Williams, JD, is the author of the best-selling medical malpractice prevention book "Physician, Protect Thyself: 7 Simple Ways NOT to Get Sued for Medical Malpractice" To contact him please e-mail AlanGWilliams@PhysiciansMedicalLegalPrevention.com



The Florida Supreme Court Rules on Amendment 7

Christine Neuhoff
Senior Associate
General Counsel
Shands HealthCare

Last month, the Florida Supreme Court issued an opinion relating to the constitutionality of legislation that implemented and clarified the "Patients' Right to Know about Adverse Medical Incidents," a constitutional amendment approved by the voters in the November 2004 general election. The "Patients' Right to Know" amendment, commonly known as "Amendment 7," provides that "patients" have a right of access to "records of adverse medical incidents." In the spring of 2005, the Florida legislature enacted section 381.028 of the Florida Statutes to implement and clarify the application of the Amendment. Constitutional challenges to the new statute immediately followed. On March 6, 2008, in the consolidated cases of Florida Hospital Waterman v. Buster and Notami Hospital of Florida v. Bowen, the Florida Supreme Court ruled on the constitutionality of the statute, finding that many of its provisions violate the Florida Constitution. Moreover, the Court found that Amendment 7 applies retroactively to records created before the Amendment became part of the Constitution.

Prior to the election, proponents of Amendment 7 publicized it as providing patients with the ability to obtain information to make better-informed choices among health care providers. The legislature enacted section 381.028 of the Florida Statutes to effectuate the stated purpose of Amendment 7, to maintain existing protections that were not inconsistent with that purpose, and to prevent requestors from inundating providers with requests of unlimited scope. To that end, the legislation provides: that only final reports of adverse medical incidents are subject to disclosure; that such documents are not subject to discovery or admissibility in civil or administrative actions; that the person requesting documents must show that he or she has been a patient of, or has an impending patient relationship with, the provider from whom records are sought; that the patients have the right to access only those documents pertaining to adverse incidents involving substantially the same condition or treatment as that sought by the requesting patient; that the health care provider must identify records of adverse medical incidents using the process for identifying "adverse incidents" that are reportable to AHCA; that the health care provider can charge a fee for the staff time necessary to respond to the request as well as for copies of records; and that the Amendment is not retroactive.

In the consolidated cases of Buster and Bowen, the Florida Supreme Court found that Amendment 7 took effect on the date of the election, November 2, 2004, and applies to records created before that date. The Court invalidated, as inconsistent with Amendment 7, most of the substantive and procedural provisions of the statute. Thus, any patient, or prospective patient, may request records relating to any adverse medical incidents, even if they bear no relationship to any care the patient has sought or may seek. Further, the records are subject to discovery in court or in administrative pro-

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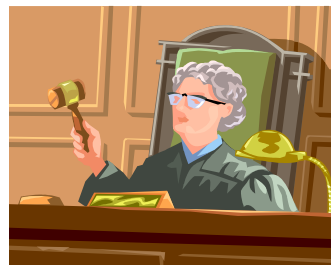
ceedings and may be admissible as evidence. The Court did preserve some of the statutory definitions and preserved the ability of the provider to charge the requestor for the cost of locating and providing the documents.

Both Florida Hospital Waterman and Notami Hospital of Florida (d/b/a Lake City Medical Center) have filed motions for rehearing and clarification. The hospitals have sought a rehearing on the question of whether Amendment 7 applies retroactively to require that providers give access to records of adverse medical incidents created before adoption of the Amendment, when the Florida Statutes unambiguously guaranteed the confidentiality of those records. In addition, the hospitals seek clarification that documents produced in response to Amendment 7 requests remain inadmissible in court; that the pre-existing grants of immunity from liability and protection from compelled testimony continue to apply to participants in self-regulation activities; and that Amendment 7 does not abrogate attorney-client privilege or work product protections. While none of these issues were raised in the cases before the Florida Supreme Court, the statutory provisions invalidated by the Court make the continued vitality of these protections unclear.

Specifically, the Court struck as unconstitutional the provisions of section 381.028 that retain the existing restrictions on "discoverability or admissibility" of records relating to adverse medical incidents, although the Court's opinion discusses only "access" and discoverability – not admissibility. That same provision references the continuing applicability of the pre-existing statutory provisions granting immunity from suit and protection from compelled testimony to participants in peer review, quality assurance and risk management activities. Nowhere did the Court indicate any inten-

tion to invalidate those protections. The hospitals have thus sought clarification that the Court intended to strike only that portion of the provision relating to the discoverability of records. While a plaintiff may argue that the Court's opinion leaves doubt as to whether immunity from suit continues to exist under Florida law, the federal Health Care Quality Improvement Act, which also provides immunity from liability for participants in peer review, is unaffected by the Florida Supreme Court's opinion.

The Court also struck the provision of section



381.028 defining a record as "the final report of any adverse medical incident." That provision also identifies documents that do not qualify as records, including those that contain or

reflect "any attorney-client communications or any attorney-client work product." Because nothing in the Court's opinion suggests that it intended to abrogate those privileges, the hospitals have asked the Court to clarify that point to avoid the unnecessary controversy in the trial courts that will result from any ambiguity.

During the nearly two years in which these cases were pending before the Florida Supreme Court, Shands and other hospitals requested that trial courts delay consideration of discovery requests seeking records subject to Amendment 7 until the Supreme Court ruled on the Bowen and Buster cases. Most trial courts granted these requests. The Supreme Court's decision in these cases will not be final until the Court has ruled on the motions for rehearing and clarification. Once the trial

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courts determine that the plaintiffs' efforts to compel discovery of Amendment 7 materials may proceed, Shands and other providers will continue to dispute the discoverability of the records on a case-by-case basis based on generally applicable objections such as relevance, over-breadth, and others as appropriate.



While some provisions of section 381.028 have been invalidated, important legal protections remain intact for participants in peer review. These include the following:

- ◆ Nothing in Amendment 7 requires that the names of the reviewers must be revealed in the records disclosed under the Amendment.
- ◆ Because peer review committees conduct their activities on behalf of the hospital, hospitals will provide the defense for claims against medical staff members arising out of their participation in peer review activities.

The Supreme Court has been asked to clarify its opinion in the Bowen and Buster cases with respect to:

- The continuing applicability of the attorney-client privilege and work product protections that apply to some records of adverse medical incidents;
- The admissibility or inadmissibility of Amendment 7 records in civil and administrative proceedings; and
- The continuing applicability of the statutory provisions protecting participants in the peer

review, quality assurance, and risk management processes from being compelled to testify concerning the contents of those processes.

Despite the outcome of the Bowen and Buster cases, hospitals must continue to conduct peer review. Florida statutes, federal law and The Joint Commission standards continue to require hospitals to conduct peer review, as well as other quality improvement and assurance processes, in order to maintain and improve patient safety. Failure to comply with these requirements has its own consequences, including lawsuits based on claims of negligent credentialing by medical staff and the hospital.



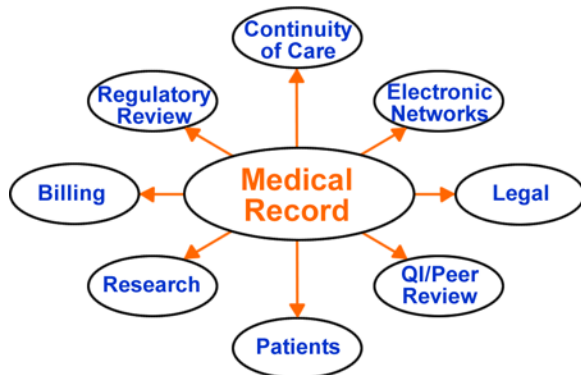
Shands medical staff and quality departments continue to improve peer review forms and processes so that the hospital, through its medical staff, maintains effective peer review, while at the same time minimizing the potentially negative impact of documents that may be viewed out of context. Shands continues to work with the Florida Hospital Association as well as other facilities to consider the possibility of developing legislation that would comport with the Court's opinion and yet mitigate the impact of Amendment 7 on hospital operations.



Good Care Bad Documentation

Jan Rebstock, RHIT, LHRM, CPHRM

Charting is a fact of life for providers; an integral part of the daily responsibilities of providing patient care. Considering all the users and uses of the clinical record in the diagram below, it is easy to appreciate just how much reliance is placed on record documentation for all aspects of patients care delivery and hospital operations.



While the clinical record serves many purposes, the primary function is to document the care of the patient to facilitate continuity of care among the many providers, current and future, who care for and treat the patient.

The medical record is also the legal business record for a healthcare organization and as such, needs to be maintained in a manner that complies with applicable State and Federal regulations, accreditation standards, and professional practice standards. From a claims perspective, good documentation is critical because lack thereof can create costly rebuttal challenges and settlement recommendations in cases that, under normal circum-

stances, would not survive the discovery process. Litigation often takes years, during which time memories grow dim leaving the record as the prima facie evidence. *Consequently, documentation can be your best defense or your biggest liability.*

“Present on Admission” has recently taken on a whole new meaning with respect to DRG reimbursement. Effective October 1, 2008, the Centers for Medicare and Medicaid (CMS) has identified several hospital-acquired conditions as preventable events and plans to withhold reimbursement for these secondary diagnoses. The conditions in this first round of proposed reduced DRG payments include 1.) object left in during surgery, 2) air embolism, 3) blood incompatibility, 4) catheter-associated urinary tract infection, 5) pressure ulcer, 6) vascular catheter associated infections, 7) mediastinitis after coronary artery bypass graft, and 8) falls with associated trauma such as fracture, dislocation, intracranial bleeds, and crushing injuries. Additional conditions slated to be added in 2009 include 9) ventilator associated pneumonia, 10) staphylococcus aureus septicemia, and 11) deep vein thrombosis/pulmonary embolism. Clearly, any successful appeal attempts will depend in large part on the thoroughness of admission assessments and the adequacy of documentation relative to care plans and treatment provided to prevent these conditions if acquired during the patient’s stay.

Incorporating some of the following general documentation guidelines into an everyday routine is a good starting point:

1. Medical record entries should be legible and complete. Illegible handwriting impedes effective communication among the health care team and increases the potential for error and/or delays in implementing treatment and medication orders.

Use of dictation, pre-printed order sheets and computerized medication administration records can help resolve issues associated with poor penmanship. The steady transition toward electronic record systems is also useful in this regard and importantly, enables simultaneous access by multiple providers. Follow your facility policies and medical staff rules and regulations with respect to documentation requirements and time frames for completion.

2. Documentation content should be specific, objective and complete. The record should reflect factual information (what is known versus what is thought or presumed), charting objective facts rather than personal opinion, using quotation marks when quoting the patient. It is important to document complete facts and pertinent information related to the patient's condition, history of past and present illnesses, examination and tests, hospital course and results of treatment, consults and any complications. The discharge summary should include the recovery status of the patient and all discharge instructions given to the patient and/or family. All significant communications with patients and *all instances of noncompliance or refusals of treatment should be documented*. Avoid generalizations and vague words such as: appears to be, as usual, status quo and the like. *When documenting unplanned events, do not make reference to an "incident report" or "risk management notified" or assign blame to anyone*. Simply document whatever occurred objectively.

3. Patient record entries should be documented at the time care and treatment is rendered. It is always good practice to chart contemporaneously while information is fresh. *All entries should be written in blue or black ink, dated, timed and authenticated*. It is also important that dictation be read, blanks filled in and corrected as indicated prior to signing. "Late

entries" do not tend to have the same perception of credibility in court as a record that clearly documents the chronology of events. However, when making a late entry, identify it as such, putting the current date and time, referencing the date for which the late entry is written and if used to document an omission, validate the source of the additional information to the extent possible.

4. Correct Errors Properly. When a charting error is made, draw a single line through the entry so that the inaccurate information is legible, write "error" by the incorrect entry, sign and date the entry and document the correct information. *To avoid suspicion of record tampering, do not obliterate or otherwise alter the original entry by blacking out, whitening out or writing over an entry*. It is also good practice not to leave blank spaces on a sheet before starting a new page unless a line is drawn through the empty space to show it was intentionally left blank.

Good documentation can help protect your patients, other providers who rely on your documentation and you in the event of a malpractice claim.

**"The spoken word perishes,
The written word remains."
Latin Proverb**

References:

Update: Maintaining a Legally Sound Health Record- Paper and Electronic
Documentation Requirements for the Acute Care Inpatient Record (AHIMA practice brief)
Hospital -Acquired Conditions in Acute Inpatient Prospective Payment System
Present on Admission Indicator Reporting by Acute Inpatient Prospective Payment System Hospitals

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Editor:

Jan Rebstock, RHIT, LHRM, CPHRM
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Chaires Hammond
Altamont Springs, FL 32701
407-834-2777

Cristina Palacio, Esq.,
Associate General Counsel
Shands Healthcare

Send comments or article suggestions to:

rmeduc@shands.ufl.edu