Volume 15, Number 1 · May 2012

Newsletter?of?Physicians?Reimbursement?Fund,?Inc.

PRF NEWS

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Covering Practice and Risk Management Issues for Physicians

The Role of Hospitalists in the Delivery of Health Care of the Future

BY SARITA SATPATHY, MD

THE EMERGENCE OF HOSPITAL-BASED SPECIALISTS

The hospital environment has changed dramatically over the past several decades. There is increased pressure to decrease the length of stay in the hospital and to manage complex diseases in the outpatient setting. These changes are driven not only by the availability of new outpatient technologies but also clear evidence that clinical outcomes are improved by minimizing inpatient hospitalization. Most hospitals now consist of several unique levels of care such as the Emergency Department, Interval Care Unit, Critical Care Unit, and Palliative Care Unit as well as the traditional medical-surgical and telemetry beds. A consequence of this differentiation has been the emergence of practitioner-specialists including emergency medicine physicians, intensivists, hospitalists, and hospice/palliative care physicians. These sub-systems frequently involve "hand-offs" from the outpatient to the inpatient environment, from the intensive care unit to the general medicine floor, as well as from the hospital to the outpatient environment.

While the term "hospitalist" was coined only 15 years ago, Hospital Medicine has grown to over 34,000 physicians today. A hospitalist generally undergoes residency training in general internal medicine, general pediatrics, or family practice, but may also receive training in other medical disciplines. Their expertise lies in the clinical management of the acutely ill hospitalized patient with various co-morbid conditions.

Hospitalists are the starting point and the end point for the majority of admitted patients. With a hospitalist physician available 24/7, patients are assured prompt and efficient care. Hospitalists are the front line in running codes, assisting rapid response teams, and they are available on an immediate basis for patient and family needs. As patient care grows ever more complex, PCPs and specialists with busy office-based practices face increasing challenges in their ability to attend to their hospitalized patients' needs in an efficient and timely basis.

CO-MANAGEMENT: THE NEW PARADIGM

One of the clearly important challenges to internal medicine physicians is to maintain continuity of care as well as information flow during these transitions, which can threaten the traditional one-to-one relationship between patient and physician. While the patient can benefit from effective collaboration among a number of health care professionals, a new model based on the "co-management" by different physicians must be implemented and embraced if this collaboration is to be successful.

Approximately 85 percent of hospitalist groups have implemented some form of co-management. The demographic trends that have increased the use of co-management include an increasing older, fragile population of hospitalized patients with complex medical problems. Co-management also fits into the larger scope of healthcare reform trends of increased efficiency and teamwork.

For the hospital, implementation of a co-management structure has the potential for increased efficiency, reduced length-of-stay, increased patient safety and satisfaction, and quality improvement in both process and outcomes. The hospitalists may be interested in marketing and expanding their services within the hospital and thereby increasing their revenue, but these goals are not mutually exclusive from improving medical quality and patient safety. For traditional specialists and surgeons, co-management has the appeal of more efficient utilization of their knowledge and time as well as increased personal and professional satisfaction through better hours and less call

(continued on page 2)

Inside PRF News

Hospitalists *(continued from page 1)*
without the sacrifice of medical quality or patient safety.

CAN CO-MANAGEMENT SUCCEED?

Despite mutually beneficial advantages for all parties, the implementation of co-management structure is not without potential clinical and medical-legal risk and raises critical questions that must be satisfactorily addressed:

- Are the hospitalists sufficiently trained and qualified to assume responsibility for all types of patients?
- Is there agreement between the hospitalists and the specialists/surgeons on treatment standards and their respective roles/responsibilities for patients?
- Will the nursing staff know who to call in a variety of clinical situations?
- Will patients accept care from a doctor they have never met prior to hospitalization?
- Will the specialists/surgeons be available to the hospitalists (and the patient) in those circumstances where their expertise/knowledge is called for?
- Is there the right balance between having hospitalists call for consultations too often or too infrequently?
- Will specialists/surgeons respect the professional autonomy and judgment of the hospitalists?
- Does the hospital have sufficient financial resources and staff capacity to support the co-management service?
- Will co-management increase the vulnerability of the hospitalist, specialist/surgeon, and hospital to malpractice litigation?
- How will the "success" of a co-management strategy be measured and assessed?

Although co-management has been proposed as a solution to improve both patient care and professional satisfaction, it cannot work if the arrangement isn't well planned. Co-management requires clearly defined roles, collaborative professional relationships, and a sense of equal and shared risk and responsibility.

HEALTHCARE REFORM: MEASURING MEDICAL 'QUALITY' AND 'VALUE'

The second driver of co-management strategies has been the emergence of healthcare reform as a potent political and financial issue of vital national importance. This emergence has brought increased attention and focus on providing improved health care in a cost-effective manner. Medicare, like all healthcare payers, is changing from being a passive payer of services to a purchaser of "value." The goal is to improve overall medical quality by encouraging teamwork between clinicians and hospitals and encouraging consumers to make decisions based on values about their individual care.

Many health plans incorporate measures of hospital or physician performance in their "pay for performance" contracts that provide increased payments for delivering higher quality care. The two main reasons to publicly report a hospital's performance on quality measures are to inform patients about the choice of hospitals for their own health care and to motivate hospitals to improve their performance. Two measures that hospitals can use to increase their "customer satisfaction" scores is to reduce the time that it takes from the patient's appearance at the Emergency Department to the time the admission decision is made and the time that they actually leave the Emergency Room for admission.

Suggestions of how hospitalists can participate in reducing the time patients spend in the Emergency Department include:

- Having a specific hospitalist designated as the "admitter" during the day shift. This physician can then be paged and be in the Emergency Room within minutes of a call.
- Write Holding Orders to help avoid delays in getting patients to their appropriate floors.
- Remove inefficiencies in communication by having direct communication between the Emergency Room physician and the admitting hospitalist.

ARE HOSPITALISTS DELIVERING HIGHER MEDICAL QUALITY?

In a recent year-long national survey on patient care, a comparison of more than 3,600 hospitals found that the roughly 40 percent that employed hospitalists scored better on multiple hospital quality alliance indicators than those that didn't. Furthermore, a 2009 study in the *Archives of Internal Medicine* study suggested that hospitals with hospitalists outperformed their counterparts in quality metrics for acute myocardial infarction, pneumonia, overall disease treatment and diagnosis, and counseling and prevention. Yet there is far from universal agreement that the data presented to date is persuasive enough to support the conclusion that hospitalists bring a higher quality of care to the table. As healthcare moves into a pay-for-performance era, payers will increasingly rely on measures of performance as a guide. But experts are cautioning that many of the measures themselves have the potential to create unfair and inaccurate comparisons among hospitals.

The obligation to gather evidence, in fact, is largely falling upon hospitalists themselves. The plethora of research abstract presented at the annual Hospitalists' Medical Society meeting suggests that many physician scientists are taking that responsibility seriously. Effectiveness of communication and seamlessness of handoffs often are assessed through their impacts on patient outcomes. Patients' overall rating and recommendation of hospitals likely will reflect their satisfaction with communication as well. It is inevitable that hospitals—and hospitalists—will pay more attention to communication ratings as patients become judges of quality.

While hospitalists work in one of the riskiest environments in healthcare, as a young specialty, hospital medicine hasn't had the same exposure to malpractice issues that the long established specialties have had. Yet, to its advantage, the hospitalist business model is built on patient safety and quality of care as hospitalist groups can differentiate themselves in the market through risk management protocols and processes that help keep patients safe. In has been suggested that hospitalists excel at handling such high-stakes medical issues as gastrointestinal bleeding, pancreatitis, sepsis, and pain management—medical crises that can quickly impact patient outcomes if not addressed properly and proficiently. But because of their day-to-day experience in these high-risk medical situations, hospitalists may, as their name suggests, be uniquely positioned to assume a more active role in designing and implementing policies and procedures that improve quality and reduce risk for patients in that potentially most dangerous of environments—the hospital. ■

Dr. Satpathy has a master's degree in public health and is board certified in internal medicine. She has practiced as a hospitalist since completing residency in 2002 and is currently the program medical director for the Cogent HMG hospitalist group in Daly City.

For Better or Worse, We Are All in This Together

BY STEPHEN J SCHEIFELE, MS, MD

California is one of the 46 states where negligence cases may be brought under the legal doctrine of "Joint and Several Liability." In non-legal terms, this doctrine makes any member of the medical team or hospital potentially liable for the entire negligence settlement's economic damages even if their alleged contribution to the negligence was only one percent. It then becomes the responsibility of the malpractice carriers to sort out their respective proportions of liability and payment.

Pregnancies that end with adverse fetal outcomes are illustrative of many issues surrounding liability and risk management. Family expectations are high, and whenever a baby is severely compromised, questions of fault inevitably arise. What we can learn from these illustrative cases from three different Bay Area hospitals is that we are all part of a team and share in the liability. There should be a coordinated team approach to every patient. We need to be expert in what we do and make sure the other members of the team are as well.

Case # 1: After an uneventful prenatal course, a 27-year-old woman was admitted at term for induction of labor because ultrasound measurements had raised the concern that she was carrying a large baby. The labor induction was initiated with prostaglandin to soften the cervix followed by the administration of Pitocin to stimulate uterine contractions. Although this intervention resulted in frequent uterine contractions, the labor progressed slowly, and there was a decrease in fetal heart rate variability. A pressure-sensing catheter was placed to assess the strength of the uterine contractions. Shortly thereafter, there was a sudden and unexpected fall in the fetal heart rate. An emergency cesarean section was performed and an 8 pound, 5 ounce infant was delivered with an Apgar score of 0 at one minute and 4 at five minutes. The baby developed seizures at 12 hours of age and has cerebral palsy with mental retardation.

Pregnancies that end with adverse fetal outcomes are illustrative of many issues surrounding liability and risk management. Family expectations are high, and whenever a baby is severely compromised, questions of fault inevitably arise.

Case #2: The second case was a also a 27-year-old who presented at term in early labor with a small amount of vaginal bleeding after an uncomplicated prenatal course. Labor progressed slowly, and when the membranes ruptured, the amniotic fluid was noted to be blood tinged. The labor was augmented with Pitocin. Also as in the previous case, there was a sudden and unexpected fall in the fetal heart rate shortly after the insertion of an intra-uterine pressure catheter. An emergency cesarean section was performed. The baby weighed 5 pounds, 5 ounces and had an Apgar score of 1 at one minute and 1 at five minutes. The child is microcephalic, with cerebral palsy and neuro-developmental impairment.

Case #3: After an otherwise uneventful pregnancy, a 24-year-old woman was admitted for induction of labor at 37 weeks because she had developed mild pre-eclampsia. Prostaglandin was administered the first day followed by Pitocin on the second day. As in the previous case, blood tinged fluid was noted after rupture of membranes. After initial slow progress, the labor then progressed rapidly with frequent uterine contractions. Significant slowing of the fetal heart rate was noted. The patient was taken for an emergency cesarean section but was able to be delivered with forceps in the operating room. The baby weighed 6 pounds,

(continued on page 4)

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MAY 16 MEETING

Plan to attend PRF's Annual General Membership meeting on Wednesday, May 16, 2012, at 5:30 p.m. at the Hotel Kabuki in Japantown. Dinner will be served, as well as wine and hors d'oeuvres. The meeting is a chance for new PRF members to meet the PRF board of directors and staff, and it's also an opportunity for all members to visit with friends and colleagues. You should have already received your meeting notice and Sphargis proxy. If not, please call the PRF office at (415) 921-0498. ■

For Better or Worse *(continued from page 3)*

3 ounces and had Apgar score of 0 at one minute and 0 at five minutes. After prolonged and continued resuscitation there was a ten-minute Apgar of 2. The child has cerebral palsy, a seizure disorder and severe global delays.

These three cases have one obvious similarity. All were unexpected outcomes in otherwise uncomplicated pregnancies that resulted in infants with the need for a lifetime of care that could total a minimum of five million dollars. But they also illustrate that common and even mundane procedures and interactions among healthcare providers can result in scenarios with poor outcomes and complex determinations of liability.

In these particular cases attention was drawn to the following factors:

- The failure of nurses to either accurately assess ominous fetal monitoring data or to notify the physician in a timely manner. Nurses are held to the same level of competency in the interpretation of fetal heart tracings as physicians.
- The use of Pitocin deviated from established protocols.
- Poor communication between physician providers, who may be co-managing from home or office, or at change of shift. Two of the incidents occurred within an hour of the on-call obstetrician assuming care.
- Conflicting documentation and inappropriate charting critical of other providers.
- Failure of the obstetrician/midwife to recognize an impending problem and act in a timely fashion.

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. . . with their defense team, the PRF obstetricians did prevail-but at a combined defense cost of over $1 million. The take-home message is that every member of the medical team can potentially contribute to liability.

Having identified these common factors, there were differences that led to a better outcome for some of the providers. In the first case, the brain showed changes on ultrasound shortly after birth and the child did not develop microcephaly—both indicating a chronic intrauterine process before the unexplained acute bradycardia in labor. The placental pathology also supported a chronic process. Even though there were liability concerns about the fetal heart rate tracing during labor before the bradycardia, the chronicity enabled the obstetricians to prevail in arbitration.

In the second case the defendant obstetrician had just started call when the bradycardia occurred. Because of a prompt response and taking charge to facilitate a cesarean section, the obstetrician was ultimately dismissed from the case. The child showed the hallmarks of an acute hypoxic encephalopathy—hence the liability for the providers before the change of shift. The anesthesiologist, who was new to obstetrics, also assumed some of the liability because of delays with intubation.

With the third case, poor communication between the nurse and physician led to liability for both.

In the first two cases, with their defense team, the PRF obstetricians did prevail—but at a combined defense cost of over $1 million.

The take-home message is that every member of the medical team can potentially contribute to liability. Proven guidelines to minimize these risks include:

- strict adherence to hospital protocols designed to ensure patient safety,
- contemporaneous objective documentation in the medical record, and
- establishing guidelines for clear communication both up and down the chain of command and between physicians when there is a transfer of clinical responsibility.

While having the best outcome for our patients is the goal, avoiding liability and its associated expense is a necessity. ■

Dr. Scheifele is the chair of PRF's Risk Management & Education Committee.

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Avoiding the Malpractice Pitfalls of Group Practice

BY GEOFFREY A. MIRES, JD

Although group practice certainly has its advantages, it is not immune from the harsh scrutiny that comes with claims of medical malpractice. Indeed, group practice and its associated call coverage presents its own pitfalls.

SETTING EXPECTATIONS

In an Ob/Gyn group practice, for example, it is virtually unavoidable that the provider with the closest rapport with a particular patient may be unavailable at an important moment during prenatal care or delivery. Patients in the obstetrical setting are intensely engaged in the process, and (perhaps unrealistically) expect their physicians to be giving them their undivided attention. Therefore it is important at the outset of the group/patient relationship that repeated and affirmative steps be taken to make it clear that the patient is being cared for by a "team," which is structured to provide a positive and reassuring depth of resources and expertise. By openly addressing patient expectations, the patient is brought in as a member of the team.

CUSTOMER SERVICE

Call coverage for in-hospital care is a necessary method of complying with the standard of care relative to labor and delivery, the potential for surgery, and assuring continuity of care for a group patient. By its very nature, however, this arrangement often puts the patient in the hands of a physician, midwife or nurse practitioner who could well be perceived as a stranger. Because the quality of "customer service" and patient communication has such a palpable impact on the potential for avoiding litigation (or at least reducing its frequency or the magnitude of claims), providers on call need to embrace this paradigm. Those who interact with the patient should be prepared to be able to converse intelligently and demonstrate a personal knowledge of the patient's history, course, and plan of care.

WHO'S IN CHARGE?

The inner workings of a call coverage structure is also a potential medical-legal pitfall as it can present a confusing tapestry of providers who are involved in the patient's care to varying degrees. At the very least, this increases the number of potential defendants should litigation arise.

Determining who among those on call is in fact responsible for any given patient would seem to be a question easily answered, but often is not. In one example, multiple obstetrical care providers were on call and in the hospital. Ob #1's primary responsibility was in the delivery room while Ob #2 dealt with laboring mothers. However, if Ob #1 was occupied, Ob #2 would be called upon should the need arise. There was also at least one nurse midwife for whom the Ob's were acting as a consultative resource, but with the possibility of assuming responsibility for the patient should the clinical situation exceed the midwife's skill set. In this instance, despite a written schedule, the providers had apparently switched roles without any documentation. Therefore it was not clear who was Ob #1. The labor was being managed by a midwife but neither Ob #1 nor Ob #2 ever made a note in the chart or on the fetal monitor strips relative to the labor. There were only brief references by the nursing staff to one of the physicians coming into the room and giving orders.

Although there were no physician progress notes, the patient's spouse was videotaping the entirety of the labor process; the tapes revealed the comings and goings of one of the two OB's—who was not involved in the delivery in any way. The OB who made two brief cameo appearances on the videotape did not walk over to the fetal monitor, and could not have seen it from his vantage point. Yet Ob #1 and Ob #2 ended up as defendants in a lawsuit because it was unclear which physician was serving in the supervisory capacity to the nurse midwife.

This example provides at least three lessons:

- Be certain that there is good documentation as to the chain of command in the clinical setting.
- When directly involved in providing care, or supervising the care of another, document all interactions.
- Be aware of contracts that define relative and supervisorial responsibilities as well as written procedures and protocols either at the acute care facility or generated by the group practice. These documents often become exhibits at trial or arbitration where the plaintiff's attorneys will attempt to demonstrate that there was some departure from these contractual obligations.

NOT ONLY BIG BROTHER MAY BE WATCHING

Physicians need to be cognizant of the pervasive use of recording devices, smart phones, laptops and tablets. Not only can many of these devices record or broadcast physician interactions with the patient and family, they can even record readings or alarms from medical monitoring equipment. A video image or audiotape can be powerful evidence for good or ill.

It is common for physicians to have no independent recollection of the events, and particularly the timing of events, concerning any one patient months, or years, after the fact. Consequently, physicians in testifying often must rely on custom and practice. It is also common to believe in retrospect that one's custom and practice was followed, or was more thorough than in fact it may have been.

(continued on page 6)

Therefore it is important at the outset of the group/patient relationship that repeated and affirmative steps be taken to make it clear that the patient is being cared for by a "team," which is structured to provide a positive and reassuring depth of resources and expertise.

Malpractice Pitfalls *(continued from page 5)*

A videotape or audio recording can remove all doubt and defeat testimony that is limited to a recitation of one's custom and practice.

PASS THE BATON, NOT A GRENADE

Change of shift among covering physicians is a recurrent opportunity for error to occur. Effective and thorough two way communication is essential between providers in giving report prior to handing off coverage. Incomplete information or complacence at this critical transition, particularly in circumstances with a high census of admitted patients and complicated clinical issues, must be avoided. Again, acuity should be assessed and triage considered in prioritizing the approach to the patients being cared for. In short, the quality of the communication between providers at this point will improve the continuity of care and limit the potential for tension between group members that invariably arises from being handed a grenade instead of a baton.

WHO'S RESPONSIBLE FOR FOLLOW-UP?

In another malpractice action, a newly pregnant patient in a group practice was admitted through the emergency department with bleeding and abdominal pain. A member of the patient's group was on call and determined that a diagnostic laparoscopy should be performed. In the course of that procedure it was found that the appendix appeared diseased. A general surgeon was called into the case and performed an appendectomy.

In that case, the Ob on call was not identified as the Ob of record. Another member of the group was identified—who had not even been involved in the current pregnancy. The surgical pathology report, which was argued to have required follow-up, was not directed to either the surgeon or the OB who performed the laparoscopy. When the report came to the desk of the previously uninvolved OB, it was believed to be a courtesy copy and that follow-up would be up to the general surgeon—who never received a copy of the pathology report. Years later, the patient had a widespread abdominal neoplasm and sued all involved.

Although there was responsibility enough to go around with multiple named defendants, the uninvolved OB, who was the only individual to see the pathology report, was among the defendants with exposure. Lessons to be learned include:

- The physician directly involved should be certain that his or her role is made clear at the facility level.
- Working as a team should mean just that.
- Laboratory data, pathology, imaging and other critical data should be appropriately routed, and the distribution lists should be checked for completeness.
- Critical data should be scrutinized by those who receive it, without an assumption that another practitioner may be responsible for responding.
- Systems should be in place to track surgical pathology, laboratory work, and imaging to provide continuity of care.

Every effort should be made to assure that the proper level of risk and acuity are appreciated, and the most appropriate available resources are engaged. This requires effective communication among the various providers and a clearly defined plan of action.

TRIAGE—NOT JUST FOR THE BATTLEFIELD

Another legal pitfall involves the triaging of patients during the course of hospitalization. In the face of an adverse outcome, the appropriateness of the allocation of resources may be questioned and the choice as to which patient or situation had priority can be challenged. There have been multiple cases in which a patient was followed by a perinatologist as a high risk pregnancy and yet was delivered by an OB who was not board-certified. Every effort should be made to assure that the proper level of risk and acuity are appreciated, and the most appropriate available resources are engaged. This requires effective communication among the various providers and a clearly defined plan of action.

Where difficult choices present themselves, documentation as to the reasoning involved in electing a particular path should be made clear. In one instance, two patients both appeared in the emergency department, both with dissecting aortic aneurisms with only one vascular team available. In that instance, it was critical that a reasoned approach be made and documented as to which patient proceeded first to surgery.

AVOID THE BLAME GAME

Physicians who immediately realize that an unexpected or adverse outcome may have the potential for litigation can respond in various ways. Where multiple providers are involved, the temptation to attribute fault to others may arise. However, if acted upon, this defensive or self-serving posture can provide considerable traction in the litigation that follows. Gratuitous finger pointing, and unbridled efforts to extricate oneself at the expense of others presents a risk for all involved—particularly when it is unwarranted, speculative or beyond the scope of the expertise of the particular provider. That having been said, the patient or patient's family should be provided full and fair information regarding the complication, its potential causes and anticipated sequelae, and direct questions should be answered if possible.

WE ARE ALL HUMAN AFTER ALL

The single unifying feature in medical malpractice actions is invariably the fact that human communication and perception are imperfect. Recognizing that fact, and vigilance in working to improve, will limit the potential for error that produces harm. ■

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