



HEALTHCARE

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Patient Non-Compliance—A Powerful Legal Defense

By: Becky Summey-Lowman, LD, CPHRM

There is little doubt to any practicing physician that patient non-compliance is a significant and contributory factor to poor outcomes. There is also little doubt that patient non-compliance can often lead to more aggressive and costly treatments. What you may not know is the extent to which a patient's non-compliance can increase your risk for a medical malpractice claim and how much good documentation can protect you.

While it is reasonable for you to expect a patient to share in the responsibility for their own care, juries nationwide have placed a significant amount of responsibility for follow-up on the provider. When patients fail to follow treatment advice, it is prudent to document this in the medical record. There are compelling reasons for providers to document patient non-compliance. If such non-compliance contributes to an injury that results in a malpractice suit, it can usually be introduced as evidence in the doctor's defense. Documentation of patient non-compliance can provide a powerful defense to any lawsuit.

Depending upon the comparative fault laws in your state, a plaintiff's recovery is reduced or prohibited based on the percentage fault attributed to the plaintiff. A recent case involved the death, while hospitalized, of a 39 year old 6'4, 225 white male 11 days post bilateral laminectomy and lumbar decompression at the L3-4 and L4-5 from a pulmonary embolism. The MAG Mutual insured neurosurgeon ordered TED and SCD devices for the patient upon his presentation in

the emergency department. This order was never discontinued, but the patient was non-compliant throughout his hospitalization, despite repeated education by the medical team of the risk associated with a deep vein thrombosis (DVT).

The plaintiff contended that because our physician never documented his conversation with the patient regarding the possible risk of DVT and because he failed to implement heparin therapy these actions rose to the level of malpractice.

The MAG Mutual defense team put forth a strong defense that showed the patient's refusal to follow medical instructions and the risks associated with heparin therapy. Our physician did an excellent job during his testimony educating the jury about the surgical procedure including his normal practice of explaining the risks associated with blood clots. It was also brought out in the testimony by the nurses, physical therapist and nursing assistant regarding their diligence in ambulating the patient and explaining the risk for DVT to both the patient and his wife. After a week of trial the jury returned a defense verdict, following 45 minutes of deliberations.

Non-Compliance versus Patient's Right to Make Decision Regarding Medical Treatments.

It is important to recognize the difference between non-compliance and the patient's right to refuse care. Patients have the right to make informed decisions regarding their care, including being informed of their health status, being involved in care planning and treatment, and being able to request or refuse

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Risk Management Transitions Department

MAG Mutual's Risk Management Department has changed their name to the Risk Management & Patient Safety Department. Since the Company's inception in 1982, MAG Mutual has been at the forefront in health care for its risk management services and products; and particularly in its accessibility to assisting policyholders' needs.

Dan Wright, Vice President, Risk Management & Patient

Safety, states, "This change better reflects our evolving role to meet the risk and patient safety needs of our policyholders, with a primary focus on risk reduction, quality patient outcomes, education and post claims management." Highly trained and experienced risk management consultants service physicians in all the states in which MAG Mutual writes coverages

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treatment. Non-compliance may be the result of an educated, rational and reasonable decision on the patient's part to exercise control over their healthcare. The medical record should include documentation that the diagnosis and proposed procedure/treatments were explained to the patient and that the explanation included the patient's prognosis without the procedure, the risks and benefits, and alternative therapies.

Consider the following suggestions to enhance patient compliance:

- Emphasize the seriousness and urgency of any recommended tests.
- Explain the rationale for your treatment advice
- Allow the patient to voice any concerns they have about recommended treatments
- Suggest treatments that are reasonable, taking into account the patient's lifestyle, finances and ability to comply
- Whenever possible, give patients the opportunity to think about proposed treatments prior to making a final decision
- Provide simple written information to patients and others who are involved in their care
- Attempt to gain agreement on the treatment plan

Risk Management Strategies

Document Non-Compliance/Informed Refusal

When the patient has failed to comply with your recommendations, document the non-compliance. Among the more common problem areas are:

- Repeated failure to keep appointments;
- Failure to have diagnostic testing or consultation as recommended
- Failure to comply with medication therapy
- Failure to follow medication monitoring recommendations (for example, warfarin monitoring)

Carefully notate episodes of non-compliance, avoiding any documentation that may look judgmental or self-serving. An example of an adequately documented informed refusal discussion is as follows:

"A breast ultrasound has been recommended to evaluate the palpable lesion on the right breast. The patient states that her insurance "will not be effective for ninety days" and elects not to have the test done pending coverage by insurance plan. The risk of delay was discussed with the patient to include the possibility of a malignancy, and the risks of a potentially life threatening delay in diagnosis and treatment. The patient verbalizes understanding of the information provided. I have asked my staff to investigate and advise her of any financial assistance that may be available. She was advised to contact me as soon as possible if she reconsiders this decision or as soon as insurance coverage is effective."

A sample informed refusal form can be found on the MAG Mutual website at www.magmutual.com.

Document Screening Recommendations

Advise patients of preventative health screenings and

document these discussions. Failure to do so could result in an allegation of a delay in diagnosis if a metastatic or potentially life-threatening condition is not detected in a timely manner.

Inform Patients of Test Results in a Timely Manner

Inform patients of test results in a timely manner. Results that are indicative of a potentially life threatening illness may be best communicated by the physician personally to allow the patient the opportunity for questions and agreement on future treatment plans.

Maintain a Reliable Clinical Tracking System

Without a reliable clinical tracking system, it may be difficult to identify patients who fail to keep scheduled appointments for tests and consultations with specialists. Whenever possible, schedule referrals and follow-up appointments before the patient leave the office. If the patient refuses the test, due to financial or other reasons, this should be well documented. Failure to maintain reliable clinical tracking systems is one of the most frequently cited problems in medical malpractice cases where there is an allegation of delay in diagnosis and/or failure to supervise care.

Coordinate Treatment Plans with Other Providers Involved in the Patient's Care

Maintain good communication with other providers involved in the patient's care and maintain a clear understanding of the expectations and role in the patient's plan of care. Ask consultants to notify you if the patient fails to keep an appointment and request periodic updates on the care and treatment plan or a summary at the conclusion of care, whichever is appropriate.

Informed Consent

Inform patients regarding any alternatives, benefits, risks and complications associated with the proposed treatments or tests. Document all informed consent and informed refusal discussions.

In conclusion, given the extensive research on patient non-compliance, it is reasonable to maintain a high index of suspicion for non-compliance on all patients. The best approach is to maintain effective communications with patients and take proactive measures to enhance treatment goals. However, when patients fail to follow recommended advice and a poor outcomes result in a medical malpractice claim, objective documentation of non-compliance can be your most powerful defense.

References:

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3. Online Reference <http://www.musc.edu/catalyst/archive/2001/co1-19pharmacy.htm> 04/02/01, 11785 bytes

A Working Model for Credentialing and Supervising Medical Assistants

By: Robert G. Chalmers

Life has been tough for private practices and will likely get tougher over time. Rising operating costs, disappointing reimbursement and stressors from every direction, combine to keep today's practice under tremendous pressure to manage costs while yet providing quality care. What a balancing act!

Practices are forced to respond to these pressures, or risk going out of business.

Believe it or not, you can help assure quality care in a cost effective manner by employing the simple methodology outlined in this article. The methodology presented here is applied to Medical Assistants (MAs). However, the process can be used with any other staff function.

For the average primary care office, the MA is likely the staff member who spends the most time with a patient. From greeting to departure, this person most represents your practice to your patient/customer. How well do you evaluate, train and monitor this employee?

How well are MAs trained?

Some of the more seasoned MAs may not have attended a structured program (MA "school"). There are currently no curriculum or content standards in place for the education and training of MAs. In 2007, The National Council of State Boards of Nursing proposed a model curriculum for MA-C's (Certified MAs). So far, nothing has happened.

A friend who is a risk management expert has visited and lectured at a number of MA schools. This expert reported an absence of consistency in curricula among the schools. MA education and training programs have, in some cases, come down to as little as six weeks! Practice administrators report interviewing MA candidates who could not take vital signs except by using a vitals station. Is this the competency level to which you will entrust your patients and the future of your practice?

In short, the leaders of the practice should set a list of duties they expect their MAs to perform, evaluate initial skills against each duty or task, and monitor for ongoing competency. Leaders should also decide how they want these duties carried out. When I was a practice administrator, I had each MA

write up a detailed description of how they performed certain duties. For example, when we focused on lab related procedures, each MA picked one procedure and wrote it up in detail. Involving your staff is a great way to help them feel invested in the process and contributing to the practice. Clinical leadership then reviewed these procedures, making changes if needed. This creates practice specific standards - "We expect you to be able to perform these tasks and this is the way we want them performed." You make your expectations clear and have them documented in a personnel or clinical services manual. These policies should also be reviewed with all prospective MA hires.

Whenever possible these candidates should demonstrate their proficiency at the interview. The practice leaders observing the candidate's proficiency in each task must also document the proficiency, or lack thereof. If the candidate cannot be checked out prior to hire, they should be evaluated as soon as possible after hire. Results of the monitoring should be documented. This only takes a check mark in a "Yes" or "No" box on a form with any deviations documented.

Deficiencies need to be addressed immediately. Once they pass this "test" you should periodically "re-test" them to ensure they haven't made any changes in the prescribed care. If they do, they are counseled. As the MA continues to "pass," the frequency of retest can be reduced.

While physicians should be directly involved in this monitoring, these duties can be shared by all licensed providers at the practice, so the ongoing time investment is indeed minimal.

To summarize: Tell them what you want them to do. Tell them how you want it done, and assess competency and periodically reassure yourself (and any potential reviewing agencies) that they are still complying with the protocols you established. By following this process your risk of MA performance problems are reduced, your quality of care and efficiency are increased, and your staff turnover is likely reduced.

Robert G. Chalmers is the Executive Director of Physicians' Alliance, Inc.

Risk Management Transitions Department *(continued from page one)*

"One of the key factors to improving patient safety is giving healthcare leadership the right data across the systems so that they can make fiscally sound decisions about environment of care and process improvement," Wright added.

The Department will accomplish this through new data programs, designed to advance internal systems, enabling them to produce accurate reports revealing insights to factors

contributing to errors and patient injury.

In addition, the Department has renewed its focus on outcomes and performance monitoring, and improved online CME educational programs. All of these activities are designed to provide decision support, and to create actionable information that will help policyholders save lives, improve their quality of patient care and ultimately conserve their assets.

Hearing Impaired Patients—Physician Obligation to Provide Interpreters

By: *Georgette Samaritan, RN, Senior Risk Consultant*

Physicians treating patients who have hearing impairments may be responsible for providing interpreters for such patients in the medical office at no cost to the patients. These requirements often surprise physicians who note that the cost of an interpreter may exceed the amount billed to the patient for the office visit. Whether a patient is entitled to an interpreter under these requirements, or whether other means of communication will be appropriate, is heavily fact dependent. This article will briefly analyze communication requirements that apply to physicians treating the hearing impaired.

The Americans with Disabilities Act (ADA) of 1990 generally prohibits discrimination on the basis of a person's disability and applies to services rendered in private physicians' offices, among other places.¹ One of the ADA's central themes is the obligation to provide reasonable accommodations so persons with disabilities can enjoy access to services offered to the same extent as persons without disabilities. The ADA has been interpreted to require physicians to provide effective means of communication to their hearing-impaired patients through auxiliary aids and services, including interpreters, notes, other written materials, and telecommunications devices.² The physician may not impose a surcharge on the hearing-impaired patient for the provision of such auxiliary aids and services.³

The ADA contains no requirement that physicians provide and/or pay for a live interpreter for each and every patient encounter. The physician should consult with the patient to determine the most appropriate auxiliary aid or service to employ. Neither the patient nor the physician should unilaterally decide upon the auxiliary aid or service to be employed without consulting with the other. While the final choice of alternatives rests with the physician, a mutual

agreement between the physician and patient will render the best result.

Under the ADA, a physician is not required to provide an auxiliary aid or service (e.g., an interpreter) if it would cause the physician an undue burden or would fundamentally alter the nature of the services normally provided.⁴ An undue burden is something that involves significant difficulty or expense, although cost alone is not determinative.⁵ Apparently, it is not considered an undue burden if the cost of the auxiliary aid or service exceeds the amount the physician will receive for treating the patient. As a practical matter, it may be difficult to show that use of an interpreter would fundamentally alter the nature of the services normally provided by a physician in most cases.

When the question is which auxiliary aid or service to utilize, physicians should be mindful that the goal is effective communication under the circumstances. With routine office matters, a pen and notepad may suffice. With more complex matters, use of a qualified interpreter may be justified. Physicians may contract with interpreters from outside interpreter services, hire staff members capable of interpreting for hearing impaired patients, or utilize friends and family of the patient. A friend or family member should be used as an interpreter only when acceptable to the patient and when the person can serve in that capacity effectively. It is clear that engaging in communication with hearing-impaired patients can be accomplished in more than one way. The challenge is finding the most effective method of communicating with the patient considering all the circumstances involved

Sources:

1 28 CFR 36.104

2 28 CFR 36.303

3 28 CFR 36.301

4 28 CFR 36.303

5 28 CFR 36.104

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment. This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion. ©2009 MAG Mutual Insurance Company.



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