Common Legal Risks Confronted in Primary Care Practice

Concepts: Law, Ethics and Risk Management

Good ethics has been described as beginning where the law ends. *See* George Annas, Standard of Care: The Law of American Bioethics, New York, Oxford University Press (1993).

Top Sources of Licensure and Litigation Risk

1. Poor communication with patients
2. Poor bedside manner
3. Delay or change in diagnosis
4. Lack of informed consent
5. Erroneous documentation
6. Scope of practice issues

Summary: Failing to practice in the way you learned in school.

Risk Management Tips

1) Do the right thing, 2) In the right way, and 3) Document the right thing.

Do the right thing: Practice evidenced based medicine.

In the right way: Maintain good relationships with your patients (and management their expectations), your colleagues and staff.

Document the right thing: First, no chart wars. Second, if it's not documented, there's no proof that you did the right thing, which makes you more vulnerable to suit. The first step in assessing a case, the plaintiff's lawyers get a copy of the medical record. There are a lot of sloppy charts out there. So, they don't tend to bother themselves with the pristine charts.

Potential consequences of doing things in the “wrong way”—licensure investigations and litigation

Communication and Disclosure

UPMC
LIFE CHANGING MEDICINE

“The Gap”

- Shift in patient expectations.
- Old way: Physicians have all of the information patients know as needed.
- New Way: Patient’s want to know everything, the good the bad and the ugly.
- Gap between what patients receive and what they would like to receive.

“Bad News” and “Good News”

- It is usually easy to provide positive information, negative information is more difficult to disclose, especially when the cause may be attributable to a clinical error or hospital problem.

- Communicating “good news” is like playing Santa, you get to make people smile.

“Bad News” and “Good News”

- It is usually easy to provide positive information, negative information is more difficult to disclose, especially when the cause may be attributable to a clinical error or hospital problem.

- Communicating “good news” is like playing Santa, you get to make people smile.

Disclosure Golden Rule…

- Honesty is the best policy.

- Ethics, regulations, common decency, AND the relevant empirical literature, suggest that timely and candid disclosure should be standard practice.

Risk Management Tips

1) Do the right thing, 2) In the right way, and 3) Document the right thing.

Do the right thing: Practice evidenced based medicine.

In the right way: Maintain good relationships with your patients (and management their expectations), your colleagues and staff.

Document the right thing: First, no chart wars. Second, if it's not documented, there's no proof that you did the right thing, which makes you more vulnerable to suit. The first step in assessing a case, the plaintiff's lawyers get a copy of the medical record. There are a lot of sloppy charts out there. So, they don't tend to bother themselves with the pristine charts.

Disclosure

- Disclosure is required by law and regulation.
- Accordingly, It is not a question of IF; rather, HOW
- Right thing to do
- Mandates
  - JCAHO RI 2.90 (2001)
  - PA. MCARE Law
    - Patient
    - State

Disclosure: Why?

- Anecdotal Evidence
  - Prevent Claims
  - Decrease Indemnity & Expense $$
- Empirical Evidence
  - U. of Michigan; VA
  - Our own experience
- Josie King Pediatric Patient Safety Program

Disclosure: Litigation Impact

- If admitted error, probably not litigation
  - Early Resolution
  - Defuse Emotions
  - Admit Liability if unable to settle

Disclosure: Policy

- Elements
  - Reporting System
  - Who Discloses
  - What (& What not) to disclose
  - How to Disclose
    - Apology
    - Explanation
    - Assurance

Disclosure: Policy

- Elements (cont'd)
  - When
  - Where
  - To Whom
  - Documentation
    - Chart
    - Letter to Patient

Disclosure: Pitfalls

- Lack of Teamwork & Preparation
  - Same issues probably contributed to error
  - Conflicting messages
  - Send the least experienced
- Blame
- Admissibility
  - Apology Laws/Rules

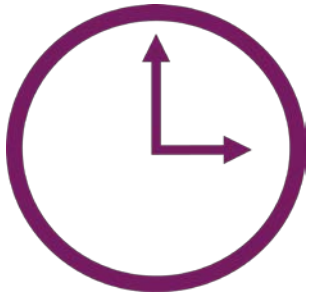
MCare

- In March of 2002, Pennsylvania established Act 13 - *Medical Care Availability and Reduction of Error Act (MCare)*

- *MCare* was established to promote patient safety and reduce soaring malpractice rates

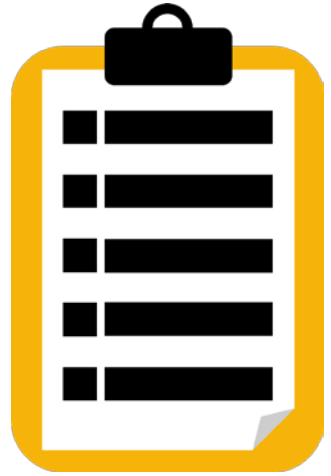
MCare Requires

- Health care workers to report serious events and incidents within 24 hours of occurrence or discovery.
- PA Whistleblower Law – No adverse action or retaliation for reporting.
- Health care workers may report anonymously to the PSA.



What to Report?

- Incident
- Serious Event
- Infrastructure Failure



What is a Serious Event?

- A serious event is an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring additional health care services to the patient.

What is an Incident?

- An incident is an event, occurrence or situation involving the clinical care of a patient which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional services to the patient.

Defenses

- Best Defense is No Claim
- How?
- Documentation
- Communication

Documentation


Good medical record
documentation
is like money in the bank.

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

Documentation

Patient Interaction

Judgment

Reconstruction

Physician Involvement

Electronic Medical Record Rules

The electronic health record tracks what you do. So ensure that your entries are:

- **T**imely-The time of your entry is clear.
- **R**eliable-Ensure that what you document is consistent with what you want to communicate orally at handoff.
- **A**ccurate-Ensure that your entries are as accurate as possible.
- **C**omplete/Consistent-Use the same words for the same things.
- **K**nowledgeable-Never, ever guess in the patient's record.

Chart

- C = clear, concise, contemporaneous
- H = honest
- A = accurate
- R = readable
- T = timely

Informed Consent

INFORMED CONSENT

WHAT IS INFORMED CONSENT?

Informed consent is based on the moral and legal premise of patient autonomy: You as the patient have the right to make decisions about your own health and medical conditions. You must give your voluntary, informed consent for treatment and for most medical tests and procedures.

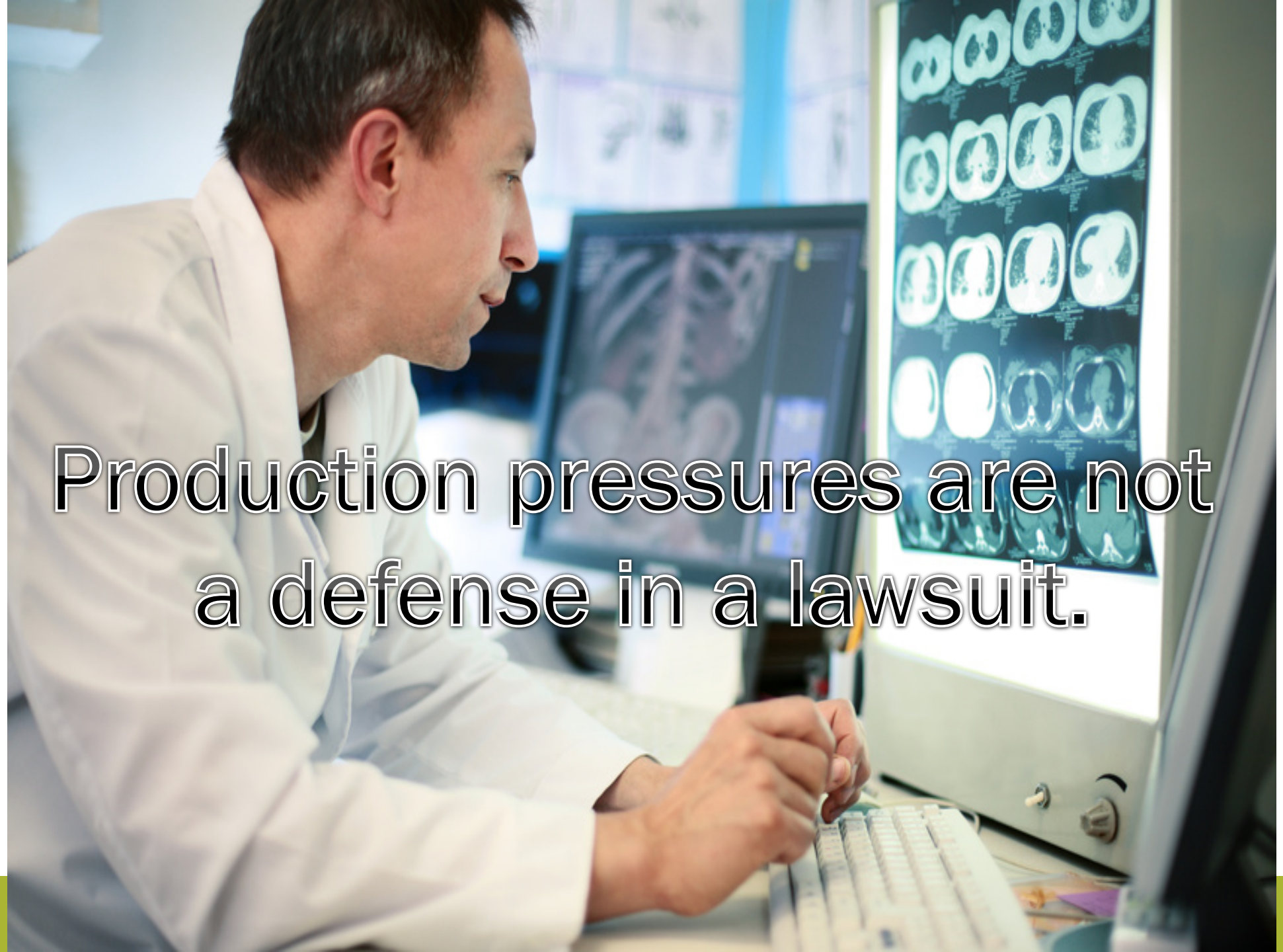
INFORMED CONSENT

Consent given by the patient based on knowledge of the procedure to be performed, including its risks and benefits, as well as alternatives to the proposed treatment.

Team-based practice has responsibilities

Bonus: Prescribing Risks

I AM UNBELIEVABLY BUSY. Surely a jury would understand that if I were sued.


Production pressures are not
a defense in a lawsuit.

Truisms…

1. Today's health care system, delivery processes involves numerous interfaces and patient handoffs among multiple health care practitioners with varying levels of educational and occupational training.
2. Ordering providers do not always provide clear direction or orders.
3. The health care environment are not slowing down and providers may not become intuitively more clear.
4. Open communication can help you avoid lawsuits.
5. A nurse is obligated to obtain clarity when the ordering provider does not provide a clear order. Failure to do so is exceeding the nurses scope of practice. So, support the nurses in obtaining clarity.

Risk Management Tips

1) Do the right thing, 2) In the right way, and 3) Document the right thing.

Do the right thing: Practice evidenced based medicine.

In the right way: Maintain good relationships with your patients (and management their expectations), your colleagues and staff.

Document the right thing: First, no chart wars. Second, if it's not documented, there's no proof that you did the right thing, which makes you more vulnerable to suit. The first step in assessing a case, the plaintiff's lawyers get a copy of the medical record. There are a lot of sloppy charts out there. So, they don't tend to bother themselves with the pristine charts.