# Loss Minimization

## a Program Outline

## for the Medical Group Practice

The following is a white paper written in 1988 taking pieces of data and idea's from PSIE, a California medmal carrier, (later sold to Fremont, then to SCPIE) CNA, and St. Paul, risk management articles, underwriting guidelines and claim reports.

The purpose of this paper was to pull together, in one working document highlights for MGMA member administrators to use in their practice.

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## A PROGRAM OUT LINE

## FOR THE MEDICAL GROUP PRACTICE

Most medical professional liability insurers, are dedicated to the premise that incidents of professional negligence can be controlled and the financial consequences minimized through the implementation of a formal Loss Prevention Program. The purpose of this presentation is to outline, for the group practice administrator and medical director, those pertinent factors which should be monitored and controlled in the interest of minimizing the possibility, aswellas limiting the economic consequences of medical malpractice incidents.

Anyone close to the practice of medicine will already be familiar with, or aware of, many of the observations and recommendations included in this presentation. The intent is to re-emphasize the importance of constant alertness to the need for refortification of the daily practice of good administrative procedures.

We will, upon request, provide assistance in analyzing the risk management needs of the group practice, including implementation and the monitoring of specific recommendations which may follow from a survey. At a minimum, a survey will cover all of the following factors which are know, through experience, to have a bearing upon the probability of an incident occurring and/or the outcome of the settlement of a patient's claim. As a guide this out line is offered.

### The Individual Practitioner

It has become axiomatic that doctors who have achieved a high level of proficiency and who are at the height of their careers, are highly susceptible to allegations of medical malpractice. The fact that doctor defendants prevail in a high percentage (70% plus) of cases alleging malpractice, including those taken to trial, gives testimony that good doctors are defendable.

### The Human Factors

There is strong evidence to suggest that a significant number of gross negligence cases are the result of inadequate training, practicing above one's ability, excessive use of alcohol or drugs, or a state of mental deterioration. These are all sensitive issues with which a group administrator must deal forcefully.

The individual practitioner is subject to those frailties which confront all human beings. It is therefore incumbent upon the group administrator to not only assist in the selection of members for the group, but to constantly monitor and evaluate their professional skills and various personality traits.

A formal program and, at least, a quarterly evaluation of each doctor should exist. A score sheet should be completed for each doctor which will cover the following pertinent points:

1. Has the doctor completed the required number of hours of continuing education as specified by the state licensure
2. During the past 90 days, has the doctor performed any patient services outside of his specialty or for which he is not properly trained or qualified?
3. Has there been any noticeable adverse change in the doctor's relationship with fellow members of the group, nurses, staff, or hospital personnel?
4. Does the doctor relate favorably with his patients? Does he make rounds regularly and visit his patients after survey?
5. Has there been any noticeable adverse change in the doctor's behavior? Does he have any problems with alcohol or drugs?
6. Has there been any adverse change in the doctor's home life: marital difficulties; problems with the doctor's children; financial difficulties.

At the end of each review, any adverse changes noted should be brought before an in house peer review committee for evaluation and appropriate corrective actions.

THE STAFF

Just as it is proposed the individual practitioner be evaluated, so should the medical support staff. All nurses and medical technicians should be subject to at least a six month evaluation of their skills, attitude, and performance of duties.

A continuing education program for staff personnel is paramount. In addition to emphasis upon medical technology, the following subjects should be emphasized:

1. Patient communications: the staff can do much to support the doctor's effort to keep the patient relationship harmonious.

2. Attention to detail. maintenance of proper medical records frequently rests with the staff. While it is the doctor's responsibility to control content, it is the staff's responsibility to make certain the records are completed on a timely basis and properly maintained.

3. Systems and Procedures: the staff must be indoctrinated in the mechanics of the group's systems and procedures relative to patient care. Emphasis should be placed upon standardization of those supportive procedures performed by staff such as taking of patient histories; taking of blood and urine samples; rendering EEGs, EKGs, and similar tests; taking of x-rays; administration of radiology; and performance of laboratory tests.

Attention must also be given to the performance of ancilliary services such as assistance to patients in completing claim forms for health insurance benefits; billing procedures and payment requirements; patient referral services; and the handling of patient complaints. Remember: a patient disgruntled over seemingly minor issues may seek relief by charging malpractice.

EMERGENCY CARDIO PULMONARY RESUCITATION FACILITIES AND TRAINING

The efficacy of CPR as a life saving method is well documented. Unfortunately, the number of doctors and nurses trained in CPR techniques leaves much to be desired. There is little question, however, that the public believes the medical practitioner is qualified in CPR and would expect a competent response to an unexpected medical emergency.

All doctors, nurses, and lay personnel at the supervisory level (as a minimum) should be trained in CPR and certified by either the American Heart Association, or the American Red Cross. Refresher courses should be taken at least once each two years.

If the size of the practice and patient traffic warrants, properly equipped bio-medical emergency equipment should be available on the premises. The staff should be trained in the use of the equipment, and written protocol established, with staff assignments made to assure response to an emergency is immediate and orderly. Of equal importance is assurance that someone is designated to immediately call a paramedic service to transport the victim to the nearest qualified trauma center or hospital facility.

MEDICAL RECORDS

No single factor reoccurs more frequently in malpractice litigation than the issue of the records relevant to the care provided to the patient. It has been stated that $.80 out of each dollar paid out for malpractice claims stems either from actual malpractice or failure to generate medical records which adequately prove good practice.

It is not adequate to emphasize only the need to complete the required forms. Extreme care must be taken in the completion of the forms to assure the quality of the information recorded. The record must fairly display the data collected and the data must be consistent with high medical standards. The record must show how the data was assessed and how the course of investigation and treatment was carrier out. It must be legible and current. It must show proper attention has been given to those pieces of ongoing data which peers would agree to be critical to the following the patient's case.

In principle, if good medicine has been practiced, good medical records will fairly display the facts and allegations of malpractice are defensible.

The keeping of good medical records starts with the first visit with a patient. The patient's medical history must be taken to provide the background data necessary for evaluation of current medical needs. It is obvious the details of each service performed and the basis for treatment must be recorded on a continuing basis. There is one extremely important document which must be made a part of each patient's record - the informed consent form.

Informed Consent is a broadly used term to designate the procedure which must be followed in making certain a patient is fully aware of the nature of his medical needs, the services to be performed, the risks involved, and the outcome which may be expected. The process should also include a frank discussion of the fees and other costs which will be charged for the treatment, including hospital charges if applicable. It is also recommended that when appropriate, the discussions include those members of the patient's family as the doctor deems advisable, such as spouse, parent, or guardian.

Whenever a patient is confronted with the need for surgery or radical treatment such as therapeutic radiology or chemotherapy, it is absolutely mandatory the patient provide written acknowledgement of his informed consent.

If drugs are dispensed, the patient must be advised of any potential reactions expected from ingestion and the drug containers properly labeled with warning or separate insertions provided.

A relatively new theory has been developed which clearly falls within the discussion of medical records. Several areas of patient compliance have been identified which, when documented, will possibly prevent malpractice suits or strengthen the doctor's defense. The concept applies primarily to the chronically ill patient, who, due to non-compliance with the doctor's prescribed treatment, does not realize the expected or desired improvements in state of health. There are 11 areas of compliance which should be included within the medical records:

1. Keeping physician's appointments
2. Reporting for medical examinations
3. Reporting for treatments, hospitalizations, operations
4. Taking medication as prescribed
5. Avoiding drug abuse
6. Avoiding alcohol abuse
7. Following smoking recommendations
8. Adhering to dietary suggestions
9. Conformity to work recommendations
10. Following exercise suggestions
11. Obtaining proper tests

PHYSICAL PLANT

In addition to claims of medical malpractice, patients are also prone to make claims for injuries sustained while on the premises such as may arise from slip or fall incidents. It is therefore pertinent that the group administrator, or his designee, perform a monthly physical inspection of the facilities and the medical equipment. Attention should be directed to the following:

Parking lot Facilities: Are surfaces properly maintained/ Properly lighted? Walk ways designated? Curbs designed for the handicapped?

Building Entrances, Exits: Are walk ways designed for the handicapped, curbs properly marked, is doorway vision obstructed, are doors properly equipped with panic bars, are there any obstructions which could cause a trip or fall., properly lighted and marked.

Floors and Hallways: Are polished floors too slippery, are carpets ragged or torn? Are walk ways clear of obstructions. Are the premises clean?

Furniture: Is all furniture well maintained and sturdy? Is it properly arranged to avoid obstruction of egress?

Medical Machinery: Are all mechanical devices modern, up-to-date, and well maintained? Are all electrical devices properly grounded? Are operating instructions or warnings clearly posted on or at each machine?

Storage and Housekeeping: Are all storage areas free of debris and inventory items properly stored? Is there regular janitorial service? Are flammable liquids properly stored? All storage areas for drugs should be inspected for drugs which have expired, have old illegible labels, or are no longer in use. All narcotics should be under lock and key.

Evacuation: Is there an evacuation plan? Are drills held regularly? Is each member of the staff assigned a specific evacuation duty? Has someone been given primary responsibility to call for county or city emergency services assistance?

CLAIMS, WHAT & WHERE

Surgical & Diagnostic issues "top allegations"

Statistics from St. Paul national 1988 physicians & surgeons "update" provide the administrator with helpful insight to problem areas.

Surgical issues accounted for the highest number of St. Paul's 13,036 reported claims for the period of, 1986 and 1987 evaluated as of March 31, 1988.

TOTAL CLAIMS BREAK OUT

| GROUP | NUMBER | COST |
|---|---|---|
| Surgery | 3,814 | 25.5% |
| Failure to diagnose | 3,667 | 33.5% |
| Improper treatment | 3,532 | 30.9% |
| Anesthesia | 354 | 3.6% |
| Other issues | 1,570 | 6.5% |
| | 13,036 | 100.0% |

## SURGERY - TOP FIVE ALLEGATIONS

| | |
|---|---|
| Postopererative complications | 1,957 |
| Inadvertent act | 478 |
| Inappropriate procedure | 340 |
| Postoperative death | 326 |
| Delay/Complicaitons | 201 |
| Top five total | 2,120 |

## FAILURE TO DIAGNOSE - TOP FIVE

| | |
|---|---|
| Failure to diagnose cancer | 768 |
| Failure to diagnose fracture/dislocation | 415 |
| Failure to diagnose infection | 350 |
| Failure to diagnose pregnancy problem | 323 |
| Failure to diagnose Myocarial infarction | 264 |
| Top five total | 2,120 |

## CLAIMS AND INCIDENT REPORTING

Again, most policies require that "all incidents which may give rise to a claim" be reported to the company "as soon as practical." All actual claims or suits made by patients or their representatives generally must be reported to the company by certified mail within 10 days of receipt.

## EARMARKS!

There are some fairly reliable earmarks of a pending malpractice problem which you should watch for and report immediately. Among these are the following:

1. A letter or phone call from a patient or lawyer foretelling a problem
2. A request to copy your records
3. Any untoward occurrence in patient care or relationship which hints of trouble
4. Receipt of a "90 day" letter
5. Service upon you of a Summons or Complaint

Should any of the above take place, there are definite "DOs' and DON'Ts" which you should follow:

1. DON'T argue with the patient
2. DON'T talk to any attorney other than ours
3. DON'T respond to letters, instructions, or requests for information
4. DON'T express any opinions

5. DO contact your agent or company representative immediately
6. DO refer any calls or correspondence to your agent or representative
7. DO report any suspicious behavior or event promptly

Summary

One of the best health care, risk management (minimum critera) summarizations was printed in Medical Economics April 1988 addition;

"Clearly, there are steps you can take that should help you steer clear of malpractice suits. Among the least controversial:

> If you don't already make a point of establishing good personal rapport with your patients, work on it. Explain what you're doing and why, and make sure patients understand.

> Make certain patients are fully informed about the risks of therapy.

> When in doubt about a diagnosis or your ability to handle a patient's problem, call in a consultant.

> Perhaps most important, get all of the pertinent information about each patient you're treating down in writing on the chart.

OTHER CONSIDERATIONS

PHILOSOPHY

It is the philosophy of most medical liability insurance companies to vigorously resist any claim presented which appears to be either without merit or otherwise defensible. For this reason, many policies will guarantee each insured has a voice in the settlement of any claim. Still other carriers go as far as actual "peer review" if there is a difference of opinion between the company management and an insured. It is also the opinion of most carriers, that meritorious claims should be settled promptly. Statistics indicate that the longer it takes to settle, the higher the amount of the award.

ARBITRATION

Most insurers leave the issue of patient arbitration agreements to the doctor and his/her personal counsel. There is much yet to be learned about arbitration and its ultimate benefit in reducing the cost of malpractice claims.

CONCLUSION

In conclusion, the effectiveness of any loss minimization program is totally dependent upon the commitment made by the group administrator

the individual practitioners and staff. Only when all parties agree to continuing their professional education and are willing to accept the disciplines imposed by a properly organized, implemented, and enforced program will meaningful results, which can be measured financially, be realized.