

## Closed Claim Abstracts

*A morbidly obese 42-year-old man complained to his primary care physician of pain in the right lower abdomen and groin that was aggravated by standing and walking. The general exam was unremarkable except for some tenderness on deep palpation of the right groin area. An abdominal examination was unsatisfactory because of obesity.*

*The physician suggested the possibility of a right inguinal hernia, but was reluctant to commit to this diagnosis because of the poor abdominal exam. He charted "Impression: possible right inguinal hernia. Treatment: 1) lose weight, 2) Donnatal AC & HS."*

*Eight weeks after the initial visit, the patient returned with the same complaints. Both the exam and vitals were unchanged from the previous visit.*

*Six months later the patient's weight and abdominal exam remained the same, but his pain was worse. He reported that he had bright red blood in his stool twice. A rectal exam was essentially normal, though a fecal test was guaiac-positive. The patient was immediately referred to a local surgeon for consultation. After routine colon prep, the surgeon performed a flexible sigmoidoscopy. He found a lesion. The pathology report noted an adenocarcinoma of the colon. A left colectomy revealed some serosal involvement and several positive mesenteric nodes.*

*Three months after the surgery, the patient sued the original family physician, alleging delay of diagnosis. The plaintiff supported the claim with a statement from the attending surgeon that said the family physician negligently tested and followed up with the patient.*

PIAA Research Notes, Fall 2005 citing "Let the Record Show," J. Kelly Avery, M.D.

## Primary Care Physicians Still at Top of Colorectal Cancer List

*By Georgette Samaritan, BSN, Senior Risk Management Consultant and Reid A. Pearlman, JD.*

Colorectal Cancer remains the second leading cause of cancer-related death in the U.S. Fully 6% of Americans are expected to develop CRC within their lifetime. The American Cancer Society estimates that 55,170 will die from CRC this year. Approximately 148,610 new cases will be diagnosed in 2006.

Over the past three years, the death rate has dropped by a modest 5% and new case diagnosis has risen by just 1%.

Though some gains have been made, this largely preventable disease is still underdiagnosed and undertreated, especially by primary care physicians. About one-third of CRC claims are filed against internists. CRC is the second most expensive and most common cancer type nationally in medical malpractice claims, trailing just behind breast cancer. Remarkably, nearly one-fifth more CRC claims result in a payout to the plaintiff than the average for the 40 most expensive conditions. This disparity clearly shows claim defensibility problems, since a greater proportion of claims end up either being settled or as plaintiff jury verdicts.

Certain themes dominate these colorectal claims:

- Failure to promptly evaluate symptomatic patients
- Failure to recommend routine screening
- Ordering a screening test, but not scheduling
- Ordering a screening test, but not following up on it
- Failing to follow up on abnormal test results
- Failing to adequately emphasize to patients the importance of keeping test and follow-up appointments
- Communication breakdown among multiple providers
- Failure to adequately document patient refusals to undergo tests or recommended care
- Failure to chart important clinical information

### Risk Management Suggestions

Appropriate screening could reduce an estimated one-quarter of all bad outcomes.

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## Primary Care Physicians Still at Top of Colorectal Cancer List

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Since fully 60% of eligible Americans remain unscreened, the real number could be even higher. It is suggested that physicians do the following:

- Take a thorough history and keep a broad diagnostic focus
- Stratify patient risk levels into average, moderate or high categories
- Discuss test options with the patient and document the discussion, along with the patient's preference in the medical record
- Remember that a single, in-office fecal occult blood test (FOBT) and digital exam are not considered to be adequate screening
- Document and track screening tests and results and follow-up tests and results
- Follow up on all positive results
- Coordinate care among specialists to confirm the roles and responsibilities of the various providers
- Communicate the follow-up plan to the patient and other providers

## Announcing New Online Resources for Small Practices and the New Physician at [www.magmutual.com/risk](http://www.magmutual.com/risk):

### Small Practice Resource Center

Our Small Practice Resource Center was developed especially for practices of one to five physicians. On this web page you'll find:

- The "30 Minute Check-up" self-assessment modules are designed to help you evaluate common risk issues all practices face.
- "Risk Management 101: The Bare Essentials," is a short self study with tools and forms that you and your staff can use.

### New Physician Resource Center

The New Physician Resource Center is designed especially for doctors starting out in practice.

- The "New Practice Toolkit" offers a short step-by-step risk management roadmap when opening a new office.
- The Frequently Asked Questions (FAQ) section allows a physician to earn CME credit and gain new insights into professional liability matters.

## Did you know?

The HIPAA Privacy Rule prohibits the charge for search, retrieval and other direct administrative costs from being assessed against the patient or the patient's personal representative who requests medical records. The HIPAA prohibition does not apply to requests by other persons.

# The Patient Safety and Quality Improvement Act of 2005, Implications for Health Care Providers

By Jacqueline M. Becker MEd, BSN, Risk Management Consultant

On July 29, 2005 President Bush signed the Patient Safety and Quality Improvement Act of 2005 (PSQIA). This legislation is designed to strike the proper balance between maintaining confidentiality and legal protection for medical error reporting, while maintaining providers' accountability and patients' rights. Previously evaluative information about the underlying causes of adverse events was not always considered confidential or protected from lawsuits, a fact that the Institute of Medicine blamed for driving errors underground and slowing progress in improving patient safety.

The PSQIA will establish/approve Patient Safety Organizations (PSOs) to which providers (individuals and entities) can voluntarily report medical errors and patient safety information. These PSOs will then aggregate and analyze the information, which is referred to in the Act as "Patient Safety Work Product" (PSWP) in order to develop strategies to improve patient safety.

## Patient Safety Work Product (PSWP)

PSWP is defined as any information in written or oral form that may result in improved patient safety, health care quality or health care outcomes and is either:

- Gathered by a provider to be reported to a PSO and is actually reported, or
- Developed by a PSO for patient safety activities

PSWP does **not** include:

- Individual patient medical records
- Billing and discharge information
- Other original patient or provider record, or
- Other information that is collected or maintained separately from a patient safety evaluation process

## Privilege & Confidentiality

The PSWP is both confidential and privileged under the Act. Subject to certain exceptions, PSWP is not subject to subpoenas, discovery or even court orders in civil, criminal, or administrative proceedings. PSWP may not be used as evidence in any civil, criminal, or administrative proceeding or in any "professional disciplinary proceeding of a professional disciplinary body established or specifically authorized under state law." PSWP is also confidential in situations other than legal proceedings. Stronger state confidentiality and/or privilege protections are not preempted by the Act.

## Implications for Health Care Providers

**PSWP does not include information that is collected, maintained or developed separately, or that exists separately, from a patient safety evaluation system. In order to ensure confidentiality and privilege protections apply, a reporting provider must ensure that its patient safety information is handled only within its patient safety evaluation system.**

**It is important for providers to act now, by taking these steps:**

- Evaluate existing peer review, quality improvement and risk management systems to determine how to best take advantage of both federal and state protections
- Establish and implement a patient evaluation system
- Develop a guiding document known as a patient safety plan
- Integrate existing/revised/new peer review, quality improvement, patient safety and risk management activities into the plan
- Develop and drive a culture of safety and no blame
- Identify a structure for reporting and reviewing adverse events, peer review and quality improvement processes and data
- Educate and implement new processes once approved

# Communication Processes Pivotal to Both Hospitalist & Primary Care Physicians

By Jacqueline M. Becker, MEd BSN, Risk Management Consultant

The role of the hospitalist is to navigate the treatment process for the hospitalized patient and to keep patients, families and primary care doctors informed of those processes throughout the hospital stay and at discharge. Successful hospitalist programs rely upon excellent communication processes established with primary care physicians and other providers. This article outlines some suggested communication processes both the primary care physician and the hospitalist might use to improve outcomes.

## Suggested communication processes for **primary care physicians** (PCPs) to enhance communication with hospitalists:

- Communicate with the hospitalists in writing as to how and when you want to be contacted. Include specific time frames as appropriate for notification of admission and/or discharge. Indicate what information is needed on discharge. Ask the hospitalist to communicate test results that are outstanding and require follow-up. If a patient requires prompt follow-up in the office, request a phone call from the hospitalist.
- Make sure the hospitalist has direct access to you.
- Encourage open dialogue with hospitalists in departmental meetings.
- Send a summary of the patient's medical history, a medication list, allergies, and a recent review of systems. Include the reason for admission.
- Verbally call to confer with hospitalists, perhaps recommending preferred subspecialists for complex patients.

## Suggested communication processes for **hospitalists** to enhance communication with primary care physicians:

- Actively participate in departmental staff meetings.
- Notify PCPs of admissions. Include the patient's admitting diagnosis and the name of the admitting hospitalist.
- Keep PCPs updated on the patient's progress, communicating directly as specified by that physician.
- Notify PCPs of major changes in health status, a new diagnosis or decline in condition.
- Discuss end-of-life issues.
- Complete the discharge summary in a timely manner and send copies to primary care.
- Consider direct notification of PCPs with copy of discharge instructions or discharge sheet. Including discharge instructions, diagnosis and other key information.
- Communicate a complete list of medications to the next provider when a patient is referred or transferred to another level of care or setting, including home. Provide the list to patient or caregiver also.

When good communication systems are in place, hospitalists working with primary care physicians are in a position to make the difference in achieving better patient outcomes while enhancing bottom lines.

An unabridged copy of this article may be found at: <http://www.magmutual.com/risk/Hospitalists.html>

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