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PRF NEWS

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Covering Practice and Risk Management Issues for Physicians

Liability and the Hospitalist

BY ARIEH ROSENBAUM, MD

Even though the term "hospitalist" did not enter the medical lexicon until 1996, the number of practicing hospitalists in the United States will exceed 30,000 by the end of 2010. As a sign of their integration into mainstream American medicine, the American Board of Internal Medicine has now introduced a new focused certification in hospital medicine.

While there has been explosive growth in the hospitalist field during the last 15 years, the liability/malpractice field has not kept pace with this rapid expansion. One problem has been in data collection. Because hospitalist duties lack a classification code that is separate from other internal medicine physicians, identifying them in case data has been difficult.

What is apparent from the data that does exist is that while hospitalists are frequently named in malpractice suits, they are most often dropped from the suit. Furthermore, suits are brought against hospitalists for very different reasons than they are brought against outpatient internists. In the outpatient world, "failure to diagnose" is the most common reason for initiating a lawsuit. For hospitalists, the two major categories of liability include "failure to communicate" and "practicing beyond scope."

FAILURE TO COMMUNICATE

It is well established that patient satisfaction correlates strongly with the risk of a suit. It is also well known that patient satisfaction, in many cases, is less about the technical aspects of the care delivered, and more dependent upon the way that delivered care is communicated to the patient by the physician.

Hospitalists begin an episode of inpatient care with an inherent disadvantage over an established primary care physician: they usually do not know the patient, and as a result, a historic relationship of trust does not exist. The hospitalist must gather information to reconstruct the patient's past medical history, establish a relationship of trust with the patient, and, at discharge, communicate all appropriate information to both the patient and the primary care physician. Breakdowns can occur in any of these key areas.

Initial data gathering through the primary care physician and other sources serves multiple purposes. First, it allows the hospitalist to gain a better understanding of the patient's medical issues in order to provide optimal care. Next, it allows the primary care provider to be a part of the treatment discussion, introducing a more longitudinal perspective.

Breakdowns in this initial process may give the patient the perception of poor communication between providers ("Didn't my doctor give you that information?"). This breakdown can result in poor treatment decisions as well as set the stage for a potential lawsuit should a bad outcome ensue.

The patient-physician trust relationship must be built quickly under circumstances of severe illness and often may involve multiple family members. The patient and family must clearly understand what is being done and why, as well as what the potential negative outcomes may be. Setting expectations is crucial. Lawsuits involving hospitalists are often based on the notion that the patient became sicker after entering the hospital and the hospitalist, as the coordinator of care, is responsible for this. Transparent and consistent communication regarding the patient's care—including any mistakes made by providers—is most important.

The discharge "handoff" is another critical point in the continuum of care. Review of the hospital course, reconciliation of medications, pertinent study follow-up, and follow-up office visit should all be reviewed with both the patient and the primary care provider.

Finally, the need for communication among providers within the hospital should not be understated. The hospitalist, as the coordinator of care, is constantly interacting with

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Inside PRF News

ENHANCE YOUR UNDERSTANDING OF CODE GREEN

Code Green is the cornerstone of PRF's philosophy for helping PRF physicians and their patients manage adverse patient outcomes. There have been several articles in *PRF News* to increase the awareness and understanding of Code Green. To further enhance that understanding and to help PRF Insureds and their office staff effectively implement Code Green, PRF has developed a booklet, "Code Green: The Process" and a 20-minute presentation to accompany the distribution of the booklet.

Enclosed with this issue of *PRF News* is a schedule of Code Green meetings that will be held at the PRF offices. We request that at least one physician and one member of your administrative staff attend a meeting. Please review the schedule and let us know which of the dates works best with your schedule. Please contact Executive Director, June Riley, at (415) 921-0498 if you have any questions. ■

consultants, ancillary staff, and other support personnel. Areas of responsibility should be as clearly defined as possible, and information should be passed back and forth freely. Chart notes—an oft used communication tool—should provide clear, detailed documentation so that any provider reviewing them would be able to assume care with a full understanding of the plan of care and associated justification. In addition, documentation should be frequently augmented with verbal or face-to-face interaction.

Indeed, it appears that the rapid growth in the specialty—both in terms of numbers, as well as introductions into new service areas (i.e., co-management)—has outpaced the formalized delineation of hospitalist responsibilities and competencies.

PRACTICING BEYOND SCOPE

The wide diversity of practice within the hospitalist profession almost inherently makes liability a concern. The recent advent of co-management, in which hospitalists help other specialists (e.g., general surgeons, orthopedists, etc.) to care for the medical problems of their patients, has further blurred the scope of the hospitalist's practice. Not infrequently hospitalists find themselves in the position of addressing a problem that may not be within the scope of their practice. They may do this at the behest of a specialist ("You can remove that tube—I'll explain how you do it."), or simply because the specialist involved in the case is not reachable to address the issue. Conversely, hospitalists may defer specific treatment they feel falls more within the scope of a particular specialist, and this also becomes a potential liability.

As an example, a woman was seen in a local emergency department in the early evening with bradycardia. The patient was admitted by the hospitalist to the ICU after consultation with a cardiologist and with the understanding that the patient would be managed primarily by the cardiologist. Through the night, the cardiologist managed the patient by giving orders over the phone, but never performed an examination. The patient died early the next morning, before the hospitalist arrived for rounds. The husband filed suit against the hospitalist.

In testimony, expert witnesses for the prosecution noted that the hospitalist should have recognized the seriousness of the patient's condition, communicated this to the cardiologist, and ensured that the cardiologist took appropriate actions. The defense felt that this analysis served to hold the hospitalist to a higher standard of care than was appropriate for the specialty. The court ruled in favor of the defense and wrote that the hospitalist had met applicable standards of care for his specialty and was not responsible for the patient's death.

But what is an "applicable standard of care" for hospitalists, and what constitutes a "reasonable and prudent hospitalist?" Scope of practice liability for a hospitalist is undoubtedly influenced by the perception of the hospitalist as a "jack of all trades." Indeed, it appears that the rapid growth in the specialty—both in terms of numbers, as well as introductions into new service areas (i.e., co-management)—has outpaced the formalized delineation of hospitalist responsibilities and competencies. This applies both in the courts as well as in the medical literature. Fortunately, this is quickly changing, as professional organizations such as the Society of Hospital Medicine develop core competencies to guide both medical education and credentialing. As these core competencies become more refined, scope of practice will presumably become more clearly delineated. In parallel, the American Board of Internal Medicine's Maintenance of Certification in Hospital Medicine will further define the broad scope of duties pertaining to the hospitalist specialty. For the working hospitalist, best practices should include aligning individual skills with the core competencies and certification requirements as delineated by these and other professional organizations.

Hospital Medicine remains a young and rapidly growing field. With this growth have come new issues and ambiguities in the area of legal liability. Although the very nature of the hospitalist role will always result in some degree of ambiguity around scope of practice, clear and effective communication in conjunction with alignment of practice with professional core competencies will do much towards limiting ultimate liability. ■

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Improving Obstetrical Outcomes

BY JORDAN HOROWITZ, MD

Improving obstetrical outcome is a priority for obstetrician gynecologists and for PRF as well. This article identifies five common and recurring clinical situations that can lead to less than optimal obstetrical outcomes.

1. **Failure to observe deteriorating fetal heart rate patterns and intervene in a timely manner.**

This failure can be attributed to a number of contributing factors:

- The obstetrical nurse monitoring the labor fails to recognize the potentially ominous FHR tracing. This requires ongoing training and competence evaluation of physicians and nurses.
- The obstetrical nurse recognizes the problem but fails to communicate the information to the correct physician. In a program where the roles of the attending physician, covering physician, and in-house physician are not clearly identified, it can be confusing as to who exactly is the responsible physician to notify in the event of a problematic FHR tracing.
- The in-house physician is not advised of a problem or is too busy to follow FHR tracings himself/herself. This can be especially true when the in-house physician has multiple duties requiring his/her attention. This scenario draws attention to the need to have a sufficient number of physicians to provide adequate coverage to laboring patients.

2. **Failure of physician to physician information transfer.**

To remedy this, clear, formal sign out of pertinent patient information must be conveyed among providers, including apprising Anesthesia and NBICU of anticipated problems. Formal whiteboard rounding attempts have proved successful , but this practice has not been universally adopted.

3. **Failure to shorten second stage of labor when a non-reassuring FHR pattern is present.**

Here are three recommendations for improving outcomes when this situation occurs:

- Despite the natural tendency to support a patient's request to continue labor and hope for a spontaneous vaginal delivery, a vacuum or forceps delivery should be strongly considered in the presence of a non-reassuring FHR pattern.
- If a physician reviews only a brief portion of the FHR tracing, he/she may fail to appreciate the deteriorating overall pattern or fail to detect the onset of complications such as chorioamnionitis, which may lead to suboptimal outcomes.
- The physician should not hesitate to communicate with the patient about the need for intervention, and the physician should document the conversation in the chart in a timely manner.

4. **Failure to deal promptly with obstetrical hemorrhage**

Follow these suggestions to improve outcomes:

- Progressive obstetrical blood loss will lead to DIC and a cascade of undesirable events. Timely intervention is crucial.
- Physicians must understand the appropriate use of blood products including packed RBC, platelets, and FFP.
- Physicians must understand the use and sequence of medications including Pitocin, Methergine, Hemeabate, and Cytotec.
- Physicians must have competence in utilizing mechanical methods to address obstetrical hemorrhage, such as the Cook's balloon and B-Lynch suture at cesarean section.
- Physicians need to be familiar with nursing, laboratory, and blood bank resources at their institution.
- Physicians should recognize their need for help and not hesitate to involve in-house physicians, anesthesiologists, interventional radiologists, and/or surgical consultants. Each institution should identify the providers of such support services and clearly post a list with names and phone numbers in labor and delivery units.

5. **Failure to document in the medical record**

Two actions are strongly recommended for alleviating this situation:

- Timely documentation of your thoughts, management plan, and actions in the medical record is your best defense against malpractice litigation even in complicated cases such as shoulder dystocia and forceps and vacuum deliveries.
- Whenever a complicated delivery or cesarean section occurs, take the time to immediately dictate a note that carefully describes the findings and what was done. ■

The physician should not hesitate to communicate with the patient about the need for intervention, and the physician should document the conversation in the chart in a timely manner.

Dr. Horowitz is a member of the Patient Care and Management Committee of Physicians Reimbursement Fund.

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Top 10 Areas of Claim Costs

BY STEPHEN J. SCHEIFELE, MS, MD

Physicians Reimbursement Fund maintains a computerized database of closed claims data. That database enables an analysis of the Code Green, defense and settlement costs of different types of claims.

Following analysis, we have learned that there are 10 types of claims, as shown in the chart below, that account for 83 percent of the total of PRF's legal expenditures (on closed claims) since our organization's inception. Claims are ranked in descending order by the highest Combined Total Costs (Defense & Liability). The types and frequency of claims experienced by PRF reflect to some extent the distribution of specialists within PRF.

This type of claims data analysis allows PRF to focus risk management initiatives where they can be most effective.

Please note that these data are representative of Closed Claims Only. Of the 289 closed claims that comprise these "Top Ten" categories, 161 claims closed with zero loss payout. Eight claims closed with a loss payout of less than $1,000 (totaling $3,689). The remaining 120 closed claims account for the remainder of loss payouts of $12,579,813 (ranging from a low of $1,121 to the policy limit of $1,000,000). Of the 289 closed claims analyzed, the Birth Injury category accounts for 35 percent of the total dollars paid out in defense and loss. ■

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

Type of Claim	Closed Cases	Combined Total Costs (Defense & Liability)	Average Loss for Cost of Defense	Discussion
Birth Injury	24	$7,598,796	$316,616	This is an obvious area for potential large losses. Implementing best practices to improve obstetrical outcomes is a major initiative.
Surgical	75	$3,911,237	$52,150	This type of complication is not specific to one type of surgery and occurs in all types of medical specialties involving surgery.
Patient Death	26	$2,388,311	$91,858	Although on average a wrongful death claim may not seem high, an individual case can be quite expensive with compensation for lifetime earnings.
Delay in Diagnosis/ Failure to Diagnose	43	$2,077,469	$48,313	Frequently delays or failures in diagnoses may be linked to pathology reports that involve miscommunication or incomplete follow-up from the physician's office and/or a non-compiant patient.
Perforation	21	$1,227,696	$58,462	In most instances a perforation is a known complication of surgery. Code Green is often an effective method of addressing the pateint's needs.
Wrongful Life	6	$1,180,708	$196,785	The cost of raising an unanticipated child escalates along with the cost of living and education.
Maternal Death	5	$1,073,176	$214,635	There has been a rise in the maternal death rate in California. Maternal deaths are always an unexpected outcome for the family and leave a newborn needing care.
Fetal or	14	$1,027,302	$73,379	A fetal or neonatal death is always a tragedy for the family. Although there are 14 occurrences in this category, only one of them resulted in a large loss payout.
Dissatisfied with Outcome	41	$749,289	$18,275	The two specialties most frequently associated with the category are Plastics Surgery and Orthopedic Surgery. Often the patient's dissatisfaction is alleviated with a subsequent procedure.
Dissatisfied	34	$529,402	$15,571	Dissatisfaction with management can and does occur in most types of practice, including Obstetrics, Primary Care and General Surgery.