

Avoiding Errors and System Breakdowns

It is easy to feel hopeless in today's malpractice climate. As the American Medical Association continues to add states to its liability crisis list, more and more physicians are finding that insurance premiums are beyond their reach. This situation is forcing difficult decisions and endangering access to care, especially in rural areas and among low-income, inner-city populations.

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But physicians have more control over their liability equation than they realize. They can find ways to protect their practices from lawsuits by finding more effective medical history or consent forms or by developing more effective systems for tracking and following up on test

results, referrals, and missed appointments. They can also make sure that their communications with patients are clear, caring, and non-confrontational.

These types of solutions are already proving effective in some areas and specialties. For example, anesthesiologists have seen malpractice premiums drop (when adjusted for inflation) because of extra measures the specialty has taken to avoid errors and system breakdowns.

Defensive vs Proactive Responses

In the face of rising premiums and increased threats of claims, many physicians are making some radical changes in their practices and their lifestyles. Some have decided to retire early; others have eliminated some of the services they normally deliver

to patients, while still others have relocated to states where medical malpractice reforms have helped bring some relief in insurance rates. Caps on non-economic damages, for example, are helping in some states to stabilize medical liability premiums, according to the AMA.

Many doctors say that they are disillusioned with their chosen field. According to a recent survey undertaken by The Doctors Company (a physician-owned medical malpractice insurer that

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offers coverage to doctors nationwide), almost four out of five doctors said that the growing threat of lawsuits makes them hesitant to recommend a medical career to their children. Physicians whose children still want to pursue medical careers advise their offspring to select a specialty that is a less-frequent

target of lawsuits. For example, two out of three of these respondents would advise offspring not to choose obstetrics or gynecology.

But while these reactions may be understandable, they may not be the best courses of action for the health of the country or the practice of medicine. Defensive medicine practices and steps taken to restrict practices have potentially serious implications for cost, access, and quality of care. (For more about the effects of defensive medicine on health care, see chapter 5.)

Physicians who want to stay in practice and serve their community are now looking for positive steps to avoid potential lawsuits without practicing overly defensive medicine, relocating, or retiring. Fortunately, there is a wide range of solutions and approaches that are working in practices across the country.

Malpractice claims and insurance are a fact of life. Medical negligence, delay in diagnosis, and failure to diagnose do happen; and the repercussions can be disastrous. Patients and their families may need the legal system to address these situations. In their book *The Wall of Silence*, authors Rosemary Gibson and Janardan Prasad Singh write that “legal action may be the only way for some patients and families to get the answers they need

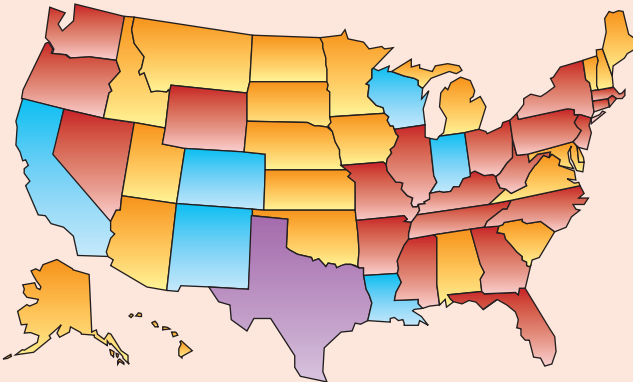
about why their loved one died or was injured. And after exhausting all other measures, it may be the last resort to hold someone accountable for a preventable death or injury.”

But the situation doesn't have to reach that point, experts say. By taking certain important steps in each and every clinical encounter, physicians can do a lot to avoid risk and to ensure that the health system works as smoothly as possible for each patient.

James W. Saxton, Esq., chairman of the healthcare litigation group at Stevens & Lee in Lancaster, Penn., says that nearly 70 percent of all claims are preventable, and 100 percent of claims will be easier to manage if proactive risk management principles are followed from the beginning. Author of the book *The Satis-*

America's Medical Liability Crisis

- States in crisis
- States showing problem signs
- States currently OK
- Effective reforms halting crisis*



*In addition to enacting a cap on non-economic damages, Texas voters passed an amendment to the state constitution validating a cap.

Source: American Medical Association, as of January 2006.

fied Patient: A Guide to Preventing Malpractice Claims by Providing Excellent Customer Service, Mr. Saxton specializes in creating customized risk management systems for health providers.

“Physicians should treat each exchange with the patient and his or her family as a moment of truth,” says Kevin M. Quinley, senior vice president of MEDMARC Insurance in Fairfax, Va., and author of the book *Bulletproofing Your Medical Practice*.

Each encounter should be approached with thoroughness, care, and candor—and, he explains, with the realization that even a brief exchange can make or break the odds of facing a liability claim.

Risk Management Steps

Physicians need to be more proactive with regard to risk management, experts say. But this doesn't automatically mean practicing defensive medicine. Rather, advises Dr. Bruce Bagley, the American Academy of Family Physicians (AAFP) medical director for quality improvement, it involves putting high-reliability systems in place in the medical office. He points to other industries, such as airlines and air traffic control, that already have such systems in place. For example, pilots follow specific checklists when taking off and landing to guarantee safety. Systematic checklists work well in medicine also, Dr. Bagley says.

Some states and licensure boards are making sure that physicians address risk management issues by requiring doctors to study medical malpractice prevention as part of their licensing requirements and by instituting mandatory reporting of medical errors by healthcare facilities. Some healthcare organizations are also encouraging—and in some cases financially helping—doctors to invest in new health information technology, such as electronic health records, electronic prescribing, and experimental safety software.

“Physicians should sweat the details,” Mr. Quinley adds. For example, he suggests the following actions that can reduce risk of errors and of malpractice claims:

- **Read and act on the results of diagnostic tests** with patients in a timely manner.
- **Communicate results to patients** with appropriate urgency.
- **Get informed consent**, including taking time to explain the pros and cons and contraindications of proposed procedures.

■ **Calibrate patient expectations** so that patients know there are no guarantees.

Fortunately, many companies and consultants offer a variety of systems and tools to reduce risk. “These tools are available to physicians and are data driven,” Mr. Quinley explains.

An excellent case in point is the experience of the nation’s anesthesiologists. Once upon a time, anesthesiologists were among the riskiest specialties to insure. Now, as a group, they pay less than other specialties. The key? Measures taken to reduce the risk of errors.

In the 1980s the American Society of Anesthesiologists set patient safety as a priority. After identifying the cause of most claims, the Society was one of the first in the country to estab-

By taking time to know their patients and making sure that their relationships with other healthcare professionals are on track, the anesthesiologists decreased risk and malpractice claims.

lish standards of care to reduce the risk of those situations. They also developed intensive training programs and raised awareness of patient safety issues. As a result, anesthesiologists have seen a significant drop in medical malpractice claims and awards, and a corresponding drop in the cost of medical malpractice insurance.

According to a recent report in the *Wall Street Journal*, anesthesiologists pay less for malpractice insurance in constant dollars today than they did 20 years ago. In addition, over this same period of time, patient deaths due to anesthesia have declined from one death for every 5,000 cases to one death per 200,000 to 300,000 cases, according to studies compiled by the Institute of Medicine.

Individual anesthesiologist practices are taking other steps as well. An article for The Doctors Company reported on actions taken by two anesthesiology groups that have had a very low number of claims over the years. From taking time to know their patients to making sure that their relationships with other healthcare professionals are on track, these doctors decreased risk and malpractice claims. For example, the anesthesiologists interviewed for the article say that they perform their own preoperative assessments rather than relying on information obtained by another provider. The anesthesiologists ask the patient specific questions about his or her prior experience with anesthesia, such

as whether the patient has any problems with nausea, vomiting, pain, or post-spinal headaches. Talking to the patients directly helps build the physician-patient relationship and ensures that the anesthesiologist gets complete information.

In addition to performing their own assessments, they also thoroughly review the medical history taken by the outpatient surgery nurse when the patient registers at the hospital. Nurses' notes often contain vital data that the patient may not have told the physician.

By analyzing actual cases of near-misses, physicians can identify systems and procedures to prevent similar lapses in the future. Mr. Quinley advises physicians take the time to step back regularly and evaluate their practice for accuracy, making sure that all staff members are up to date on the latest techniques, procedures, and tests.

Another tactic these practices have used is to encourage their doctors to specialize in areas like obstetric, cardiac, or neurosurgical anesthesia so that they develop a strong skill set and a good rapport with a small group of surgeons. All physicians in the groups take advantage of quality-assurance committee activities, which keep them abreast of the latest developments in the field

and in their particular practice. They participate in medical records reviews so that they constantly see the importance of good documentation and trade tips on how to improve record-keeping habits. All group members are encouraged to report any unusual events immediately. They then work on the problem together to make sure that they achieve the best possible outcome.

Physicians in other medical specialties can take similar steps to institute effective risk management strategies. Mr. Saxton recommends that physicians start by looking at what puts their practices at risk. For example, by analyzing actual cases of near-misses, physicians can identify systems and procedures to prevent similar service lapses in the future.

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ECRI, an independent, nonprofit health services agency based in Plymouth Meeting, Penn., has developed tools for evaluating

risk areas for medical practices. A collaborating center of the World Health Organization, ECRI's mission is to improve the safety, quality, and cost effectiveness of health care.

The organization has developed a Web-based survey to help medical practices identify gaps in compliance with procedures, patient care, and business operations. The confidential, evidence-based survey probes high-risk areas such as patient flow, timeliness of treatment, communication of critical information, obtaining authorization and consent, adequate staff and staffing mix, infection control practices, managing urgent situations, confidentiality, and more. This survey is available to physician practices and multi-practice groups on a fee-for-project basis. (For more information, go to www.ECRI.org.)

Follow-up is essential in the successful medical practice to avoid the risk of things falling through the cracks. For example, if patients are not notified of abnormal test results promptly, successful treatment may be more difficult, and the delay may open the way to a malpractice claim. Legal problems develop when lab tests were not actually performed or when the office staff or physician neglected to follow through on abnormal results, says Dr. Troxel. He advises setting up systems—either computer or paper-based—so that staff religiously follow up on lab tests, X-rays, and consultations ordered.

R. Stephen Trosty, J.D., director of risk management consulting for the American Physicians Assurance Corporation, an East Lansing, Mich.-based commercial carrier, backs this up: “Every year, American Physicians receives claims regarding patients who were not notified of abnormal test results or other significant findings,” he explains. “This typically happens because the physician did not receive or review the test results, the results were misplaced, or the patient was just not notified. In all of these instances, a delay in diagnosis and treatment or failure to provide timely treatment can result in physician liability.”

According to Mr. Trosty, claims data clearly demonstrates that a lack of systems to track and follow up on laboratory tests, referrals and missed appointments significantly increases the likelihood of claims. Furthermore, cases involving lack of notification are difficult to defend. It's important to be able to show that the physician did have a mechanism or system to track and follow up

on these details. Specifically, Mr. Trosty recommends developing and following policies and procedures that ensure that:

- All test results are returned to the physician's office from the lab.
- The physician reviews the results, then dates and signs (or initials) them to verify review.
- The patient is notified appropriately.
- Notification is documented in the patient's record, including method of communication, time, date, content, and recommended follow-up.
- The results are filed in the patient's chart.
- Appropriate follow-up occurs.

Follow-up tracking systems should ensure that every step in the follow-up process is documented in the medical record,

Creating Satisfied Patients

Each person in a physician's office—from the front desk to the back office—has an important role to play in making sure that patients receive excellent service and are satisfied when they leave.

In a Medical Group Management Association article entitled "Six Steps to Customer Satisfaction—From Patient Survey to Action Plan," Kevin W. Sullivan says that all office staff members must address customer service as a priority, not an option or an ideal to be pursued only on good days. Here are nine steps recommended to make a great first impression:

1. Acknowledge patients immediately; use eye contact and smile.
2. Let patients know of expected delays; keep them informed of their status.
3. Use the patient's last name until you sense that using first names is appropriate.
4. Use layperson's language whenever possible.
5. Be an active listener; pay attention to what the patient is saying.
6. Be helpful to patients who need help finding their way around the facility.
7. Give clear directions; answer all questions with patience and professional concern.
8. Reassure anxious patients; ask what you can do to make things easier.
9. Conclude with a friendly thank-you.

including verification and date and time information. For example, the tracking system for tests and referrals should note whether the patient actually went for an ordered test or consultation. Missed appointment documentation should provide the dates of the missed appointments as well as information about any attempts to contact the patient about the missed appointments, including time of calls and who made the calls.

Whenever the unanticipated happens, the quality of the communication that takes place after the poor medical result will drive what the patient does next.

The Importance of Communication

Physicians are sometimes surprised to learn that taking a course in physician-patient communication satisfies some state and insurance companies' requirements for risk management education. But inadequate communication between the physician and patient creeps up in many malpractice suits. In fact, says Mr. Saxton, communication issues are at the root of many malpractice claims.

Patients are much more likely to sue if they feel that the doctor has been abrasive, abrupt, uncaring, or short with them, he says. In addition, patients can sense when a doctor is rushed, preoccupied, aloof, or uninterested; so it is important to take the time to model best practices for interpersonal exchanges—such as looking at the patient while taking a medical history and giving clear, detailed explanations in lay terms.

“Communication and interpersonal skills pay off as much as technical competence for physicians because patients don't sue doctors they like, even in the face of adverse outcomes,” Mr. Quinley adds.

The Harvard Risk Management Foundation, which provides risk management and malpractice-defense services for Harvard-affiliated medical institutions, also contends that a significant number of malpractice claims stem from poor communication and mismanaged expectations before a medical procedure is performed.

Whenever the unanticipated happens, the quality of the communication that takes place after the poor medical result will drive what the patient does next. Immediate interaction with the patient or family after an event is invaluable in avoiding claims.

Experts say that physicians need to take better advantage of that first 24- to 48-hour window after an event, when patients are starting to form judgments.

Encouraging patients to take an active role in their own health care shifts the decision-making responsibility from the physician alone to a mutual responsibility of both parties.

In his book *The Satisfied Patient*, Mr. Saxton says that patients seek attorneys in the first place because of a lack of information. They may experience an undesirable result and want to know why, but their physician doesn't return their calls. The patient begins to feel angry and

wants to get the attention of the doctor.

Communication with the patient may become part of the plaintiff attorney's evaluation and evidence. For example, a physician may offer only vague non-answers when a surgical complication occurs, Mr. Saxton explains. An insensitive answer may prompt the family to go to an attorney to get the facts.

Establishing good lines of communication with patients is an essential part of running a medical practice. "If you have created a positive environment and relationship with the patient, he or she will be more likely to seek answers from you than an attorney when problems occur," Mr. Saxton explains. "It is important to get on and stay on the same side of the table as the patient. The physician is the one who can tell the patient what happened, what didn't happen, explain why it didn't happen, and what treatment or procedure the doctor is going to do," Mr. Saxton says. This is called "event management."

In addition, be alert for signs that the physician-patient relationship is souring. For example, Mr. Quinley advises physicians to review the practice's collection activity. "A lot of malpractice claims arise as counter attacks to collections," he maintains. In some cases, writing off all or part of a balance or disputed bill can go far. But before taking this step, discuss it with your malpractice insurer.

Encouraging Patients to Take an Active Role

Achieving an accurate diagnosis requires patients to provide physicians with accurate information about their health. In

return, physicians must provide sufficient information to patients so that a reasonable and informed decision regarding the treatment plan can be made. Encouraging patients to take an active role in their own health care shifts the decision-making responsibility from the physician alone to a mutual responsibility of both parties.

This should start with the first form that patients fill out at the doctor's office: the medical history. It is a good idea to place a few words at the top of the form reminding patients that the physician relies on them to provide complete and accurate health history information. For example, insert a sentence saying: "The following information is very important to your health. Please take the time to fill out this form fully and accurately."

It's also important to add a space for the patient's signature and a date at the end of the form. Mr. Saxton suggests including a phrase saying: "I attest that the above information is true and correct to the best of my belief." This helps emphasize the key role that patients play in their own care.

Be sure to discuss the diagnoses, treatment plans, risks, and expected outcomes with the patient, using medically correct wording and names, but avoiding medical terminology. Take the time to present information on treatment options, and discuss them in detail. Be sure to discuss the recovery process with the expected short- and long-term impact on the patient. (For more on communicating effectively with patients, see the July/August edition of *Doctor's Digest* on "Patient-Physician Communication.")

Another important step involves developing disease- or condition-specific information brochures that you give to patients so that they have a good understanding of the services or procedures that they will be receiving. Brochures should include a number of important points including the patient's and physician's responsibilities, the sources where patients can access additional information on their disease or condition, and contraindications and risks associated with treatments or procedures, Mr. Saxton explains in his book.

Brochures should be easy to understand and should list the pros and cons of the procedure or service that you will be performing or providing. Take the time to discuss the content with patients, reviewing key points and asking them if they have addi-

tional questions. This will not only improve outcomes and control your liability risk, but is also a good way to reduce patient anxiety and increase compliance, says Mr. Saxton. In addition, it helps prepare patients for the process of informed consent.

Informed Consent

Informed consent is required in most jurisdictions for any operative or invasive procedure. Whatever your specialty, be sure that your patient is thoroughly informed about the procedure or service before he or she signs an informed consent form. In most cases, the patient has to have time to absorb and understand the information presented.

According to ECRI, many patients in the U.S. do not receive the information they need to make meaningful decisions about healthcare treatment.

Medical experts point out that informed consent is not just a

signature on a document. It is a process that includes patient education and information exchange, and it needs to be handled very carefully. The failure to obtain informed consent is considered a form of negligence and can result in legal liability. Inadequate informed consent can increase the risk of harm to patients and expose you to liability. On the other hand, improving the informed-consent process enhances patient safety and protects against liability claims.

Physicians should look at informed consent as a way to manage the expectations of their patients, says Dr. David Troxel, medical director of the The Doctors Company. "It is important for doctors to fully explain to patients what to expect when a procedure or surgery is going to be done so they are not disappointed or misled. Take time to explain the reasons why the procedure is necessary, what the risks are, the potential complications, the benefits, and what would happen if they didn't have the surgery or treatment, he explains.

According to ECRI, many patients in the U.S. do not receive the information they need to make meaningful decisions about healthcare treatment. Unfortunately, many patients do not read the consent forms before signing them and cannot or do not understand the information presented.

Obstetricians, for example, often encounter litigation problems regarding informed consent, says Mr. Saxton. Some courts have ruled that informed consent would be necessary before performing an episiotomy or using forceps. Mr. Saxton maintains that it is extremely important for patients to know when an episiotomy must be done and why an assisted delivery might be advisable for both mother and child. The time to give that information is well before delivery—not in the heat of the moment. If the patient has received, read, and signed a brochure discussing the various options during childbirth, the parents should understand what an episiotomy entails and why it is necessary.

The consent document should include the patient's name, doctor's name, diagnosis, proposed treatment plan, alternatives, potential risks, complications, and benefits. It is a good idea to include a statement to the effect that the information listed on the form covers only information that applies generally, and that the physician will personally discuss specific factors with the patient. The form should be signed and dated by the physician

A Personal Health Record

Electronic medical records offer many advantages for augmenting patient safety and providing continuity of care. Unfortunately, many physicians' offices—especially small practices—have not been able to implement a system. But that doesn't mean patients have to wait to start using an EMR. Technology that can provide individual patients with a secure, interactive personal health record is already accessible to patients. iHealthRecord, for example, is one available system that has received the endorsement of the American Medical Association.

The system was developed by the San Francisco-based Medem, a physician-patient communication network founded by U.S. medical societies including the AMA and the American College of Obstetricians and Gynecologists.

iHealthRecord houses critical personal health data for use by physicians or emergency departments, including current medical conditions, medications, past surgeries, and allergies as well as end-of-life directives. Patients can update their own medical data, or their physician's electronic medical records system can do the updating. This helps to facilitate information exchange between healthcare providers.

and the patient or his or her legal guardian.

The Doctors Company offers an online informed consent resource. Sample consent forms are available for a wide variety of general and specialty-specific procedures. For more information, visit www.thedoctors.com/consent.

ECRI offers a report titled “Informed Consent,” which discusses the challenges involved in obtaining the patient’s consent. The report includes tools to assist with patient education, as well as lessons learned by facilities that have been sued by patients who alleged that these organizations failed to obtain informed consent. For information on ordering the report, contact Sharon Murphy at smurphy@ecri.org.

Multimedia Solutions

Research shows that during consultation with physicians, patients retain only a portion of the information they hear. One study published in *Patient Education and Consulting* found that patients who hear information recalled only 15 percent of what

This electronic medical information is also helpful when a patient goes to the emergency room. Patients can control who can view their records, and they receive a history of each use. “The patient presents a card in the ER and the card is run through a scanner to access that individual’s personal health record and medications,” explains Dr. David Troxel, medical director for The Doctors Company.

iHealthRecord also provides a suite of unique services to help increase medication adherence, to enhance continuity of care, and to improve patient-physician communication. In addition, patients are able to receive education programs specific to their medical conditions, automated reminders regarding their medications and conditions, as well as Food & Drug Administration-related safety warnings and recalls.

The services that Medem Network offers adhere to the eRisk standards for physician-patient interaction on the Internet, developed by the nation’s top professional liability carriers, medical societies, and state boards.

Medem says that the iHealthRecord system is available to anyone in the U.S., at no cost, from many physician practice Web sites, as well as leading physicians groups and via www.ihealthrecord.org.

was said. Patients who do not fully understand their condition, procedure, or post-operative care are more likely to have problems afterwards.

Presenting information in different formats may help them understand and remember more of the material. (In the study cited above, recall rose to 85 percent when the information was presented with pictures as well as words.) Being able to review information a second time may also enhance understanding.

Advocates say that multimedia patient education programs help to manage patient expectations, improve satisfaction levels, save time, and provide critical documentation.

Experts say that it makes sense to look into the use of multimedia programs, which allow patients to view a virtual procedure on a computer in your offices or at home on their own computer.

“The programs take patients through the pre-operative, the operative, and post-operative expectations for various procedures,” explains Dr. Troxel. After viewing the program, they can ask their doctor any questions they may have.

Physicians and hospitals that use these multimedia programs believe that they help patients and their families understand the procedure and the recovery period. These interactive programs better prepare patients to care for themselves after the procedure. In addition, they help match a patient’s expectations with reality, which in turn reduces the possibility of a lawsuit.

One Chicago-based developer, Rightfield Solutions, produces multimedia, interactive programs, which it sells under the name Emmi (Expectation Management Medical Information). Each Emmi is a brief, interactive, multimedia program that improves the overall patient experience by giving patients a working understanding of their upcoming medical procedure, its risks, benefits, and aftercare.

The program generally begins with a simple anatomy lesson, followed by a description of the condition, and an overview of the procedure for which the patient is scheduled. Patients can interact with the program, and each click is recorded to create a permanent record of anything the patient types or selects.

If necessary, the entire patient experience can be recreated for

judge or jury in the event of a malpractice claim. Dozens of procedures are available for patients to view, including gastric bypass surgery, C-sections, laser eye surgery, coronary artery bypass surgery, and colonoscopy.

The programs are considered a powerful risk management tool. A number of malpractice-insurance carriers provide premium-rate discounts to physicians who use the programs with patients. Those who advocate their use say that they help to manage patient expectations, improve satisfaction levels, reduce the time the physician has to spend on the informed-consent process, and provide documentation critical to risk management. (For more information on the Emmi programs, go to www.rightfield.net.)

Another company, Patient Education Institute in Iowa City, also provides interactive patient education systems for 20 medical specialties to more than 1,000 hospitals, clinics, and physicians' offices around the country. The company has interactive kiosks in waiting rooms to educate patients about procedures and to document the sessions for risk managers in order to verify that the information was actually received and that patients took the time to listen and interact with the program.

Keeping Meticulous Records

Medical malpractice lawsuits can be won or lost based on the quality and content of medical records. "It is especially important to document in the medical record the rationale for any critical decision-making because this focuses more on areas that are difficult to evaluate accurately," says Dr. Troxel. Crucial decision-making also requires a combination of experience and subjective judgment, which means that the same information can lead different physicians to different conclusions. It is especially important to document your line of thinking in these cases.

It is possible that a suit without merit may actually be lost because the medical record was vague, incomplete, or altered. For example, rather than saying the patient is doing "OK," be more specific—for example, "He has less pain today and ate a full diet." It is important to avoid being subjective. Instead of saying that the patient is "drunk," write that the patient is "unsteady, speech is slurred, and breath smells fruity."

In addition, each time you see the patient, be sure to record a

full set of vital signs and the weight of the patient. Dr. Edward G. Zurad in his article “Don’t Be A Target for A Malpractice Suit” (June 2006 issue of *Family Practice Management*) writes that when he reviews charts for cases that have gone to litigation, he often finds that this important information is missing. Such missing data can be very important in “failure-to-diagnose” cases.

“Juries never forgive physicians with dangerously messy handwriting—or the colleagues who let them get away with it,” says Mr. Saxton.

Phone calls often escape the documentation process. As a result, experts maintain that the telephone can be one of the most dangerous communication methods when it comes to profes-

sional liability. When talking by phone with a patient, be sure to obtain as much information as possible about the patient, and prescribe or advise by phone only when you are knowledgeable about the patient’s medical history. Once the phone call ends, make sure that the encounter is noted in the patient’s record.

Physicians should use a standardized method of documentation, especially those in a group practice. Always make sure that the chart is clear, well-organized, easy to use, and understandable, and see that it includes important information to allow continuity of care. Clear documentation reduces liability exposure, prevents medical errors, and creates a safer environment. If you are not using an electronic medical record, be sure that everyone writes as clearly as possible so that entries can be read easily by those who need the information.

“Most defense attorneys have sat through a deposition in which one member of a group could not decipher another doctor’s notes. Juries never forgive physicians with dangerously messy handwriting—or the colleagues who let them get away with it,” writes Mr. Saxton in his book.

The Doctors Company offers the following guidelines to make sure that your records are thorough and accurate:

- Be certain that your entries are clear and readable. If possible, dictate all long entries that require more than brief or routine annotations.
- Do not squeeze words into a line or leave blank spaces of any sort. Draw diagonal lines through all blank spaces after an entry.

■ Never erase, write over, or try to ink out an entry. In case of error, draw a single line through the incorrect entry, with the date, time, and your initials in the margin.

■ Do not add anything to the record unless you write a separately dated and signed note. The patient, a third-party payer, or a plaintiff's attorney may have a copy of the patient's original records. The entry date for ink or type cannot be made accurate retrospectively, and any alteration after the fact will seriously compromise the defense of your case.

■ Also indicate the date and time of an entry. Be sure that each page is dated and has the patient's name, and that each progress note is also accompanied by the date and time. Initial and sign all entries.

■ Keep a record of when and by whom the medical record is photocopied.

■ Retain records for adult patients for at least 10 years from the date of the last visit; for minor patients, keep them for 28 years from birth.

Dr. Zurad recommends documenting every test that you order or recommend. "Record your proposed diagnostic and treatment plan so that if the patient chooses to disregard your advice, you will have a strong written defense rather than relying on your memory," he advises. It is also a good idea to document non-compliance on the part of the patient to any of the treatments or tests that you recommend.

Some entries to include are the following:

■ Results of a patient's physical examination, noting any variation from normal

■ Patient history, with particular emphasis on current medications and allergies

■ Signed and witnessed consent forms for special procedures or surgery

■ Patient's response to medication and procedures

■ Patient's failure to follow advice or keep appointments and refusal to cooperate. Always log missed appointments and follow-up telephone calls and letters.

■ All significant laboratory or x-ray reports and the dates when ordered and read

■ Thorough documentation of any patient's grievance, including

the date and time

Mr. Saxton also recommends keeping track of all educational and other information that you give to patients. This includes patient brochures, informed consent, pre-operative instructions, and dietary restriction instructions. A simple check-off sheet in the patient's chart can help document the types of handouts that you have given the patient. This provides a record in case a patient says, "I never received that information."

Technology Solutions

Technology is helping to reduce medical errors and may help physicians avoid potential lawsuits. Implementing an Electronic Medical Record (EMR) system, for example, can enhance the flow of and access to important patient information 24 hours a day, 7 days a week. EMRs also eliminate the nagging problem of not being able to find a patient's chart because all these records are available on the computer. "These systems also force better documentation," says AAFP's Dr. Bagley.

EMRs are an organized collection of records pertaining to an individual patient stored in the computer systems and databases of providers who care for a particular patient. They can provide a patient's treatment history, including medical records, medication history, laboratory results, and other pertinent health data. They have been shown to facilitate the work of physicians and other providers by supplying the clinical information that doctors need. In addition, they provide physicians with alerts and reminders, such as the need for specific tests.

Unfortunately, EMRs are expensive to set up and are not being implemented as rapidly as many in the health profession would like them to be, says Dr. Troxel. Another problem, he points out, is that while some individual physicians and practices may have an EMR system, it is unlikely that all the other physicians from whom they receive referrals will have the same electronic capability. It may take some time before these problems are solved.

In the meantime, one important development that promises to help reduce errors and the potential for lawsuits is the electronic personal health record that individual patients are beginning to use. With this system an individual's health information is available electronically via the Internet. The patient can offer a new

physician access to the file, or print it out instead of filling out a history form. Since each time someone else writes down health information, there is the possibility of error, this system can result in a more accurate, consistent record, says Dr. Troxel. In addition, patient safety is increased because personal health records can provide drug alerts and help identify missed procedures and services. (For more on personal health records, see sidebar on iHealthRecord).

Electronic prescribing systems, known as computerized prescriber order entry (CPOE), are available to help reduce medication errors, especially those relating to the legibility of a doctor's handwriting. These systems require doctors to enter medica-

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tion orders into computers installed throughout an organization, rather than to write them on paper or to tell a nurse which drugs to order. These systems can check for harmful drug interactions and can alert physicians to a patient's allergies. Many hospitals now require staff physicians to use a CPOE.

Personal digital assistants (PDAs) also allow physicians to carry computerized patient information outside the office as well as enabling them to input data collected outside the medical office. There are also computerized clinical decision support systems (CDSSs) that are designed to improve clinical decision-making. These systems provide physicians with patient-care recommendations through the analysis of patient-specific clinical information.

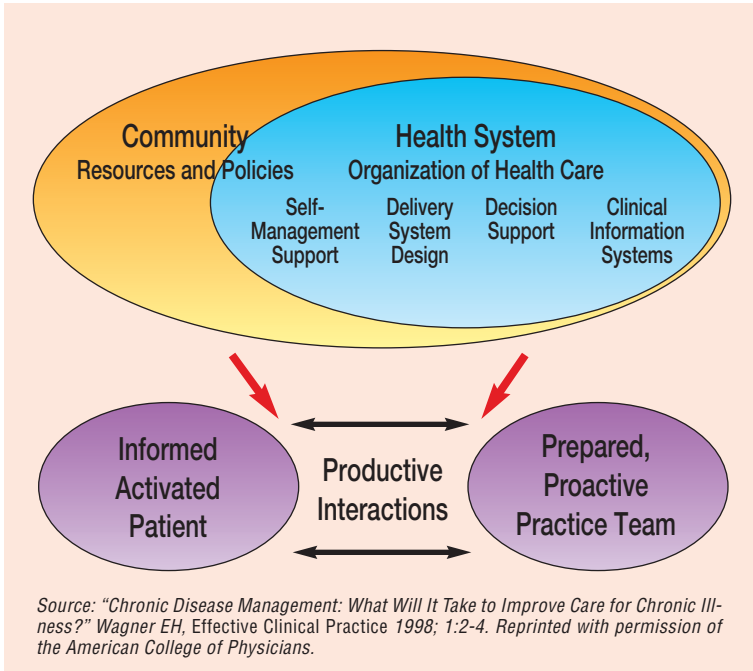
Despite these helpful improvements, bedside manner and interpersonal skills may count more than the latest gee-whiz technology when a physician is at risk of becoming a defendant in a claim or lawsuit, says Mr. Quinley. "Electronic prescribing, medical records systems, and electronic reminders are quickly becoming the state of the art and the standard," he adds. "The latest technology is not a panacea, but it can help you manage in a way to routinize the more mundane tasks so you have more time to provide higher quality interactions with your patients," he says.

(For more about EMRs and other technology solutions for medical practices, see the January/February 2006 edition of *Doctor's Digest*, "Technology in Practice.")

Utilizing the Chronic Care Model

Physicians should take the time to investigate and implement what is known as the Chronic Care Model in their medical practices, says AAFP's Dr. Bagley. The model encourages providers to be prepared and proactive, and encourages patients to be informed and active in their own health care. Those who support this systematic approach to care believe that it will help reduce medical errors, improve outcomes, and reduce liability claims.

This Chronic Care Model was developed during the 1990s by Dr. Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation and Group Health Cooperative of Puget Sound, a health maintenance organization in the state of Washington. It is based on the premise that providers who care for



patients with chronic conditions can be better supported with guidelines, specialty expertise, and information systems.

To help with this effort, the Robert Wood Johnson Foundation set up a national program known as Improving Chronic Illness Care (www.improvingchroniccare.org). The effort is designed to correct many deficiencies in current management of chronic diseases, such as rushed practitioners who are not following established practice guidelines and the lack of active follow-up to ensure best outcomes.

A recent University of Pittsburgh study, published in the April 2006 issue of *Diabetes Care*, found that a clear association exists between implementation of the chronic care model and improved health in diabetic patients. The study involved diabetic patients who visited 11 Pittsburgh-area primary care clinics between 1999 and 2003.

Primary care physicians may want to start such a program for patients with chronic diseases, such as diabetes. By establishing a registry of patients with diabetes, along with their key health measures, it is possible to track the care provided and to ensure that patients receive necessary laboratory work and preventive screenings according to established guidelines, helping to avoid errors and potential lawsuits.

Dr. David D. Ortiz, in his *Family Practice Management* article “Using a Simple Patient Registry to Improve Your Chronic Disease Care,” recommends using a spreadsheet program, such as Microsoft Excel, or a database program, such as Microsoft Access, to create a list or registry of your practice’s patients with a given chronic disease; you could then use that list to track key measures and to remind you and your staff when patients need certain labs and preventive services.

Saying “I’m Sorry”

Even with the best risk-avoidance measures in place, unexpected outcomes happen. A growing group of health and legal professionals are advocating that physicians use two simple words to help avoid lawsuits: “I’m sorry.”

This strategy is being promoted by The Sorry Works Coalition, a national educational and lobbying group (www.sorryworks.net) based in Illinois. This national organization encour-

ages physicians to immediately disclose to the patient when there is an adverse event, complication, or error, says Dr. Troxel. According to Dr. Troxel, this is most effective when physicians are involved in a structured program with written protocols that involve training on how to communicate bad outcomes. “It is not

Proponents believe that apologies and upfront financial offers could mean the difference between settlements costing thousands of dollars and prolonged malpractice lawsuits costing millions in attorney fees and jury awards.

something we think is a good idea for a doctor to do on the spur of the moment,” Dr. Troxel points out. The Doctors Company is promoting the idea to its member doctors who practice in institutions that have such a program in place.

A big advantage of these programs is that they help diffuse anger. “If something happens and no one tells the patient or his or her family, they feel like something is being concealed. They get angry, and anger has a lot to do with rising malpractice claims,” says Dr. Troxel. In most cases, these programs also involve compensating the patient for additional medical expenses or additional time loss beyond what would have been anticipated as the normal recovery period.

In 2005, Illinois became the first state to adopt this type of disclosure program. Their pilot project supports provider organizations that agree to implement and study the impact of full disclosure of medical errors. It also provides economic and regulatory protection in the unlikely event that their disclosure activities increase liability exposure.

The University of Michigan Health System has been encouraging doctors since 2002 to apologize for mistakes. This change in policy has dramatically reduced the number of pending law-

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suits against its hospitals, reduced the costs of defending against suits from an average of \$65,000

per case to \$35,000 per case, and cut the time it took to resolve cases from three years to about a year.

But how does the program work? If a bad outcome occurs, the hospital investigates the suspected error and confers with the patient and the patient's lawyer to review what happened. If the staff is found to have made a mistake, they apologize and offer a settlement. If the treatment is shown to be justified, the staff meets with the patient to explain why. If a patient decides to sue after this, the hospital still defends itself against the litigation.

Some doctors worry that if they actually say they are sorry, the gesture could backfire in a court of law. To deal with this concern, many states have passed legislation saying that doctors' apologies may not be used against them in court.

Proponents of this approach believe that apologies and upfront financial offers could mean the difference between settlements costing thousands of dollars and prolonged malpractice lawsuits costing millions in attorney fees and jury awards.