Risk Management

Communicating Critical Test Results, Part III
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General Introduction/Overview

Communication issues underlie many patient safety problems, and communication breakdowns are contributing factors in most malpractice suits. The following claim abstracts provide examples of communication breakdowns with respect to critical test results that can affect patient safety and result in liability claims for healthcare providers and/or organizations.

Healthcare risk management and patient safety literature contain numerous accounts of medical errors caused by communication failures and a high proportion of liability claims and malpractice lawsuits have been attributed, at least in part, to communication-related issues. Additionally, ineffective communication was the most frequently cited root cause of sentinel events reported to the Joint Commission between 1995 and 2004.

Common risk factors in these types of claims include:

• Failure or delay in ordering tests
• Failure or delay in detecting incorrect test results
• Failure or delay in reviewing test results
• Failure or delay in acting upon abnormal test results
• Failure to inform (provider, patient, primary care or attending physician) of existence of test results

And a trend that has recently resulted in some large claims:

• Failure to ensure that the patient has actually had the tests done that were ordered.

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General Liability

Preventing Wrongful Termination Lawsuits
By: Amy Slufik
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In this section of Risk Review, our risk management experts highlight important information, tips and recommendations as they relate to safety and security issues that could arise at your practice or facility.

Preventing Wrongful Termination Lawsuits

Employees are becoming more and more knowledgeable about their rights, resulting in an increase of wrongful termination claims, as well as an increase in the amount of damages and legal costs to defend them. There are several laws that employers need to be aware of when terminating an employee, including the Conscientious Employee

about how to prevent wrongful termination lawsuits – please be advised that Princeton Insurance DOES NOT offer this type of coverage. If you are interested in learning more about wrongful termination coverage, or would like to review the details of your policy, always contact your independent agent.

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**CME & CDE Training**

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In Princeton Insurance’s continuing effort to partner with our insureds, we are pleased to offer you an opportunity to improve your risk management practices and earn continuing education credit (CME and CDE). This opportunity has been well-received by New Jersey physicians and dentists, and is offered through Zarin’s Medical Liability Alert and Dental Liability Alert publications.

These publications provide a composite of actual malpractice cases, complete with details about trials and practical risk management advisories written by experienced malpractice attorneys.

This excellent program offers the following benefits:

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- Reduced exposure to liability through avoidance of common practice errors
- Twelve hours of Category 1 CME credit for physicians
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Risk Management, in addition to

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**Risk Management**

**Physicians’ Response to Patient Safety and Quality Initiatives: Coordinated Efforts Recommended**

By: James B. Couch, M.D., J.D., FACP
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**First: The Good News for Physicians!**

Literally in the eleventh (if not twelfth) hour at around 4 a.m. on Saturday, December 9, in its final gasp, the 109th Congress voted to forego the previously HHS ordered 5.1 percent decrease in Medicare reimbursement for physicians in 2007. Instead, reimbursement will be frozen this year. That may not be cause to pop the champagne corks, but as W. C. Fields would respond to a question about his life: “Not bad, considering the alternative.”

**A Hidden Bonus: Pay for Performance?**

Tucked into the legislation freezing 2007 Medicare physician reimbursement rates was a provision that beginning in July, 2007, those who submitted quality information in 16 (as yet to be finally determined) areas on some (also as yet to be determined percentage of their Medicare patients) would qualify for a 1.5% “bonus” in their Medicare reimbursement. At least initially, all that physicians will need to do is to submit the quality information. Their 1.5% bonus will not be conditioned on their quality results. Also, those physicians not submitting the required quality information will not be penalized. They just won’t get the 1.5% bonus.

This represents yet another move by the federal government into what has now come to be known as the “Pay for Performance” arena. There are over 100 such initiatives in various states of evolution in the private sector. Also, last August, President Bush signed an Executive Order requiring all those delivering health care services to federal beneficiaries in the Medicare and Medicaid programs, the Veterans and Military Health Systems and civilian federal employees (covered by the Office of Personnel Management) to make the quality and cost (price) of their services known. This is all part of the Bush Administration’s Transparency Initiative intended to provide this type of information to patients, their families and others in the federal sector involved in both the receipt and purchasing of health care services. HHS Secretary Michael Leavitt is pushing hard for Pay for Performance (also known as Health Care Value Purchasing) to become a significant force in

the purchasing and delivery of care to government subsidized beneficiaries before the end of his tenure in 2009.

**Is All This Going to be Worth It? Recent Research and Other Initiatives**

For now, the reward for submitting the required quality information is not that great – only a 1.5% increase in reimbursement. For physicians who would either have to expend a significant amount of their or their staffs’ time to collect and report this information and/or to install electronic systems capable of doing this, the return on investment (strictly from a financial perspective at least) may not justify it. Based on the relatively limited number of studies completed on the impact of Pay for Performance, the consensus is that incentives approaching 10% of base reimbursement will probably be required for most physicians to make the necessary investments not only to report on quality, but, more importantly, to improve results sufficiently to qualify for that extra money.

In addition, most researchers would have to admit that the proverbial jury is still out on whether improved adherence to best medical, safety and preventive practices results in significant improvements in the outcomes of medical care. A recent study by researchers at the University of Pennsylvania published in the December 13 edition of the “Journal of the American Medical Association” (JAMA) demonstrated that there was not that significant a difference in the mortality rates of patients whose physicians were in the 75th vs. 25th percentile in adhering to 10 of the so-called Hospital Quality Measure Set standards of care promulgated by the federal government for the treatment of myocardial infarction, congestive heart failure and pneumonia. (Werner, Bradlow, Relationship between Medicare’s Hospital Compare Performance Measures and Mortality; JAMA; 2006: 296:2694-2702).

However, the Penn researchers were comparing mortality, as opposed to a potential myriad of other

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Dealing With Deceased Patients’ Medical Records

By: Denise L. Sanders, Esq.

Question: What do I need to know about releasing copies of medical records of deceased patients in my practice?

Answer: Unless involved in performing autopsies, most physicians generally do not consider the liability that exists from the way patients are treated after they die. However, at a time when many different areas of law can apply to the same issue, it is important to understand how to deal with a patient’s medical records, once he passes away.

The main body of law that governs patient records is the Health Insurance Portability and Accountability Act’s (HIPAA) Privacy Rule, which requires a covered entity (which includes a physician and/or medical practice) to protect the medical records, or “Protected Health Information” (“PHI”), of a patient. This obligation continues even post-mortem, and is quite similar to the obligation that exists when a patient is still alive. The primary, and obvious, distinction is that authority over records can no longer belong to a deceased patient. Upon death, this authority gets transferred to the patient’s “personal representative.” Under 45 CFR § 164.502(g)(4), a covered entity must treat a person as a personal representative, “If under applicable law an executor, administrator or other person has authority to act on behalf of a deceased individual or of the individual’s estate.”

A personal representative is generally appointed in a will, where an individual selects the person to carry out her wishes at death. This person is then granted either a letter testamentary or a letter of administration. If a personal representative has been appointed, it is important to note that authorization to release records then lies only with that person, who may be someone other than a former spouse or another family member. In fact, even if a decedent had provided a surviving party with a separate form granting authorization to obtain or grant disclosure of medical records, there is risk in relying on that as continuing authority. Even though the actual person whose records are at issue granted authority to another person to obtain or release the deceased’s records, technically that person loses authority to the appointed representative immediately upon death. To avoid this conflict, a separate authorization should be included from the deceased’s representative for any further disclosure of the patient’s PHI. Any use or disclosure that has already been made in reliance on the now deceased patient’s authorization is valid, however.

If an individual dies without appointing a personal representative in a will, then state intestate laws govern. In New Jersey, this authority would automatically first pass either to a surviving spouse or a surviving domestic partner, who receives the same treatment for these purposes under New Jersey law. To officially become appointed through intestate law, a party must first consent to the responsibility (See N.J.S.A. 10:3B-2.)

Exceptions

Since privacy laws were created to protect patients from having their personal histories made public in ways against their wills, exceptions were created to avoid preventing professionals from carrying out their jobs in good faith. For example, healthcare providers can exchange the PHI of a deceased patient among one another if the purpose is to treat another patient, mainly in the case of a relative with a potentially similar genetic makeup. Also, in the event that covered entities want to notify family members or representatives of a death, or need to identify deceased persons to establish the cause of death, authorization is likewise not required. Some additional exceptions for professionals permit funeral directors, organ procurement organizations, and law enforcement personnel to obtain information consistent with carrying out their jobs.

Beyond these carefully carved out exceptions, PHI can also be transferred under the umbrella of research, but only if the researcher provides a covered entity with assurance that the information will strictly be used for, and is necessary for, research on the PHI of decedents, and provides supporting documentation to confirm the death of the individual.

Perhaps the most unnerving requests for medical records are those associated with any pending or

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The above listed communication errors can happen in laboratory, radiology, and other diagnostic tests in inpatient, emergency and ambulatory settings.

Ordering tests, reporting results, reviewing results and acting on them are all steps in a complex medical care process. This process must be recorded in the medical record, both for quality of care needs and to provide a defense in the event of a claim.

In this issue of Risk Review, we conclude our three part series on this topic and review strategies for improving communication, with focus on reporting and acting upon critical lab test results, and action recommendations to improve communication among healthcare providers and between providers and patients.

Case Summary

The 57 year old male patient presented to the local hospital ED with complaints of severe left lateral back pain, lethargy and fever. Chest x-ray was interpreted as showing retro-cardiac infiltrates and WBC was elevated (12.5). On physical exam, the ED physician found crackles and wheezes in the left lung. Blood cultures were drawn during the ED visit. A diagnosis of pneumonia was made. The patient was treated with antibiotic and discharged to home on a ten-day course of antibiotic. Written discharge instructions stated to take meds as prescribed and contact his family doctor if he had any of the following symptoms: trouble breathing, increased fever, chest pain or blood in cough; if not better in 2 days; not completely better in 10 days or if he experienced any new or severe symptoms.

Approximately 20 hours later, the pathology lab called the ED and advised the nurse that the preliminary blood cultures showed gram positive cocci in chains. The nurse brought this to the ED physician’s attention, and he called the patient soon after. There is a factual dispute, however, as to what happened during this call. The ED physician documented this call on a “Call Back Documentation” form. He wrote, “Called patient and updated him of results. Negative fever. Less pain. Negative cough. Negative nausea/vomiting. Negative lightheadness. Will follow-up with family doctor. Return ED PRN.” He also noted, “positive blood culture: gram positive cocci in chains.” According to the patient, the ED physician simply asked him if he planned to call his PCP and the patient replied that he would.

The patient testified that the next day he called his primary doctor’s office, spoke with office personnel and told them he had been diagnosed with pneumonia at the Hospital ED. He did not make an appointment to see the doctor at that time, because (as he later testified), he was feeling better on the day time, the PCP obtained the prior lab results and learned that the patient’s blood culture tested positive for viridian strep, which can cause endocarditis. Also during this office visit, the patient first reported having had extensive periodontal work done in the month before the first ED visit. The PCP’s differential diagnosis after this visit included endocarditis, lung cancer and pneumonia.

When repeat blood cultures, drawn during that visit, came back positive for the same organism, the PCP admitted the patient to the hospital for IV antibiotic therapy. During this admission, a cardiac echo was interpreted as showing findings consistent with endocarditis with vegetation on the aortic valve. The patient was subsequently discharged to home after 4 days, with a treatment plan for continued IV antibiotics via a PICC line. Two days later, the patient suffered a stroke; he was initially brought to the community hospital, but then transferred to a tertiary hospital for further care.

The patient has permanent disability related to the stroke: Impaired neurological function of the left arm and leg; significantly impaired gait; and, he sometimes uses a cane to walk.

Case Outcome

The lawsuits were settled without trial, on behalf of the Hospital, Primary Care Physician, and ED Attending Physician.

Risk Issues

• Delay or failure to diagnose often arises when patients see several different healthcare providers who don’t communicate with each other, or when patient’s complaints aren’t taken seriously. In this case, blood cultures were ordered and begun while the patient was seen in ED, but was discharged home before results were available. The responsibility for notifying the patient or his PCP with critical test results was not clearly spelled out.

• The patient did not understand significance

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Wrongful Termination, continued from page 1

Protection Act (CEPA) which protects employees from retaliation, the Age Discrimination in Employment Act, Americans with Disabilities Act, the Equal Pay Act, and the Civil Rights Act. These laws are constantly changing, and it is important that employers are knowledgeable and keep up with them.

Most employees are hired for an indefinite period of time and are considered employees “at will,” though an employee can be hired via express contract for a specific period of time or the “at will” provision may be overridden by an implied contract (i.e. employer assuring continued employment, salary increases, bonuses, commendations, etc.). Though the State of New Jersey recognizes the concept of employment “at will,” which means that an employer can terminate an employee at any time, for any reason or no reason, and without giving the employee prior notice, this will not prevent a lawsuit based upon violation of the above employment laws.

Handbooks and policies

Employers should have a written employee handbook and employee policies and procedures which include the types of conduct that are subject to disciplinary action, including termination. Employers should also make sure their employees are aware of the handbook and employee policies and procedures, whether they are posted in a conspicuous place and/or given to the employee and a written acknowledgement of receipt is obtained. The state recognizes that employee handbooks, etc. can be considered contracts, unless there is a prominently displayed disclaimer, so it is important to have your employee handbooks and other employee policies and procedures reviewed by an employment law attorney, not only initially, but after any changes or amendments.

Performance expectations should be outlined in a written job description and provided to the employee. Also, these expectations, specific examples of not meeting the expectations, ways to improve, and the consequences of continuing to not meet the expectations should be reviewed at least annually with the employee during a written performance evaluation and filed in the employee’s personnel file after the employee signs it acknowledging the meeting. Any additional follow-up meetings should be documented in the same fashion. Disciplinary action, including termination, should be based upon the employee’s performance and/or conduct, not on their age, race, color, national origin, religion, gender, prior complaints, etc. Employers have to be especially careful when an employee falls within a class protected by acts mentioned above.

Be mindful – don’t retaliate

It is also important to treat an employee who complains about discrimination or harassment with care. Retaliation is often subjective and can include actions that the employer takes with the best of intentions. Remember to focus on the wrongdoer, not the complaining employee when trying to resolve a situation. The employer needs to fix the problem, not remove the complaining employee from the situation. Even if the original complaint turns out to be unsubstantiated, as long as an employee can prove that there were negative effects as a result, the employee can win a retaliation claim. Steps to take to prevent retaliation is to establish a policy against it, communicate with the complaining employee, keep the complaints received confidential, and document everything, consider sending the complaining employee a letter confirming your discussion. Remember, you can take actions against a complaining employee for other reasons, but be prepared to show that you have valid reasons unrelated to the complaint, including documentation of prior warnings.

Stick to the rules

When disciplining an employee it is very important to follow your company’s written policies and procedures. Make sure managers work with Human Resources and are trained properly on these policies. Follow a progressive disciplinary action approach, whenever appropriate, which includes the use of verbal and written warnings, probation, suspension, transfer and/or demotion. Make sure the disciplinary action is in proportion to the seriousness of the action/violation; be consistent with the type and severity of the corrective action imposed on other employees under similar circumstances, no matter who the employee is. This progressive approach will prove that the company’s policy was applied fairly and allow for the employee to be aware of their action/violation and an opportunity to correct their behavior. Ample time should be given to the employee to improve his/her performance as determined by your company’s policy, but be fair and consistent. In general, several warnings should be given to the employee before termination is considered, unless it’s related to extreme misconduct.

Every step of the process should be thoroughly documented in common sense language that can be easily followed, with specific corrective actions and, if possible, quantifiable performance measures. Verbal and written warnings, with specifics about the particular issue, details of the conversation, and the potential consequences, should be documented and signed by the employee acknowledging the discussion and placed in the employee’s personnel file. It is important that no evidence is destroyed, because, if this is discovered, the courts will more than likely assume it would have supported the plaintiff. Key personnel documents should be kept for at least a few years.

Take time to investigate all sides

Employers should carefully investigate the situation surrounding the disciplinary action/termination and make sure they have a specific, legitimate, non-discriminatory reason for terminating the employee. Obtain all sides of the story and be fair to everyone involved, obtain sufficient evidence to back-up your decision, and make sure you are not swayed by one individual’s version, especially if the person has their own agenda. Never terminate an employee on the spot. If the action/violation is extremely serious, consider suspending the employee (with or without pay) pending the outcome of the investigation to allow you sufficient time to confirm the circumstances surrounding the action in order to discipline appropriately. Make sure you keep the names of the individuals you spoke with confidential, especially from the person being terminated. Consider contacting your employment law attorney for guidance.

Take the proper steps before termination

Before terminating an employee, make sure your decision was well thought out and that you have reviewed and taken into consideration all prior disciplinary actions for the same type of action/violation, as well as the possible impact of the employment laws. Have at least one high-level management representative trained in employment-related matters review the situation, making sure there is solid evidence and the reason would be considered fair and reasonable by an unbiased third party hearing both sides of the story (i.e. jury) prior to approving the termination. Discuss your
future litigation. PHI requested for purposes of
litigation are subject to an entirely
different set of very specific rules, the
precise details of which are beyond the
scope of this article, but physicians should
always first ensure that the PHI requested
for legal proceedings can legally be
disclosed. If a physician is a party to the
litigation (e.g., a defendant in a medical
malpractice suit or plaintiff in a suit for
reimbursement), PHI can be used or
disclosed as part of the physician’s “health
care operations” (See 45 CFR 164.501),
including for the purpose of justifying a
particular course of treatment. However,
physicians can only offer this information for
that narrowly defined purpose.

When a physician is not a party to the
litigation, and consent cannot be obtained to
release PHI, physicians are again charged
with the burden of making reasonable
efforts to ensure that the PHI is being used
only for the narrow purpose that it was
intended for. The specific intentions can be
found by reading the original requesting
document, which may appear in various
forms including a subpoena or court order.
Moreover, when responding to a subpoena,
covered entities must confirm that efforts
have been made to inform the patient that a
request has been made for disclosure of
her medical records and the patient given a
sufficient time to respond or object. In the
event that the party for whom the records
apply is deceased, efforts to locate and
notify the representative should then be
undertaken instead.

Even after patients die, physicians and
covered entities can still face liability for them.

This article is intended to make healthcare
professionals aware of these risks and to
serve as a general guideline for dealing with
requests for the PHI of a deceased patient.
This article does not offer any legal advice
and should not be relied on for such. Prior
to sending any records or taking any action
that could be governed under HIPAA, it is
suggested that physicians consult their
personal attorney.

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WRONGFUL TERMINATION, continued from page 5

termination decision with only those that need to
know (i.e. supervisor, legal counsel). If you have
already had several discussions with the employee
via verbal and written warnings, termination should
not be a surprise.

Once you have decided to terminate the
employee, schedule a meeting; don’t wait any
longer than you have to. Make sure you are
prepared. Include Human Resource
representatives, the employee’s supervisor, and
one other person who can serve as a credible
witness, if needed. Have the final paycheck
available at the meeting, if possible. Allow the
employee to briefly discuss the decision with you
and/or vent, but don’t make promises you can’t
keep and don’t argue. Tell the employee the truth
and be sure not to candy coat it to spare their
feelings because it may have repercussions. Treat
the employee with respect and dignity; do not
embarrass the employee and do not badmouth
them after they leave. If the employee needs to be
escorted out immediately, monitor their exit, but don’t
get security involved unless absolutely necessary.

In summary
To prevent wrongful termination lawsuits, consider
the following:

• Do not make promises you can’t keep;
• Establish policies and procedures and make
sure all employees are familiar with them;
• Be fair and consistent;
• Tell the truth;
• Use a progressive discipline approach, where
possible, except in cases of extreme misconduct;
• Consider other disciplinary actions, other than
termination;
• Treat employees with dignity and respect;
• Do not discuss the termination of an employee
with others, unless they need to know; and
• Consider evaluating your termination process
on a regular basis, comparing the policy and
the actions taken, looking for strengths and
weaknesses and revising as necessary.

References:
that Lead to Termination Lawsuits. Special Report from the ‘B21 Coach’ Series.
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KEY=wrongful%20termination%20cases&OVMT=
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of his test result. To him, the information that he had a “positive blood culture” and was to follow-up with his family doctor did not mean he needed to see the doctor, but rather just that he should call the office and tell them of the ED visit.

• Final lab results were sent to the ED printer two days later, but not seen by the ordering ED physician. There was not a system in place that would ensure that an ordering ED physician actually reviewed results.

• Preliminary results were not communicated effectively to the patient’s PCP.

• PCP office staff did not follow up the patient’s phone call to try to obtain any lab test reports and bring them to the physician’s attention.

Case 2
The case shows communication errors in the transition of a patient from one facility to another.

Claimant is a 50 year old male who alleges failure by hospital 1 (H1) ED nursing staff to communicate preliminary blood test results to hospital 2 (H2), after he was transferred; he also alleges failure by H2 to follow up on test results (allegedly) provided to the attending physicians.

Co-Defendants included Hospital 1 (ED), Hospital 2 (ICU), H1 ED Physician, 2 Neurosurgeons, 2 Infectious Disease specialists, Radiologist, Neuroradiologist, and nurses from both hospitals.

Case Summary
(Day 1) The patient initially went to the ED of a local hospital (H1) with complaints of fever, lower back pain, hallucinations. ED physician ordered back x-rays and urinalysis, which were unremarkable. He was diagnosed with strep throat/pharyngitis and back pain. The patient was discharged as stable, to home, with prescriptions for pain medication (penicillin and Darvocet), and instructed to follow up with his primary care physician (PCP).

(Day 3) The patient returned to the same ED, this time with complaints of continued fever and back pain, plus progressing neurological deficits (complete paralysis of lower extremities and partial paralysis of upper.) Blood was drawn for C & S studies, but results were not available when it was decided to transfer the patient to a tertiary care hospital (H2) for emergent MRI scan of the spine.

The patient was admitted to H2’s ICU, with differential diagnosis of epidural abscess and transverse myelitis. An MRI was done but no spinal abscess (infection) was seen. An Infectious Disease consulting physician started the patient on a high dose of IV antibiotic therapy, even though at the time, the physician was not aware of the positive blood culture results.

A factual dispute arose regarding the sending and receiving of the blood test results. ED Nurse (H1) alleged that she provided the report of positive blood culture study to the ICU (H2), by fax and phone. She noted the same in the nursing progress notes. However, the ICU nurse attending the patient (at H2) testified that she did not see a fax report nor take a phone call. There was no documentary evidence of the report in the medical record, and no notes confirming that anyone received a fax or took a call from the ED nurse. Moreover, the ED Nurse could not identify the person to whom she spoke or the number she had called. (Note: Some physician experts opined that, since the antibiotic given in the ICU was appropriate treatment for the patient’s bacterial infection, whether or not the test report was received in the ICU was a moot point.)

(Day 5) The patient was transferred and admitted to a larger university-affiliated hospital (H3). Repeat MRI on day 2 of admission revealed evidence of a small epidural abscess and osteomyelitis. The patient remained at this hospital for 6 weeks, during which time he underwent a series of procedures, including drainage of the abscess, cervical decompression and stabilization. He was next transferred to a physical rehabilitation facility for about 6 weeks, and then discharged to home.

In the years since, the patient has suffered multiple medical complications related to his paralysis. He is permanently wheelchair bound and dependent for all activities.

Case Outcome
The lawsuit was settled without trial, on behalf of H2 and the ICU Nurse at H2. Suit was dismissed as to all other defendants.

Risk Issues
• The transferring hospital had a duty to ensure that an accurate record of the patient’s completed and pending tests were sent along with the patient at time of transfer. The attending physicians at the “receiving” hospital might have made a diagnosis of bacterial spinal infection sooner, in light of the lab result and clinical condition of the patient, had they been aware of the critical positive blood test results, in a timely manner, from the “transferring” hospital.

• Questions could be raised about whether all appropriate tests were ordered by the ED physician during the patient’s first ED visit.

Case 3
This case demonstrates the following errors in critical test value reporting:

• failure of radiology staff to report the value to the ordering physician
• failure of ED physician to communicate the result to the patient or his PCP

Claim/Lawsuit Allegations
Claimant alleges that all defendants failed to diagnose and inform him of a pelvic fracture, based on x-ray findings; that this failure resulted in a 7-month delay in getting treatment and much more extensive reconstructive surgery.

Co-Defendants were the Hospital, ED Physician, Primary Care Physician, Radiologist, and Physician Assistant (in ED), later dismissed.

Case Summary
The patient, a 58 year old man, was brought by ambulance to the ED of his local hospital after he had fallen out of his car and one of the tires rolled over his upper thighs. He complained of severe pain in his pelvic area and legs.

The patient was examined by a Physician Assistant (PA), who ordered X-rays of LS spine, pelvis, left hip and right lower leg. There was no radiologist present in the hospital at that time. (after 5 pm), so the PA looked at the films. She noted her impression: all the films appeared negative except for pelvic region, which indicated pubic symphysis dyasthesis. She did not request an orthopedic consult or

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inform patient that a preliminary reading (before radiologist) of his x-rays showed a possible fracture of his pelvic bone. When she saw him, the patient was able to stand. (Although it wasn’t established by the documentation, the PA testified that it would have been her practice to tell the ED physician what her impression was after reviewing films, and that she also would have shown the films to the ED physician.)

The PA turned the patient’s care over to the ED Physician when her shift ended at 11pm.

While in the ED most of the night, the patient received various pain medications. At 5am the next morning, the ED physician examined the patient, and concluded that he was pain-free and able to walk, and then discharged the patient to home. The patient was given instructions for contusion care, a prescription for pain medicine, and to follow-up with his PCP that day. The record did not reflect that the ED physician either informed the patient that he might have a fracture or referred the patient to an orthopedist.

In the afternoon of the same day, the radiologist read the patient’s pelvic x-ray as showing diastasis and minimal subluxation of symphysis pubis, with clinical correlation recommended. All other films were read as negative for fracture. Again, there was no documentation that this final reading was reported to that day’s ED physician. Testimony revealed that the radiologist had issued a written report but, because he didn’t follow the hospital’s Radiology/ED “Follow-up Protocol” and complete the follow-up form correctly, the clerical staff in the ED was not alerted to call the patient with this diagnosis.

5 months later: The patient went to an orthopedist due to continuing pain. This physician ordered new x-rays and he diagnosed multiple pelvic fractures, dating from the initial accident, and disruption of the pelvic ring. This doctor informed the patient about the fractures and referred him to an orthopedic surgeon. 2 months later: The patient had reconstructive surgery to restore integrity of the pelvis. It was the surgeon’s opinion that the procedure that was necessary after the 7-month delay was much more extensive than it would have been had the diagnosis been made immediately and the patient advised to seek further medical care.

Ultimately, the patient had an excellent result from the surgical repair. Currently he seems to be functioning well, with almost no residual disability, although he complains of constant back pain.

Case Outcome

The lawsuit was settled prior to trial, on behalf of the ED Physician, Radiologist and Hospital. The claim was dismissed without payment, as to the Primary Care Physician.

Risk Issues

• As noted above, the patient had been discharged several hours before the radiologist looked at the films. However, the Hospital and its ED failed to notify the patient and/or his PCP of the abnormal x-ray findings, once the report of the final reading (showing fracture) was issued.

• Even though the hospital had a policy and procedure for patient notification of test results, there seemed to be misunderstanding among the physicians (both Radiology and ED) about who had what responsibilities under it. By not complying with its own policy, the hospital put itself at risk for a claim of breach. Policies need to be clear as to responsibility.

• The radiologist issued a written report of his interpretation of the patient’s films. There was, however, an error in the way he filled out a hospital form that went with his official report. Due to this error, the clerical staff in the ED were not alerted to make the follow-up contact with the patient, in accordance with the hospital policy.

• The radiologist failed to notify the ED physician on duty at the time he made his x-ray interpretation, although he knew or should have known that his diagnosis of fracture in the pelvic region was significant.

Action Recommendations

Based on the examples discussed above, taken from real claims, we have illustrated how negative consequences can occur as a result of ineffective communication of CTRs.

We suggest the following actions for hospitals:

• Hospitals need to develop policies which clearly define roles and responsibilities and timing for notifying the appropriate responsible provider (often the attending, or PCP). There also needs to be a back-up system, with clear identification of who gets results when an ordering provider is not available, and when to use it.

  • Pay attention to and develop special procedures for situations where delays typically occur:
    • post discharge (ex: transition from ED to home)
    • ambulatory areas (surgical suites, emergency department)
    • shift changes

• Agree on which specific tests require communication, and establish a shared policy for uniform communication for all types of test results (lab, radiology, pathology, etc.) to all recipients.

• Build in reliability: Create tracking systems to assure timely and reliable reporting of test results; require an acknowledgment of receipt of test results by the provider who can take action.

• Provide ongoing education on procedures for communicating critical test results to all healthcare providers (physicians, nurses, lab personnel, all other clinical disciplines).

• Monitor effectiveness of systems (call schedules, feedback loops, response times, number of “lost” test results).

• Support infrastructure development. To the maximum extent possible, hospitals should adopt advanced communication technologies, and improve laboratory and other testing system capabilities.

The Massachusetts Coalition for the Prevention of Medical Errors has studied this issue extensively. The Coalition has developed a group of Best Practice Recommendations that hospitals should try to implement, to improve their ability to provide timely and reliable communication of CTRs. This information can be found at: The Coalition’s “Safe Practice Recommendations” was published in Feb. 2005 issue of the Joint Commission Journal of Quality and Patient Safety, Vol. 31, No. 2, http://www.jcrinc.com
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Massachusetts Coalition for the Prevention of Medical Errors
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We suggest the following actions for Primary Care Physician Practices:

• Develop and implement systems that address critical value test results, to ensure that clinical information crucial to an accurate diagnosis and follow-up is received and handled by the office, and that it reaches the responsible physician quickly. This may involve a checklist for staff that identifies information that is considered urgent.

• Develop and implement an internal system for following up to ensure that recommended tests or consults are actually completed as ordered.

• Develop a system which requires office staff to confirm, before patient documents (lab test results, consult reports, etc.) are filed, that patients are promptly notified of abnormal test results, along with any recommended course of action.

• Document when the patient chooses not to follow up on recommended tests or referrals and that the patient has been advised of the consequences of not following up on testing recommendations or referrals.

Summary

The three cases discussed in this article were selected because they illustrate the importance of developing systems, policies and procedures for reviewing, reporting and acting on patients’ critical test results.

The process of test ordering, sample testing and results reporting involves many departments (nursing, ED, laboratory, radiology, etc.) and communication by many different personnel. The scope of this issue cuts across all clinical areas, inpatient as well as ambulatory settings.

By implementing the recommendations presented here, aimed at enhancing communication of CTRs, providers will improve patient safety and reduce risk in their organizations.

References:

U.S. Dept. of Health and Human Services
540 Gaither Road
Rockville, MD 20850
(301) 427-1364
http://www.ahrq.gov/clinic/ptsafety

Agency for Healthcare Research and Quality (AHRQ) Morbidity & Mortality Rounds on the Internet
http://www.webmm.ahrq.gov
Web-based patient safety resource and journal that showcases patient safety lessons drawn from actual cases of medical errors.

AHRQ’s Patient Safety E-newsletter;
http://www.ahrq.gov/qual/ptsflist.htm
Patient safety news and information; features research findings, new product announcement, and update on initiatives in the safety and quality filed.

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Kraser GD. Failure modes and effects analysis; building safety into everyday practice. (FMEA). Marblehead, Ma; HCPro, Inc. 2004.

ARCHI-Improving Patient Safety Discussion Group
http://www.archi.net.au/content/index.phtml?
Forum for health professionals to discuss issues pertaining to patient safety and quality in health care.

https://members.ecri.org/members/

Joint Commission Facts about Patient Safety -
http://www.jointcommission.org/PatientSafety/

National Quality Forum.
http://www.qualityforum.org/
Promotes change through development and implementation of a national strategy for health care quality measurement and reporting.

National Patient Safety Foundation
1120 MASS MoCA Way
North Adams, MA 01247
(413)633-8900
http://www.npsf.org/
Information, research and resources on professional, consumer, and systems issue related to patient safety. Online discussion forum about development of a safer health care system.

Patient Safety and Quality Healthcare
http://www.psqh.com
Provides broad range of safety and quality information for patients, clinicians and healthcare administrators, online and in print format.

American Society for Healthcare Risk Management
One North Franklin Street
Chicago, IL 60606
(312) 422-3980
http://www.ashrm.org

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The Value of Patient Safety and Quality Improvement Initiatives for Physicians and their Patients

In announcing the 5 Million Lives Campaign at IHI’s Annual Meeting in Orlando on December 12, Dr. Donald Berwick, President and CEO of the Institute for Healthcare Improvement (IHI), defined medical harm as “….the unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death…” IHI provides a more detailed description of this medical harm at its website: http://www.ihi.org.

It is important here to recognize the much more sweeping approach that IHI is taking here in its newest campaign—this one lasting two years. As dramatic as the success of its first campaign was resulting in the saving of an estimated 122,300 lives at 3,100 participating hospitals based on their implementing between three and six of the original set of safety and quality improvement interventions, this new campaign goes much further. By seeking the involvement of 4,000 hospitals and their staff physicians to implement up to 12 safety and quality improvement interventions, this time, the goal is to eliminate around one-third (5 million) of the estimated 15 million instances of medical harm which occur to patients annually as a result of preventable medical errors and suboptimal practice.

The most obvious benefit of implementing the 12 interventions (explained in their entirety at http://www.ihi.org) is to avoid the preventable harm (as Dr. Berwick defined this, above) to millions of patients. As Dr Berwick said, “We can and we will, equip all willing health care providers with the tools they need to make the motto ‘First, do no harm’ a reality.”

For the physicians of these millions of patients whose medical harm may be averted, however, the value is equally great, viz. to improve physician patient relations and minimize the risk of litigation that might otherwise follow from suboptimal care. This constitutes a potentially huge benefit to physicians. Fear of potential medical liability is one of the most important reasons for the significant drop in physician morale across the country (The American College of Physician Executives Poll on Physician Morale; Physician Executive; December, 2006). Although never being able to eliminate the possibility of litigation altogether, being involved in these twelve improvement interventions should both protect physicians from being sued and from weak defenses in the event of litigation. The concluding section of this article will discuss how physicians may join with themselves, their hospitals and liability carriers in this and other safety and quality improvement initiatives to acquire these protections.

Physicians, Hospitals and their Liability Carriers: Their Mutual Stakes

Plaintiffs’ attorneys can testify that their favorite cases are those where defendant hospitals and physicians are not united in their defense. That makes it really easy for judges and juries to find liability against one or the other (and usually both) defendants. Not being on the same page can prove very costly in so many ways for defendant hospitals, their staff physicians and liability carriers.

The success of any quality and safety improvement initiative depends on the alignment of interests and ongoing cooperation of participating hospitals and their staff physicians. Since physicians still control approximately 75% of the more than $2 trillion spent on health care annually in this country, that fact goes without saying.

The precarious intra-organizational relationship of hospitals with their autonomous medical staffs, lends itself to conflict. However, the area of improving the safety and quality of care is one in which all hospitals and their staff physicians can (indeed must) be aligned. It strikes at the very heart of their individual and mutual reasons for being. Achieving ongoing collaboration and success in pursuing the noble goals of the 5 Million Lives Campaign (and those of other safety and quality improvement initiatives such as Princeton Insurance’s discussed in the December, 15, 2006 Risk Review Online) can and should result in significantly improved hospital physician relations. This should also produce a much more aligned mutual defense posture in the event that litigation involving both parties still occurs.

The Way Forward

Although this piece is not intended to kick-off a formal series of articles, it is intended to introduce what will be a common theme throughout 2007, viz. the necessity for hospitals and physicians to cooperate and coordinate their safety and quality improvement initiatives. Subsequent articles in Risk Review Online will focus on more specific ways for hospitals and physicians to cooperate in improving the safety and quality of care, especially in those areas most likely to result in potentially compensable medical harm to patients.✓

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