PRF NEWS

Covering Practice and Risk Management Issues for Physicians

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PREVENTING MEDICAL ERRORS

Patient Follow Up

BY STEPHEN J. SCHEIFELE, M.S., M.D.

Delay in diagnosis is a frequent allegation in a malpractice action - a delay which can be the result of a breakdown in processing and communicating test and procedure results to patients. Informing patients of test results is such a critical component of medical practice that it requires the establishment of clear and consistent office procedures that accomplish several important objectives.

These objectives must not only maintain patient privacy, but also include the ability to:

- **TRACK** test results accurately
- **COMMUNICATE** test results in a timely manner
- **DOCUMENT** that the information has been transmitted and received

TRACK

Tracking starts with procedures that ensure that the patient has followed through with the ordered tests. Next are measures that track whether test results have been received by the office. The final tracking step is to attach the test results to the chart where they can be reviewed and signed by the appropriate medical staff, often preferably a physician. Failure of patients to follow through with recommended critical tests or important follow-up appointments should prompt a reminder to the patient of the importance of the recommendation. In the absence of electronic medical records, which can effectively track testing and missed appointments, a paper tracking system should be employed.

COMMUNICATE

Maintaining confidentiality, results of testing are communicated directly with the patient. "No news is good news" is not an adequate approach. Because patients frequently change addresses and phone numbers, communicating by e-mail or cellular phone may potentially be more reliable. The patient must authorize the electronic disclosure of information (e.g. voice mail, e-mail, text messaging) or disclosure to another family member. Authorization must be documented in the chart in writing. Tests pertaining to HIV, hepatitis, malignancy or substance abuse may never be communicated electronically.

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DOCUMENT

Discussions with patients about the indication for tests and procedures as well as the potential risks if he/she fails to follow through with recommended procedures need to be documented. Although it is a patient's right to decline recommendations, this discussion must be documented. Test results (and their implications!) should be communicated and documented clearly. Even in the face of tests or procedures that are negative or "normal," it is advisable to document leaving the option open for the patient to return should concerns persist. "Everything is okay" sometimes isn't!

What should be done when attempts to reach a patient are unsuccessful? There is no clear answer, and in part this depends on the critical nature of the test result. Every attempt to reach the patient should be documented. Certified mail with return receipt is an appropriate option for some results. If test results reveal a life-threatening situation, extraordinary steps need to be undertaken to inform the patient. ■

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PREVENTING MEDICAL ERRORS

Wrong Site Surgery - Avoiding Common Mistakes

BY ROBERT L. SACHS, D.D.S., M.S., F.A.C.D., F.I.C.D.

Over the past several years, protocols to prevent "wrong site surgery" have been instituted in hospitals across the country. Patients are now required to initial the surgical site before anesthesia. A "time out" by the surgical team to identify the patient and surgical procedure is completed before a case can be started. The same principles should apply in the office setting, where a patient is equally at risk for experiencing an erroneous procedure or treatment.

It may be surprising to recognize that even among the most diligent and experienced dental clinicians in Northern California, there is hardly an individual who has not been involved in an allegation of the removal of a wrong tooth. This is not a trivial matter as such an allegation can cost $25,000 to $50,000 to defend and may require that a report be filed with the Dental Board.

The most important point to remember is that although the removal of a wrong tooth may occur relatively frequently, it is almost always avoidable. A common clinical scenario is the patient who presents with pain and/or infection with several teeth in poor condition in the same quadrant. Based on the clinical appearance and radiological findings, the clinician will generally extract the tooth with the poorest prognosis. Yet postoperatively the patient may claim that the extracted tooth was not the specific tooth causing the acute pain—even if the removed tooth evidenced clinical and radiological indications that justified its extraction. Although the clinician may have thought he or she was doing the patient a favor by removing a diseased tooth that cannot be restored, and even without charging for the additional procedure, the patient may allege that the doctor performed a procedure without consent.

Errors in the removal of the wrong tooth are often secondary to the referral. Ideally, the referral slip should have a clear diagram with the tooth number stated and the description of the tooth written in detail in longhand. There is always the potential that the referral slip may have been written in error, either by the referring doctor or a member of the referral staff, or may have been communicated wrongly to the staff member, or the instruction may have been interpreted incorrectly by the staff member. If there is any question about which tooth is in question, the treating doctor should make a prompt clarifying personal phone call to the referral source before proceeding with the extraction as the clinician performing the procedure is ultimately responsible for the outcome.

A major source of error in wrong tooth allegations can be traced to the numbering systems for the identification of teeth. Teeth may be numbered 1 through 8 in each of the four quadrants, or 1 through 32 for the entire mouth. Compounding this confusion is that a tooth indicated for removal may not be in its usual numbered anatomic position because a tooth had been removed during childhood. The bottom line is even if the patient has consented to the procedure, when the consent form is signed as ". . . extraction of tooth number 18," the patient really does not know which tooth it is. To avoid any misunderstanding, it is recommended that the location of teeth be described in common English and that the patient be asked to look through a hand mirror while the clinician touches the designated tooth with an

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MESSAGE FROM THE PRESIDENT

Annual General Membership Meeting

PRF's Annual General Membership Meeting is scheduled for Wednesday, May 28, 2008. Once again the meeting will be held at the Hotel Kabuki in Japantown and begin at 6:00 PM. A buffet dinner will be served as well as wine and refreshments. Proxies and meeting notices will be sent out six weeks prior to the meeting date.

The year 2008 marks the 32nd year that PRF has provided affordable professional liability premiums and occurrence based coverage to Northern California physicians and allied healthcare providers. PRF has been able to provide this service over these many years by consistently adapting to the ever-changing medical and insurance environments. This year we are again recommending a structural and operational change to both streamline operations and ensure equitable ownership to all Shareholders.

I strongly urge each PRF Insured and former Insured to attend this year's Annual General Membership Meeting. The PRF Board of Directors is working to ensure that the Company will be able to continue to serve the physician community for decades to come. We need your support, your feedback and your attendance. Please make Wednesday, May 28, 2008 a priority in your busy schedule. I hope to see you there.

George F. Lee, MD
President and CEO

BRIEFCASE

SAVE THE DATE!

Plan to attend the Annual General Membership meeting at 6:00 p.m. on Wednesday, May 28, 2008, at the Hotel Kabuki in Japantown.

Wrong Site Surgery—Avoiding Common Mistakes

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instrument. With a clearer method of tooth identification, wrong tooth extraction errors can be significantly minimized or eliminated.

Each office must develop and follow a routine risk management protocol to avoid the removal of wrong teeth. The most important recommendation is for a "time out" before the actual procedure, where the doctor and at least one staff personnel confirm that the patient to be treated and their records are correct and that the radiographs are mounted and viewed accurately. During this time out, the tooth to be treated must be verified by all, especially the patient. After anesthesia is obtained, the tooth should be visually and clinically identified and verified as correct, not merely as a review of the tooth number or location. Finally, when the forceps are placed, a staff member should be designated to authenticate that the tooth selection is correct prior to any manipulation for removal. If there is ever any hesitation or questioning, the operator must stop and review all the data before proceeding. ■

Dr. Sachs is an Associate Professor in the Department of Oral and Maxillofacial Surgery at the University of the Pacific, Arthur A. Dugoni School of Dentistry.

PREVENTING MEDICAL ERRORS

Retained Foreign Bodies

BY STEPHEN J. SCHEIFELE, M.S., M.D.

The Institute of Medicine's 1999 report on the quality of healthcare in America led to a number of initiatives intended to promote patient safety by reducing medical errors. Not surprisingly, the unintentional retention of a foreign object in a patient after surgery or other procedure has been deemed unacceptable. JCAHO considers a retained foreign body as a "Sentinel Event" which mandates not only that the incident be reported, but requires that an analysis of the root cause of the event be undertaken. California Senate Bill 1301, which went into effect in 2007, also requires hospitals to report any retained foreign objects to the Department of Health Services (DHS) as well as to the patient. DHS in turn is required to make such substantiated adverse events public starting in 2009.

Retained foreign bodies not only may cause significant injuries and require additional surgery for removal, but discovery may be delayed for years. Retained objects include objects that are part of the surgical count such as needles, instruments, and sponges, and others, such as towels, which are not. Sponges are the most frequently retained foreign body, followed by clamps. Over half of objects are left in the abdomen or pelvis and almost a quarter in the vagina. Almost any surgical procedure or specialty is at risk.

Prevention is a joint responsibility of the entire surgical team. System failures occur when physicians dismiss an incorrect count without further exploration or nurses allow an incorrect count to be accepted. Factors contributing to the retention of foreign objects include lengthy cases, difficult procedures, fatigue and staff changes. Nursing protocols for surgical counts should be strictly adhered to. All members of the surgical team are encouraged to voice their concerns. A final "surgical pause" acknowledging a correct count should be taken before the wound is closed. Any discrepancies should be investigated by re-exploration or x-ray.

Retained foreign bodies can result in significant medical expense, lost wages and emotional distress for both the patient and physician. Loss of trust in the physician does not need to be the inevitable outcome. The same principles of disclosure and apology apply in maintaining the doctor-patient relationship. Application of "Code Green" coordinated with hospital risk management may avert a malpractice action and the additional costs involved.

A retained foreign body suit is usually a case of "res ipsa" (the thing speaks for itself) and is rarely defensible. In one large study of closed claims the average award was $52,500, however settlements can be as high as $1.5 million. Both the hospital and physician may contribute toward the settlement.

PRF has experienced 27 management reports of retained objects, averaging approximately one per year. Retained sponges accounted for almost two-thirds of cases, half associated with a vaginal delivery and half with abdominal/pelvic surgery. Retained instruments and needles were involved in the other cases. Roughly half of the events culminated with a mediated or negotiated settlement while no action was taken in the remainder of incidents. When settled, the cost to the PRF averaged $3600 for a vaginal sponge and $41,500 for an abdominal sponge—but the highest cost exceeded $100,000. ■

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Dr. Scheifele is a board member and chair of the Risk Management & Education Committee of PRF.