

the Reporter

PROFESSIONAL LIABILITY and the HOSPITALIST MODEL



by Laura Hale & Barbara Rose

While “specialists” in inpatient medicine have long been providing hospital care in Europe and Canada, the United States has only recently adopted a hospitalist model. Studies indicate, however, that systems using dedicated inpatient physicians are proliferating rapidly.

Whether you practice as a hospitalist or refer your patients to hospitalists, it is worthwhile to become aware of the many liability risks unique to this type of care arrangement. This article will provide some background on the role of hospitalists in today’s health care setting and will discuss specific malpractice concerns.

Introduction

The term “hospitalist” was first used in a 1996 *New England Journal of Medicine* article, but the definition has been evolving ever since: “a physician who spends at least 25 percent of his or her professional time serving as the physician-of-record for inpatients, during which time he or she accepts ‘hand-offs’ of hospitalized patients from primary care providers, returning the patients to their primary care providers at the time of hospital discharge.”¹

When first introduced in the United States, the hospitalist model encountered strong resistance from many in the medical community. The most serious criticism focused on the discontinuity of care, which is purposefully introduced in the model. Concerns were also raised when a few

managed care organizations attempted to make the use of hospitalists mandatory. This step was vigorously opposed by organized medicine, including the National Association of Inpatient Physicians (NAIP), and further attempts to create mandatory programs have been rare.² Voluntary hospitalist programs, in which primary care physicians may decline to use hospitalists, now account for 98 percent of all such programs.³

Currently there are more than 5,000 hospitalists practicing in the United States,⁴ and a 1999 study estimates there could be 19,000 within ten years.⁵ Hospitalists have established their own professional society, the NAIP, which is formally affiliated with the American College of Physicians-American Society of Internal Medicine.

According to the NAIP, physicians who currently practice as hospitalists have training in the following specialties:

- 55 percent are trained in general internal medicine;
- 35 percent are trained in an internal medicine subspecialty, such as pulmonary or critical care medicine;
- 6 percent are trained in family practice;
- the remaining are trained as pediatricians and are practicing pediatric hospitalist medicine.⁶

An NAIP survey found that hospital-based physicians practice under a variety of arrangements:

- 35 percent are employed by hospitals;
- 23 percent are employed by group practices;
- 11 percent are employed by university-based medical practices;

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- 9 percent are employed by managed care organizations;
- 8 percent are employed by independent hospitalist groups.⁷

Acceptance of the hospitalist model has been growing, especially in instances where primary care physicians help design the program. In 1999, 65 percent of internal medicine physicians had hospitalists in their community and 28 percent reported referring inpatients to their care.⁸ A 2000 survey of 524 California physicians found that 41 percent believed hospitalists improved the overall quality of care, and 44 percent believed they did not change the quality of care. The survey was split among internists, family physicians and pediatricians.⁹

The growth of the hospitalist model and its implications have been closely followed in the medical literature. A review article recently published in *JAMA* examined the medical literature for studies about the impact of hospitalist programs on financial and clinical outcomes. Out of 19 published studies, 15 found significant decreases in both hospital costs and lengths of stay. Two studies found only decreases in length of stay, and two studies found no significant decreases in either. The review article found little evidence to suggest these cost savings affected quality of care. Most studies found no change in quality measures, while five studies found conflicting results regarding readmission rates and inpatient mortality rates. "These results, while provocative, are insufficient to support an unqualified statement that hospitalists improve quality."¹⁰

Despite the proliferation and apparent success of the hospitalist model, the debate about its use continues, centered around one main issue — continuity of care. The use of a hospital-based physician deliberately disrupts care between inpatient and outpatient settings. "Discontinuity of care existed before the advent of hospitalists and is tolerated with a hand-off approach to specialists, surgeons and intensivists. However, the use of hospitalists dramatically changes the scope and impact of this discontinuity by imposing complete, rather than partial, disruption when patients most need the protection provided by a long-standing relationship."¹¹

This issue has been addressed but remains unresolved. "Effective hospitalist programs have created mechanisms to mitigate the impact of this discontinuity, including calling primary care physicians on admission and discharge, faxing daily progress reports and encouraging primary care physicians to visit or call their hospitalized patients."¹²

Malpractice concerns

The Achilles heel of this care model could be the loss of information during the patient care process. Continuity of care and communication with primary care providers, as well as communication among hospitalists, encompass the main malpractice concerns for these physicians. As hospital-based physicians, they are in general at a higher risk of being sued than their office-based colleagues. Today's inpatient is a higher acuity, more complicated individual in an environment where more personnel are involved in providing care. Consequently, more can go wrong.

Consider the following for successful implementation of a hospitalist model:

1. Informing patients of the partnership with hospitalists is beneficial to the physician-patient relationship. Patients accept the process best when advantages are discussed, patient concerns are addressed and questions are answered.

2. Notification of the primary physician upon patient admission facilitates coordination of care when multiple health

care providers are involved. Additionally, the method of communication during the patient's hospitalization can be discussed, as well as a plan for hand-off and follow-up upon discharge. Documentation of these interactions in the record also enhances communication and helps prevent loss of information.

3. Intershift reports between colleagues will ensure appropriate hand-off of information. Documentation of pertinent information regarding these discussions will facilitate continuity of care.

4. As with any hospital discharge, appropriate discharge orders are necessary. Patient education regarding the discharge instructions is important as well as the patient's acknowledgement of understanding. Notifying the primary physician and communicating pertinent discharge information likewise facilitates continuity of care. Advising the patient regarding who should be contacted if a medical problem arises between discharge and the first follow up appointment with the primary physician promotes quality care, patient compliance and good outcomes.

5. Developing a protocol regarding pending diagnostic reports that outline which provider should receive, review and act upon them will assist in preventing claims related to error or delay in diagnosis.

6. Surveying patients after discharge will assist in identifying areas for improvement. Addressing patient concerns such as confusion regarding multiple physicians providing care, and sharing those issues with colleagues will facilitate timely process changes to improve patient care.

In the hospitalist model of care, consistently sharing information with colleagues and documenting medical decision-making and treatment plans can improve coordination among the health care team. With the hospitalist model in its infancy, claims data is limited. Considering the lack of a prior physician-patient relationship and the acuity of hospitalized patients, hospitalists can utilize the above suggestions to promote good outcomes and reduce medical liability claims.

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tmlt perspective



The medical malpractice crisis and your physician-owned trust

by Howard Marcus, MD, Chairman, TMLT Board of Governors

Two thousand two has been a tumultuous year for Texas physicians. Caught up in a crisis swirling with accusations that bad doctors are harming patients, physicians are also facing unprecedented premiums for medical malpractice protection and continued high frequency and severity of claims and lawsuits. In this unfriendly climate, doctors are frustrated, insurance carriers are frustrated, and patients who cannot find needed physician services like OB are frustrated. The medical liability crisis in our state has progressed to the point where our patients are feeling the impact, and, as physicians, we cannot allow it to continue. Fundamental and long-term changes to our civil litigation system must occur if we are to effectively solve the problems of spiraling liability insurance premiums and limited patient access to care.

In 1999, TMLT alerted policyholders that a potential medical liability crisis was looming. Since then, the Trust has worked steadily and diligently as your advocate. TMLT staff members have researched and written numerous articles on the crisis for county medical society publications and for *the Reporter* newsletter; TMLT executives have traveled statewide to provide detailed presentations to meetings of county medical society and specialty society members; and, the TMLT Board of Governors has communicated updates on the crisis by letter to policyholders in an effort to keep Texas physicians informed.

We have also worked to marshal the support of others in the medical community. TMLT became a founding member of the Texas Alliance for Patient Access (TAPA). A unique coalition of professional associations, health care organizations, specialty societies and insurance carriers, and medical clinics and groups, the TAPA consortium has grown rapidly in less than one year from seven founding members to 100 participating organizations. TAPA is focused on increasing access to health care through meaningful medical liability reform. Such reform, we

believe, will result in long-term benefits to patients and to the health care system.

TAPA is modeled after the successful California consortium, (Californians Allied for Patient Protection) which has sustained the California MICRA reforms of the 1970s. Those reforms, which include a \$250,000 cap on non-economic damages, have resulted in fairness and stability for patients and health care providers. At the same time, California patients who are truly injured are justly indemnified as they have full access to the courts without limits on compensation for medical bills or economic losses.

This past year, TMLT met with Texas Insurance Commissioner Jose Montemayor on several occasions to brief the Department of Insurance with our latest data and to advise the department of our view of developing trends in Texas. At its last general meeting, TAPA members also met Commissioner Montemayor who reviewed the current crisis and gave an overview of the fundamental problems in the tort system which are undermining access to care. The Commissioner restated his position that the medical liability and patient access crisis are the result of increases in claim frequency and severity.

TAPA has been successful in lining up initial funding, organizing legislation and research committees, and in hiring an experienced team of lobbyists to execute the legislative agenda. TMLT has provided valuable expertise to the TAPA legislation committee which includes expert defense and appellate counsel and claims executives. The TAPA legislation committee has meticulously written a comprehensive and detailed tort reform package of more than a dozen bills which have been endorsed by our association partners. TAPA's health care liability reform agenda, modeled after California's MICRA statute, addresses frequency and severity of claims and physician and hospital reforms. Specifically, proposed reforms include:

- limitation of \$250,000 on non-economic

damages per claimant in a claim against a health care provider

- allow for the periodic payment of future damages in excess of \$100,000
- allow evidence of collateral source payment to be introduced
- limitation on attorney contingency fees
- procedural issues that address frequency of claim and cost of litigation, such as prohibition of pre-suit depositions, elimination of cost bond and expert report filing extensions, clarification of expert witness qualifications
- establish charitable immunity for health care providers
- limitation on liability for prescribing of drug or device.

Today both TAPA and TMLT are represented at the Texas Capitol by skilled and influential lobbyists. We are rapidly gaining support and sponsorship for our proposals with key legislators. TAPA has also worked closely with Governor Perry's office since last winter. Some of this effort was reflected in Governor Perry's tort reform initiative of March 2002. During the legislative session, TAPA will continue to work closely with the political advisers and lobbyists of our many consortium members in order to focus and unify reform efforts.

The November elections have demonstrated that the people of Texas are behind our efforts for meaningful and sustainable tort reform. Texas voters understand that the out-of-control tort system has made health care more costly and less available. They realize that unless reforms are passed in 2003, more doctors, nursing homes and hospitals will close their doors or restrict patient access in order to survive.

What can you do? Join this effort now! Physicians in California came together at a time of crisis, and were able to pass one of the nation's strongest reform packages that is still working for doctors today. We need to do the same in Texas.

For additional information please call (512) 306-1616 or email galitski@tapa.info.

What liability risks lurk in your office?



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By Jane Mueller, Vice President, Risk Management

In the volatile Texas medical liability environment, it is more important than ever for physicians to be aware of potential risks in their medical practices. Determining risk exposure improves patient safety and outcomes. Additionally, it protects physicians from claims of medical negligence and improves defensibility if a claim or lawsuit occurs. Whether you are a solo practitioner in a rural area or a member of a large physician group, the TMLT risk management staff can assist you in improving your practice.

The practice review

The practice review is a comprehensive risk evaluation offered free to all TMLT policyholders, and available to both office-based and hospital-based practices in all specialties. This on-site, direct interface with physicians and office personnel enables risk management staff to address specific risk exposures in the following areas:

- medical records
- informed consent

- peer review and QI
- physician/patient relationships
- procedures for follow-up
- medication administration
- patient complaints
- release of medical records
- surgical procedures
- diagnostic procedures
- procedures for exams/treatments
- procedures for office emergencies
- biohazardous management
- medical equipment safety
- HIV protocols
- infection control
- general office procedures
- patient visits
- staffing
- telephone protocols
- appointments
- fees, billing and collections
- electronic medicine.

During the review the risk management representative will:

- examine the office for physical safety concerns;
- review the practice's policies and procedures;
- evaluate medical record documentation;
- provide resources on how to reduce risks in the office;
- discuss outcomes with the physician(s) during an exit interview;
- follow-up with a confidential, written summary.

Participation in a practice review helps raise physician awareness of the medical practice issues and legal pitfalls in their practice and also offers the opportunity for a premium discount. Following completion of the review and compliance with any recommendations, physicians are eligible for a 3 percent discount and 2 hours of continuing medical education (CME). The discount continues through the expiration of the current policy plus an additional two full policy periods.

Positive feedback from physicians is indicative of the value and benefit of this service. "These are areas of my practice I never considered . . . very informative and helpful. We are all enthused about initiating practice changes," said Mark Wentworth, MD, a family physician.

The process

The process begins with a request from a physician.

A risk management representative contacts the office to schedule a time for the review that will accommodate physician, office personnel and patient schedules. The review takes approximately four to five hours (longer for large groups) and can be completed without interrupting patient appointments. A specialty-specific questionnaire is mailed to the office to be completed prior to the review. Generally, the representative arrives mid-morning and begins by reviewing the questionnaire with the physician and/or office administrator. This gives both parties an opportunity to ask questions and address specific concerns related to their particular setting.

With assistance from the office staff, the representative will complete a walk-through tour of the facility. If there are multiple sites it may be necessary to visit each site depending on the specialty, procedures performed, rotation of medical staff through various sites or other unique situations. The office tour includes front and back office areas, patient exam rooms as well as procedure rooms, laboratory and x-ray areas. The tour provides an opportunity for the representative to observe and evaluate areas of particular risk to patient safety, as well as regulatory and statutory compliance.

Office policies and procedures will also be reviewed. Telephone communications with patients, refills of prescription medications and procedures for follow-up are critical areas that lend themselves to standardization.

As failure to diagnose is the most frequent allegation in claims against primary care physicians, the representative spends a significant amount of time reviewing and discussing procedures for follow-up related to diagnostic testing, missed appointments and patient compliance. For example, the representative will discuss with the physician and office personnel what procedure is routinely followed for reviewing diagnostic tests upon receipt in the office as well as communicating results to the patient.

"The discussion was most helpful because it raised my awareness on how I can improve my current method of documentation. Some suggestions were also made on tracking results and triaging 'no shows,'" said Marissa Largoza, MD, an ob/gyn.

A medical record review for documentation strengths and weaknesses will be conducted during the review. In the event of a claim or lawsuit, documentation is the backbone of the physician's defense. In many situations, even when there has been no medical negligence, it is difficult to take a case to trial secondary to poor documentation.

The records review focuses on complete, thorough documentation of each patient encounter, including but not limited to documentation of allergies, history and physical, clinical decision-making, telephone encounters with patients and appropriate follow-up on outside referrals, consultations and diagnostic testing. The representative will emphasize areas where specific documentation will help protect the physician in the event of litigation. For example, physicians and staff are frequently observed discussing in detail the risks and benefits of certain procedures or medications. All too often, these discussions and instructions are not documented in the medical record. According to Texas statute, obtaining informed consent is a non-delegable respon-

sibility of the physician. However, office personnel may assist the physician in this process by obtaining patients' signatures on printed consent forms and reinforcing the information given to the patient by the physician. It is recommended that the physician include a note in the patient record indicating that the associated risks, benefits and alternatives were discussed with the patient and any family members, as well as the patient's understanding and agreement to proceed with the treatment plan.

"The entire experience was very positive and helpful. I know it will help my practice become more efficient and increase my awareness of improved risk management," said Jim Colvin Jr., MD, an ob/gyn.

The follow up

Upon completion of the on-site visit, the representative will discuss with the physician and appropriate office personnel any areas of concern, and make recommendations for implementing changes to the medical practice. Relevant resources and materials will be provided to assist in implementation. A formal written report will be mailed to the physician requesting written responses to the recommendations within 30 days. Upon receipt of the responses, the physician is eligible for the risk management discount. Qualified risk management staff are available to provide ongoing assistance in identifying risk exposures and relevant solutions.

In conjunction with the practice review, physicians may be eligible for an additional 2.5 percent discount for use of electronic medical records and/or electronic prescribing. Eligibility for this discount is contingent upon documented use of a program for a minimum of one year. The program must also meet specific risk management criteria. Much of medicine is routine, requiring compulsive attention to details and protocols. Computers are well suited to enhance medical decision-making. An electronic medical record or electronic prescribing system has the potential to greatly enhance quality of care, providing a safer environment for patients.

Just as we recognize that seat belts and air bags in automobiles and smoke detectors in our homes are essential in decreasing the risk of injury in our personal lives, the implementation of basic risk management principles in medical practice is essential to improving patient outcomes and minimizing the risk of claims.

"Exactly what I was looking for . . . excellent recommendations," said Jeffery B. Gibberman, MD, a physical medicine and rehabilitation specialist.

To schedule your practice review, please contact the Risk Management Department at 800-580-8658, ext. 5912 or visit the TMLT web site at www.tmlt.org.

RISK hot topics MANAGEMENT

FDA public health notices

Non-corrective, decorative contact lenses dispensed without a prescription

The FDA continues to receive reports that non-corrective, decorative/cosmetic contact lenses are being distributed directly to consumers without a prescription or proper fitting by an eye care professional. These products present significant risks of blindness and other eye injury if distributed without the involvement of a qualified eye care professional. Because of these safety concerns, FDA has cautioned consumers against using decorative contact lenses that have not been prescribed and fitted by a qualified eye care professional.

FDA is requesting that health care professionals report adverse events resulting from the use of decorative/cosmetic lenses distributed to consumers without appropriate professional involvement. If you become aware of a problem associated with these contact lenses, please contact MedWatch, the FDA's voluntary reporting program. You may submit reports to MedWatch one of four ways: online at www.accessdata.fda.gov/scripts/medwatch/; by telephone at 1-800-FDA-1088; by fax at 1-800-FDA-0178; or by mail to MedWatch, FDA, HF-2, 5600 Fishers Lane, Rockville, MD 20857.

Complications related to the use of bone cement in vertebroplasty and kyphoplasty procedures

This is to inform you about reports related to the use of polymethylmethacrylate bone cement to treat osteo-

porotic compression fractures of the spine using surgical procedures known as vertebroplasty and kyphoplasty. Complications related to these procedures have been reported in the literature and to the FDA. Reported complications, such as soft tissue damage and nerve root pain and compression, are related specifically to the leakage of bone cement. Other reported complications include pulmonary embolism, respiratory and cardiac failure, and death.

The FDA is currently working with appropriate professional organizations and manufacturers of orthopedic devices to consider the regulatory options available to evaluate the long-term safety and effectiveness of bone cement in vertebroplasty procedures. We encourage you to be aware of considerations and recommendations regarding patient selection, vertebroplasty and kyphoplasty techniques, complications, and patient monitoring described in the literature when considering these procedures to treat osteoporotic compression fractures of the spine.

The Safe Medical Devices Act of 1990 (SMDA) requires hospitals and other user facilities to report deaths and serious injuries associated with the use of medical devices, including bone cement. Follow the procedures established by your facility for such mandatory reporting. We also encourage you to report bone cement malfunctions. You can report these directly to the device manufacturer and also to MedWatch in the four ways described previously.



CME at your fingertips

Earn CME when and where you need it with TMLT's online risk management courses. By completing an online course, you can earn CME credit, ethics hours and a 3 percent premium discount (maximum \$1,000) per course. These courses are available at www.tmlt.org:

- *Fraud and Abuse Prevention: What Physicians Need to Know*
- *How You Can Stay on the Right Side of the Law: Beginning, Maintaining and Ending Physician/Hospital Relationships*
- *Medical Records Handbook for the Physician's Office*
- *Streetwise*

For more information, please visit the TMLT web site at www.tmlt.org or call (800) 580-8658.

closed claim study

Medication error and failure to monitor

by Barbara Rose, Senior Risk Management Representative

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purposes of emphasizing the issues of the case.

Clinical presentation

A 50-year-old Asian male was referred to a nephrologist for renal insufficiency. The patient had a history of ankylosing spondylitis and scleroderma. He had an elevated serum creatinine, low creatinine clearance, anemia and proteinuria. The patient had previously been prescribed 5 mg of Prednisone daily for treatment of his renal disease.

Physician action

The nephrologist, the defendant in this case, felt there was no evidence of acute sclerodermal crisis to account for the patient's renal failure. He placed the patient on an ACE inhibitor. After 10 weeks, the patient's creatinine failed to improve and proteinuria was still significant. The nephrologist believed the patient had an undefined connective tissue disorder characterized by probable membranous glomerulonephritis renal lesion. He followed the patient for several weeks. In the interim, the patient had seen his rheumatologist, who increased his Prednisone to 10 mg daily.

When the nephrologist next saw the patient, he documented that he discussed the possibility that renal replacement therapy would be needed. According to the physician, the patient indicated he did not want to go on dialysis because he was afraid it would impair his ability to work. The patient's kidney function continued to deteriorate. During the next visit, the nephrologist decided to place the patient on 120 mg of Prednisone every other day to see if renal function would improve. The physician sent an email to his

nurse stating, "Kidney function is slightly worse. As a last ditch effort to keep him off dialysis we need to have him take Prednisone 120 mg every other day."

The next day, the nurse called in the prescription to the pharmacy for Prednisone 120 mg every day, and completed the medication summary in the chart to reflect 120 mg daily. Using the practice's computerized records system, the nurse emailed a copy of the prescription back to the nephrologist, which reflected 120 mg daily. When the nephrologist, who had been out of town, returned 10 days later he simply signed off on several emails (including the prescription) without opening them. He clicked a signature box and deleted the prescription from his email list.

The pharmacy's computer flagged the prescription because the dosage was too high. The pharmacist called and spoke to the nurse, who confirmed the dosage. The patient's wife also questioned the dosage, and was told by the nurse that the dosage was correct. (The nurse later testified that she confirmed the dosage in the computer system by looking at her documentation rather than the actual physician's order.)

Nine days after beginning the daily Prednisone, the patient presented to the clinic for a Procrit injection. He complained to the nurse of tremors, esophageal burning, hiccups, stomach pain and swallowing problems. The following day, the nurse emailed the nephrologist, who had just returned to the office, and told him of the patient's complaints. The physician never saw this email and may have clicked it off his email list as he had done the prescription.

Eight days later, the patient called and spoke to the nephrologist, who was unaware of the prescription error. The patient indicated he was not feeling well, and the nephrologist advised him to drop his Prednisone dose back to 10 mg per day. An appointment was scheduled for the next day. When the patient presented the following day, he had extremely low blood pressure, elevated heart rate and was going into shock.

The patient was admitted to a nearby hos-

pital where he was diagnosed with severe dehydration, gastrointestinal bleeding and symptoms of sepsis. Despite aggressive treatment from a number of specialists, the patient died two days later.

An autopsy performed on the patient did not identify a cause of death. However, chronic gastritis was identified with angioinvasive GMS positive micro-organisms most consistent with aspergillosis. Multiple ulcers were found in the colon with full penetration through the muscular wall with reactive peritonitis. The center of the ulcer showed prominent necrosis. The patient was also found to have interstitial lung fibrosis bilaterally.

Allegations

Allegations against the nephrologist include:

- prescribing a high dose of Prednisone
- failure to properly supervise staff in placing an order of Prednisone
- failure to monitor patient's progress
- failure to give appropriate medical orders to stabilize and maintain the patient's deteriorating condition.

The nurse and the practice association were also named in the lawsuit.

Legal implications

In reviewing this case, defense consultants were critical of the prescription error by the nurse and her failure to detect the error when questioned by the pharmacist and the patient's wife. There was further criticism of the nurse for not reporting the patient's symptoms of esophageal burning to a physician.

Regarding the physician's action in this case, defense experts expressed their greatest concern regarding the sign-off of the email prescription. The physician indicated that he did not read the email because the manner in which he pulled it up on the computer screen did not show the text of the email. Some experts believed the physician had a right to expect the prescription would be called in as ordered and it was not necessary to read the

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TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140
Austin, TX 78716-0140
800-580-8658 or 512-425-5800
Fax: 512-425-5998
E-mail: dana-leidig@tmlt.org
Web address: www.tmlt.org

Editorial committee

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HIPAA — it's not going away!

Federal HIPAA regulations apply to every physician office. If your practice has not begun compliance initiatives, the time to start is now. Please be aware of the following timelines.

April 14, 2003 — Compliance deadline for Privacy Standards.

October 16, 2003 — Compliance deadline for Transaction Standards.

The final Security Standards are expected to be published in December 2002 with a compliance date in 2004.

Helpful web sites: www.cms.gov
www.hipaadvisory.com

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email sent to him regarding the prescription. However, the physician did sign off on the prescription, an official physician's signature on a chart. There was speculation that a jury might hold the physician at least partially responsible for the prescription error since he signed off on it.

The plaintiff's attorney was able to retain credible experts who were critical of the physician's decision to initiate steroid therapy and who related the patient's death to the prescription error. However, the defendant's decision to place the patient on alternate-day high dose steroids was very well reasoned. One of the plaintiff's own experts agreed with this decision, as did defense experts. Defense experts also agreed with the plaintiff's assertions that daily high dose steroids likely contributed to the patient's death. Though most believed that the patient's underlying systemic sclerosis was the primary cause of his death, placing him on steroids likely caused him to become suffi-

ciently immuno-compromised that he could not fight the infection when the perforations in his colon occurred. This led to overwhelming sepsis and organ failure.

Disposition

This case settled before trial with the physician's consent. TMLT paid a six-figure amount on behalf of all defendants.

Risk management considerations

Twenty-eight percent of medical malpractice claims involve actions or omissions by office staff. The physician may delegate appropriate duties to staff, but in doing so, assumes responsibility for their actions with vicarious liability should a patient be harmed.

Both the nurse and physician made errors in this patient's health care. The information reviewed for this study did not include why the nurse did not respond to the pharmacist's appropriate query regarding the Prednisone prescription. Was the nurse too busy? With an electronic medical record, confirming the physician's order would not take long. Faced

with days of email, was the physician also too busy to open and read all orders requiring his signature? Electronically signing an order is an affirmation it is correct.

Whether a paper or electronic record, standards of care and documentation requirements remain the same. There were two opportunities for the nurse to reconfirm the prescription with queries from the pharmacist and the patient's spouse. A third opportunity to intervene and stop the daily dose was in the physician's hands when reviewing email and signing off on orders. A physician cannot defend his/her actions if established standards are not followed. Signing off on unread orders would likely be considered below the standard of care by a jury.

Patients not only appreciate quality care provided by physicians but also that of their staff. Realizing the important role staff plays in the delivery of care, the majority of medical malpractice claims can be avoided through the diligent efforts of the entire health care team.