

## Working with Hospitalists

— by Marva West Tan, RN, ARM, FASHRM  
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**H**ospitalists, physicians “whose primary professional focus is the general medical care of hospitalized patients,” face a unique constellation of risks due to their specialized inpatient role.<sup>1</sup> Hospitalist-specific claims data are scarce as this new medical specialty was rarely known in American hospitals prior to 1996. But future claims may emerge as this specialty has grown rapidly from a few hundred to an estimated 8,000 to 10,000 practitioners currently.<sup>2</sup> The Physicians Insurance Association of America (PIAA), a trade association of physician liability insurers, only recently requested that members separately report claims involving hospitalists to the PIAA data bank; three closed claims were reported for January - June 2004.<sup>3</sup> Lifespan Risk Services has not seen any hospitalist-specific claims.

**D**espite lack of detailed claims data, hospitalists are primarily drawn from internal medicine specialties and are likely exposed to similar diagnosis- and treatment-related professional liability risks. Additionally, risk analysis of hospitalists’ inpatient roles indicates that discontinuity of care, communication failures, unclear role definition, and role creep present specific risk exposures for hospitalists.

Primary care physicians (PCPs) who occasionally or

often work with hospitalists, while appreciating their value, should be aware of the risks that this new practice model can create for both specialties. This article describes these exposures and suggests strategies that primary care physicians and hospitalists might consider for proactive risk reduction.

### Constellation of Risks

Hospitalists’ responsibility for the care of hospitalized patients from admission to discharge often involves them in coordination of needed consultation, perioperative and post-acute care. Additionally, in some hospitals, hospitalists often fill several other roles such as providing night and weekend coverage for the hospital, supervising and teaching residents, being a rapid response team member and providing medical leadership for patient safety or performance improvement programs. Risk exposures can arise from any of these roles.

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### Discontinuity of care

The hospitalist model of care creates a “purposeful discontinuity”<sup>4</sup> between inpatient and outpatient care that can lead to important clinical information being lost or misunderstood at hand-offs between the PCP and hospitalist at admission and discharge.

The PCP’s best strategy to reduce this risk is to use a standard, structured process for communicating with the hospitalist, by telephone, fax or other electronic method. PCPs should provide the hospitalist with current clinical information when one of their patients

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is admitted, such as most recent history and physical, current outpatient notes, medication list, allergies, advance directives, significant recent diagnostic studies and results, and other significant clinical information or patient preferences.<sup>5</sup>

PCPs should also be clear about what treatment the hospitalist can, and should be providing or if there is an expected deviation from established care protocols. And, hospitalists should also have a standard process for keeping PCPs informed about their hospitalized patients with contact on admission, discharge, critical junctures of care such as transfer to critical care, and at significant changes in the patient’s condition.

If the patient has a lengthy hospital stay, the hospitalist should periodically update the PCP in an agreed-upon manner. If the PCP wishes more information, she should actively seek it from the hospitalist. At discharge, the hospitalist should provide the PCP with a

### Key Handoff Information Checklist

The following checklist includes information that should be discussed by the hospitalist with the patient’s primary care physician at various stages of the patient’s hospital care.

#### At admission:

- ▶ **History of illness**
- ▶ **Current medications**
- ▶ **Recent relevant test results**
- ▶ **Pending tests**
- ▶ **Advance directives**
- ▶ **Living circumstances (i.e., social supports)**
- ▶ **Family issues**

#### During hospitalization:

- ▶ **Important change in management strategy**
- ▶ **Condition downgrade**
- ▶ **Transfer to critical care unit**
- ▶ **Death**

#### At discharge:

- ▶ **Known and pending test results**
- ▶ **Discharge medications**
- ▶ **Medical equipment ordered**
- ▶ **Consultations**
- ▶ **Visiting nurse services requested**
- ▶ **Recommended follow-up**

Source: Lucas, BD, Working with hospitalists to improve continuity of care. *Patient Care* 2000 Jan 15; 34(1):138-42

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discharge summary, including the discharge plan, medication list, patient instructions and recommended follow up by the PCP or other physician.

Relying on a mailed copy of a discharge summary prepared from dictation may be too slow for good continuity of care. Some clinicians suggest use of a computer application that generates a discharge letter

Hospitalized patients, if not prepared, when first confronted with a hospitalist, may wonder why their family physician is not caring for them

from the hospitalist to the PCP. In this approach, a standard template is populated with data from hospital databases and then the letter is further individualized by the hospitalist and forwarded by fax or mail.<sup>6</sup>

Additionally, hospitalists should assure that there is a good hospital system for forwarding tests results to them that return after patients are discharged so they can follow up with patients and their PCP if indicated.

### **Other Communication**

Hospitalized patients, if not prepared when first confronted with a hospitalist, may wonder why their family physician is not caring for them.

To avoid any patient confusion or dismay at

the time of hospitalization, PCPs should inform their patients during routine office visits that hospitalists may care for them should they ever require hospitalization.

PCPs should also reassure their patients that while the hospitalists may provide some or all of their inpatient care, their primary physician will remain informed and involved. This information could also be included in an office brochure along with other details about office hours, emergency numbers and other basic practice facts. Hospitalists may need to repeat this information to new patients, particularly those with stressful unplanned admissions.

Difficult ethical issues can arise when hospitalized patients are seriously ill and their advance directives change or are unclear. While PCPs may have a more long-standing relationship with the patient, the hospitalist may have some unique insights into the current medical situation. Clear and detailed communication among involved parties, while protecting patient autonomy and confidentiality, is advised.<sup>7</sup>

Some hospitalist programs have also prepared brochures which can be left with patients explaining their role and answering frequently asked questions. Letting patients know that they may be seeing different physicians in the hospitalist practice helps manage patient expectations.

### **Lack of role clarity and role creep**

These are two related phenomena which can lead to dangerous misunderstandings about “who is managing what?” in patient care as well as contributing to hospitalists’ burnout.

Hospitalists who begin their positions with responsibilities limited to care on inpatient units may find that gradually and informally their role has grown. Their role over time may expand to the point that one physician

*Insights* is published quarterly by Lifespan’s Risk Management Department. Submissions and ideas are welcome and may be submitted to Peggy Martin via e-mail: [pmartin2@lifespan.org](mailto:pmartin2@lifespan.org) or fax: (401) 444-8963.

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**T**he purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, or may be composites of several cases with very similar fact patterns. We present these cases because we believe they have some relevance to situations that you may encounter.

## The Patient:

A 73-year-old woman was referred to a surgeon by her primary care physician (PCP) for an incidental finding of blood in her urine. The surgeon ordered an IVP, a cystoscopy, and a CT scan.

The scan suggested two unusual findings in one kidney, one in the interior and one on the exterior, either of which could have represented a potential malignancy.

The surgeon in this case demonstrates one of the most common cognitive errors physicians make, the premature diagnostic closure

The radiologist's final report recommended further testing on both the abnormal findings.

As a result of the scan, the surgeon performed the cystoscopy and obtained specimens from the interior of the kidney, which were negative for malignant cells but which could explain some episodic microhematuria. He did not follow the radiologist's recommendation to investigate the other finding also.

The surgeon, satisfied that there was no malignancy, instructed the patient to return in six months for follow-up. In the interim, the patient returned to her PCP with renewed complaints of hematuria, and he sent her back to the surgeon.

The surgeon then focused on the second unusual finding from the original CT scan, which revealed an invasive cancer on the exterior of the kidney.

Surgery to excise the kidney was scheduled and performed by the surgeon and a surgical resident. During the procedure a major vessel was damaged, requiring a vascular surgeon to repair the vessel before the primary surgery could be completed.

The blood loss adversely affected the patient's recovery and extended her hospital stay. About nine months elapsed between the time the patient was initially referred to the surgeon, the diagnosis of cancer was made, and the patient was referred to an oncologist. Eight months later the patient was diagnosed with metastatic disease.

## Damages:

The patient alleged that the delay in diagnosis resulted in her cancer becoming more invasive than it would have been had the diagnosis been made and treatment rendered following the surgeon's initial work-up.

She also alleged that the nephrectomy became a more difficult procedure because the tumor had grown to involve more anatomical structures, and resulted in the complication that delayed her recovery and required a prolonged hospitalization.

## Liability:

The patient brought a medical malpractice suit against the surgeon for delayed diagnosis of kidney cancer, and

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for all of the complications during and after the surgery including prolonged hospitalization, and reduced chance of survival.

The focus of her claim was the surgeon's failure to follow up on the second unusual finding identified on the CT scan (and the radiologist's recommendation for further testing), after the first abnormal finding proved benign. She also sued the surgeon for failing to tell her about the second finding on the CT scan and the radiologist's recommendation, depriving her of the opportunity to make an informed choice about whether to pursue any further evaluation.

### Risk Management Issues:

The surgeon believed that he was looking for one type of cancer, in one location.

When the cystoscopy showed one abnormality was benign, he assumed that all other findings were benign. The surgeon in this case demonstrates one of the most common cognitive errors physicians make, the premature diagnostic closure, seen more often with emergency physicians, radiologists, and pathologists. Also known as "anchoring", premature diagnostic closure "describes the practice of locking onto an early working diagnosis, subsequently ignoring or failing to seek further data that might refute one's initial impression."<sup>1</sup>

The medical, psychological, quality improvement, and risk management literature all describe such cognitive errors and their effect on patient care and physician

liability.<sup>2</sup> Claims for failure to diagnose or delay in diagnosis account for a significant percentage of claims against hospitals and physicians.<sup>3</sup> In Lifespan facilities, from 2000-2005, 20% of malpractice claims involved errors in diagnosis.

If the surgeon in this case had developed a differential diagnosis at the outset, taking into account the other significant radiologic impression on the CT scan, he would have worked his way to the second item on his differential when his first provisional diagnosis was ruled out. A non-invasive ultrasound and/or a more focused radiographic study of the kidney may have more clearly identified the second abnormality that could then have been studied further, perhaps with biopsy. Instead, convinced that he had discovered the reason for the abnormal findings, he did not return to the CT scan report and follow the recommendation for further studies.

### Outcome:

The lawsuit was settled in the moderate range. The patient died a few months after the settlement, almost three years after the initial referral to the surgeon and a little over two years after her cancer was diagnosed.

- 1 Gallagher, EJ, "Thinking about thinking," *Annals of Emergency Medicine*, 2003, 41(1). 122
- 2 Bartlett, EE, "Physicians' cognitive errors and their liability consequences," *Journal of Healthcare Risk Management*, 1998, 18(4), 63
- 3 Physician Insurers Association of America: Data Sharing Reports. Rockville, MD: PIAA, 2003 ☀

## Risk Management staff

is available to provide risk management education to clinical and hospital departments at any of the Lifespan affiliated institutions. Requests should be directed to:

**Peggy Martin**, Senior Risk Management Coordinator, Lifespan Risk Services.

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# Implementation of a Validated Triage Rule in the Rhode Island Hospital Emergency Department

— by Andrew Sucov, MD, Director, Emergency Department

**T**his is the first in a series of articles describing the results of educational/research projects funded by R.I. Sound Enterprises Insurance Co., LTD (RISE), the malpractice insurance company owned by Lifespan. Lifespan Risk Services administers this grant annually as part of their loss prevention and educational activities. Information about the 2006 grant proposals will be distributed in November, 2005.

In the Emergency Department (ED) setting, triage is the art of rapidly identifying which patients need priority for scarce resources, which can wait, and for how long. In large EDs where patients routinely wait for access to staff and rooms, making the proper decisions as to which patients are seen first can truly be a matter of life or death.

ESI involves two assessments — what is the time urgency of being seen, and how many resources will a patient likely need

Traditionally, triage has been done in a different way in each ED. In the past few years, the Emergency Severity Index (ESI) has gained considerable support as a triage approach that has been validated to correlate with outcomes — need for admission, resource intensity and likelihood of death. ESI involves two assessments — what is the time urgency of being seen, and how many resources will a patient likely need. The greater the time urgency or the more resources, the higher the acuity. Most other approaches use a gestalt sense — relying on the provider's training and experience — to determine only what the time urgency is.

The Rhode Island Hospital ED Safety Committee identified that incorrect initial triage decisions are the most common source of anonymous Error Reports to

the Committee. Information from Lifespan Risk Services confirmed that incorrect triage decisions were a factor in some claims originating in the ED. Senior leadership agreed to implement ESI as our triage approach in June 2004. Funding through Lifespan Risk Services was critical to the success of the training of so many ED nurses (roughly 70) in a very short period of time. After implementation, a retrospective look at initial triage decisions under our previous triage scheme and with ESI was undertaken, to see what gains had been made.

Two nurses reviewed charts and independently determined the triage score under each approach; only if their scores agreed were the charts included in the review. Less than 2% of cases were excluded due to lack of agreement. In 412 charts pre-ESI, 43 (10.4%) incorrect initial triage decisions were identified. In 743 post-ESI charts, 58 (7.8%) incorrect initial triage decisions were identified. The vast majority of those decisions indicated a lower triage score than recommended by either approach. For example, most of them resulted in patients being given a triage score of 3 instead of a 2. A score of 2 is typically given to patients who are having chest pain or shortness of breath, patients who need to be seen within the next 30 minutes or less. A score of 3 or more is used for patients who can wait up to 90-120 minutes to be seen, and might be appropriate for patients with abdominal pain that does not show any serious findings.

In addition to a modest decrease in less than optimal triage decisions, switching to ESI has provided an

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## Implementation of a Validated Triage Rule

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additional operational advantage, in that triage destination has now been formally uncoupled from triage acuity. Now certain patients with high time urgency but few resource requirements are appropriately being seen in a low acuity area, but with priority over other patients who may be waiting. For example, health care workers who are exposed to body fluids from a patient have a high time urgency to identify whether treating for HIV may be appropriate, but take very few resources to manage.

Next steps include publishing and comparing our results to other sites that have implemented ESI, as well as formalizing the decision-making process to more accurately and consistently assess resource requirements that is at the heart of ESI.

As we continue to formalize the process, monitor our progress, and sharpen our skills with this system, we will determine how ESI may be implemented system-wide, bringing higher reliability to a process that remains very dependent on the experience and training of the clinicians involved. ☀

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cannot safety cover all of the functions which have implicitly become absorbed into the position. Or medical staff may assume that a one-time weekend coverage situation is now the norm. To prevent these potentially dangerous situations, the hospitalist's role should be defined in a written job description or contract that is periodically updated. And, the hospitalists' formal responsibilities should be clear to the entire medical and hospital staffs. When a PCP is sharing inpatient care responsibilities with a hospitalist, it is critical that the whole care team knows at any point which physician is ultimately coordinating the care and that formal hand-offs and sign-outs be used when indicated.

### Conclusion

While PCPs were initially skeptical about the value of hospitalists, more recent studies find that office-based physicians are more accepting of hospitalists after working with them.<sup>8</sup> This new practice model can bring increased efficiency and career satisfaction to all physicians involved but also can lead to communication failures that expose both groups to liability risks. Awareness of exposures, structured communication templates and well defined roles and responsibilities are key strategies to help protect patient safety and prevent liability claims.

- 1 Society of Hospital Medicine at [www.hospitalmedicine.org](http://www.hospitalmedicine.org)
- 2 Wachter, RM, "Hospitalists in the United States- Mission Accomplished or Work in Progress," *NEJM*, 350: 1935-1936, May 6, 2004
- 3 Personal communication, *The PIAA*, February 11, 2004
- 4 Wachter, op cit, p. 1935
- 5 James, TJ, online notes from " Highlights of Hospitalists: The Next Level, Learning from the Leaders, Implementation & Improvement Strategies by Cambridge Health Resources, March, 1999" at [www.hospitalist.net](http://www.hospitalist.net)
- 6 LI, J, Feinbloom, D, Zullo, N, Beth Israel Deaconess Medical Center, Harvard Medical School, " Creation of a Computerized Application to Facilitate Hospitalist - Outpatient Provider Communication at a Tertiary Academic Medical Center" on [www.hospitalmedical.org](http://www.hospitalmedical.org)
- 7 Pantilat, ST, Alpers, A, Wachter, RM, " A New Doctor in the House: Ethical Issues in Hospitalist Systems, *JAMA*, Vol. 282, No.2, July 14, 1999
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# TEN Questions Residents and Fellows Most Often Ask about their Malpractice Insurance

—Rick Almeida, Director, Insurance & Business Operations, Lifespan Risk Services

**Q** I know my malpractice (professional liability) insurance has been provided as part of my residency with Lifespan. What's the name of the insurance company?

**A** The insurance company name is R.I. Sound Enterprises Insurance Co., Ltd. (RISE), a wholly-owned subsidiary of Lifespan. This Bermuda-based company, founded in 1991, is called a "captive" insurance company because its primary obligation is to provide professional liability (malpractice) coverage to the Lifespan system. RISE insures all the Lifespan affiliates, employees, residents, fellows and some closely aligned physician groups.

**Q** How can I contact RISE?

**A** Because RISE is located in Bermuda, an organization called Lifespan Risk Services (LRS) was created here in Rhode Island to provide administrative services.

LRS personnel provide financial/insurance management, claims management, loss prevention, and education on behalf of RISE.

## **Lifespan Risk Services is located at:**

**167 Point Street, Suite 170  
Providence, RI 02903**

A customer service coordinator can be reached at 401-444-8273 to answer questions. Our fax number is 401-444-8963.

**Q** What do I need to know if I am staying within Lifespan facilities to do a fellowship?

**A** If you stay with Lifespan, your coverage stays the same as it was when you were a resident.

**Q** What if I'm going to a fellowship outside of Lifespan?

**A** If your fellowship is not in a Lifespan facility you will need to speak with your new program director at that facility to determine what your coverage will be. When you speak with them, you can tell them that **the coverage you have had with Lifespan will continue to cover you for claims or suits that arise from an incident that occurred while you were a resident at a Lifespan facility.**

As a condition of this coverage you will be required to participate in the investigation and defense of the claim or suit that occurred during your training at a Lifespan facility, even though you are no longer employed as a resident at a Lifespan facility. If your new program director needs more information, the LRS customer service coordinator can help.

**Q** I am going into private practice. What information will I need to apply for a full license?

**A** The state licensing board will require that you complete an application form and they will also require a claims history from your malpractice insurance company. You will have to provide the licensing board with a signed release that allows your insurance company to release claims information to the parties that you designate. The LRS customer service coordinator can help you with that process.

**Q** What information will I need to secure my own malpractice insurance coverage in my private practice?

**A** To secure malpractice coverage from a new insurance carrier, you will have to complete their application form and provide them with a claims history summary, as described in the previous answer.



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**Q** How can I decide what insurance company to choose?

**A** In most cases you will have to secure the services of an insurance agent/broker to purchase your malpractice coverage. They should be familiar with the companies that can be used. If you are going into private practice, ask colleagues in the same specialty about their insurance companies. Medical societies and licensing boards may be able to give you recommendations as well. If you will be seeking privileges at a hospital, ask their medical staff services representatives which companies are commonly used.

Please keep in mind that most hospitals now require that you have a specified amount of liability coverage to be eligible for a medical staff appointment. You will have to conform to that requirement.

Although the cost of the premium is important, you should talk to your insurance agent/broker to ensure that the company that you will be using is financially sound and well established. Inquire about their claims handling practices and whether they have a good reputation or not.

**Q** I have heard that there are different types of malpractice insurance. What are they?

**A** Professional liability (malpractice) insurance companies write two basic types of coverage, called **claims-made policies** and **occurrence policies**.

**Q** What's the difference?

**A** **Occurrence** insurance policies provide coverage for claims that occurred during the policy period, regardless of when the claim is made. Few medical malpractice insurance companies continue to write occurrence policies.

The type of policy more often available today is the claims-made policy, which is the type of policy issued by Lifespan's captive insurance company, RISE. A **claims-made policy** covers claims that are made during the policy period and that occurred since the policy *retroactive date* (which in your case would be the date your new policy begins).

Although policy definitions vary somewhat, most claims-made insurance policies consider a claim to be made when it is reported to the insurance company, subject to certain terms and conditions.

**Q** How do I know what I need?

**A** Either form of coverage should meet your immediate needs because your Lifespan coverage will respond to any claim that relates to your clinical activities on behalf of a Lifespan facility.

The Lifespan coverage provides an extended reporting endorsement to you that is often called "tail coverage."

Discuss your insurance needs with the insurance agent/broker that you will be using to ensure it is right for you.

You need to remember that if you select claims-made coverage in your new practice, you need to be certain that you secure "tail coverage" if you ever leave that insurance plan. The cost can be substantial and needs to be carefully coordinated.

The customer service representative at LRS is available to answer any specific questions you may have as you prepare for this important transition in your professional life.

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