insights into risk management

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# Office-based Malpractice Cases: 1989-1998[1]

Historically, patient safety initiatives and medical error research have focused primarily on adverse events occurring in hospitals.[2] Thus, we have a paucity of empirical data on the nature and extent of medical error in the office setting, where the majority of today's patient encounters occur.[3] One data source that is available is malpractice cases based on adverse events related to care rendered in some outpatient settings. In an effort to understand major areas of liability, CRICO[4] studied 532 cases closed between 1989-1998 in which care was delivered in a physician's office or clinic.

## Cases with diagnosis-related allegations

Allegations of diagnostic errors were made in 40 percent (214) of CRICO's office-based cases. The most common allegation in these diagnosis-related cases was delay or failure to diagnose cancer (44 percent), most often breast cancer. Failure to diagnose infections and missed myocardial infarctions were also among the common allegations.

Predominant risk factors identified in the diagnosis-related cases were poor clinical judgment, inadequate communication, lack of documentation, and system errors. Many cases involved combinations of these factors. System errors occurred in more than 25 percent of the diagnosis-related cases. Systems related to tracking diagnostic tests, recalling or monitoring patients, and notifying patients of abnormal test results were most problematic. Systems for tracking patient referrals and coordinating patient care were also frequently seen as failing to ensure adequate communications.

The reduction or elimination of system errors commonly found in malpractice cases offers the potential for preventing adverse events. The risk management strategies outlined on Page 3 can serve as valuable tools in quality improvement efforts aimed at this goal.

A more complex quality of care factor is clinical judgment, which was questioned in 83 percent of the diagnosis-related cases. However, clinical judgment factors seldom stood alone as a single issue; they were most often coupled with other risk factors such as poor communication, lack of documentation, or system issues. Together, these resulted in a diagnostic delay or error. Clinical judgment issues in diagnosis-related cases generally involved a narrow diagnostic focus, delay in ordering a test or referral, lack of patient monitoring, misinterpretation of test results, or over-reliance on negative findings despite continued symptoms.

## Examples

*Case 1:* **Delay in ordering a diagnostic test**
A 43-year-old male was seen by his internist for complaints of intermittent rectal bleeding and fatigue over six months. A rectal exam and barium enema were negative; occult blood test was documented. The internist diagnosed hemorrhoids. Three months later, the patient returned complaining of rectal bleeding. Lab test results showed a hematocrit of 29 and a hemoglobin of 8.5. The patient was told to take an iron supplement; he denies he was told to schedule a colonscopy. Discussion about a colonscopy was not documented and no follow-up was ordered by the internist. One year later, when the patient returned with worsening symptoms, adenocarcinoma of the rectum was diagnosed. A lawsuit against the internist alleging delay in diagnosis was settled in the high range.[5]

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In addition to questionable clinical judgment, Case 1 highlights several system issues including the lack of a follow-up appointment to ensure that the patient's medical problem had been resolved, and lack of documentation of oral instructions to the patient to schedule a colonscopy.

*Tip:* In some circumstances, it may be more prudent for the physician to schedule tests for the patient than to rely on the patient to do so.

*Case 2:* **Lack of follow-up re: post-op office visit**
A 54-year-old male underwent resection of a cancerous sigmoid tumor. An X-ray done prior to surgery indicated the possibility of another lesion at the hepatic flexure, but no abnormality was felt during surgery. Postoperative follow-up was to include a CT scan and colonoscopy. The surgeon wrote a note that the patient would schedule a postoperative return to his office in one month, after which the colonoscopy would be arranged.

The patient never returned for his postoperative visit, but one year later, returned to the surgeon's office. A subsequent colonoscopy revealed a 6cm lesion requiring a right colectomy. The patient filed a claim against the surgeon alleging a delay in diagnosis. Expert review of this case was not supportive of the surgeon's postoperative care. The case was settled in the low range.

The surgeon in Case 2 believed that it was up to the patient to arrange the first post-operative office visit. His office manager did not maintain a list of patients who needed such appointments.

*Tip:* While expecting the patient to arrange follow-up may be convenient, some system is needed to ensure that the patient is actually seen. In adjudicated cases alleging lack of follow-up, the physician is usually held responsible because he/she is in a better position to understand the seriousness of a patient's situation and the ramifications if no follow-up occurs.

## Cases with medical treatment allegations

Medical treatment allegations were made in 24 percent (127) of CRICO's office-based cases. These included the delay, failure, or inappropriate management of medical conditions, such as infections, fractures, and dental conditions. Approximately 25 percent of the alleged injuries and complications occurred as a result of an office-based procedure.

In adjudicated cases alleging lack of follow-up, the physician is usually held responsible because he/she is in a better position to understand the seriousness of a patient's situation...

## Examples

*Case 3:* **Delay in review of lab tests**
An 82-year-old woman complained to her internist of a month of pain in her temporal area and headaches. Her sedimentation rate from a month earlier was 43. She had soreness of muscles and joints, particularly in the temporomandibular joint. A diagnosis of TMJ dysfunction was made and another sed rate was also ordered to rule out temporal arteritis. The patient was referred to a dentist for facial X-rays and another appointment was scheduled with an ophthalmologist. Her repeat sed rate was 77, but this report was not seen by the internist, who had left the country on short notice. The patient was not told of the abnormal test result. Eight days later, before being seen by the ophthalmologist, the patient experienced a sudden permanent loss of vision. Her lawsuit against the internist alleging delay in treatment was settled in the low range.

The protocol followed in this office practice was for the physician's secretary to review each incoming lab report. The staff had no instruction for having patients followed by a covering associate in an emergency.

*Tip:* The events of this case reflect the importance of having physician coverage to monitor and review test results when a physician has an extended time away from the office.

*Case 4:* **Inadequate technical performance**
A 49-year-old female underwent needle aspiration of a breast mass in her general surgeon's office. Beforehand, the patient was informed that the risks of the procedure were bleeding, pain, and infection. Approximately 4ccs of clear yellow fluid were aspirated. Immediately following the procedure, the patient developed pleuritic chest pain. A subsequent chest X-ray revealed insertion of a chest tube. The patient's lawsuit against the surgeon alleging improper performance of the needle aspiration was settled in the low range.

Credentialing issues such as training and experience in performing invasive procedures were raised in Case 4. The surgeon actually had experienced the same aspiration complication with another patient.

## Cases with medication-related allegations

Nine percent (48) of the office-based cases cited medication-related allegations including failure to monitor, drug toxicity, overdose leading to suicide or attempted suicide, addiction, wrong medication or dosage, omission of medication, lack of consent, and inadequate patient instructions.

## Example

*Case 5:* **Improper medication management**
A 77-year-old female with a recurrent urinary tract infection was referred by her primary care physician to a urologist who treated her with Macrodantin. Two months later, the patient presented to her PCP with complaints of cough and possible upper respiratory infection. The PCP was unaware the patient was continuing on Macrodantin. The patient was referred to a

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pulmonologist who attributed her symptoms to chronic bronchiectasis. One year after the initiation of Macrodantin, the urologist renewed the prescription without monitoring the patient for side effects. Subsequently, she developed fibrosis, bronchiectasis, hypoxia due to the Macrodantin, and ultimately died. A lawsuit against the urologist, PCP, and the pulmonologist alleging improper management of the medication regimen was settled in the mid range.

Case 5 shows lack of communication and poor coordination of care between the urologist and the PCP. In addition, neither the patient nor any of her caregivers were cognizant of the potential side effects of long-term Macrodantin therapy.

*Tip:* This case highlights the importance of asking patients at regular intervals if they are taking any continuing or new medications.

### Cases with communication-related allegations

Communication factors were specifically noted in five percent (27) of cases in this study. Allegations were related to lack of patient instructions or informed consent regarding medications and treatment. The most common risk factors associated with these cases were poor communication between patient and provider, inappropriate selection of therapy, and inadequate documentation.

### Example

*Case 6:* **Lack of communication among providers about the patient's condition**

A 58-year-old woman with stage IA non-Hodgkins lymphoma in her tonsils was referred by her ENT physician to a radiation therapist for evaluation and treatment. The patient received radiation therapy only (chemotherapy was considered as adjuvant therapy only in the event of future metastasis). No further testing or follow-up was done by the radiation therapist, with no referral to or follow-up by medical oncologist. The patient died of metastatic lymphoma. Her estate alleged that she should have received initial chemotherapy and close follow-up at regular intervals. The case against the radiation therapist was settled in the high range.

In Case 6, the ENT assumed that the patient would be followed by the radiation therapist for any additional therapies; the radiation therapist assumed the ENT would coordinate future care.

*Tip:* The communication breakdown may have been avoided if the role expectations between the two clinicians had been spelled out, in writing, during the referral process.

### Conclusion

As health care continues its shift to the outpatient arena, the physician's office will be the focus of more health care delivery services, including many invasive procedures. Common procedures currently being performed in a physician's office include laser cosmetic surgery, biopsies, liposuction, dilatation and curettage, breast augmentation and reduction, abortion, endoscopy, and microlaparoscopy. Good medical practice dictates that patient safety standards of office-based practices mirror the clinical monitoring practices required in the hospital-based centers.

1 *Cases reviewed for this study involved patients seen in physician's office or clinic. Cases stemming from ambulatory care in an emergency department or day surgery center were not included.*

2 *Leape L., et al. Promoting patient safety by preventing medical error.* Journal of the American Medical Association. *1998; 280: 1444-47*

3 *Fischer G. Adverse events in primary care identified from a risk-management database.* The Journal of the American Medical Association. *1997; 45(1)40.46.*

4 *Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.*

5 *Low range: <$99,999; Mid range: $100,000 - $499,000; High range: >$499,999.*

*Adapted with permission from* FORUM, RMF, *vol20, no.2, February 2000*

## Tips for Improving Office Practice Systems to Reduce Adverse Events

### Follow-up Ordered Tests

- Establish a system to track test ordering, performance, and results.
  **Confirm that**
  1. the patient had the test,
  2. the results have been returned to and reviewed by the clinician,
  3. the physician has dated and initialed the results,
  4. these results have been communicated to the patient, and
  5. the results have been documented in the medical record.
- Arrange for physician coverage to review tests during time away from the office.

### Patient Referrals

- Fully inform patients about the need to seek a consultation. Document the discussion in the medical record.
- Consider making the referral appointment for high-risk patients.
- Send pertinent medical information to give the consultant an opporturuty to review patient information prior to the visit.
- Make clear in the referral who will take ongoing responsibility for the patient.
- Establish a tracking system to monitor patient referrals and to check for a timely written report from the consultant.

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# Tips for Improving Office Practice Systems

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## Patient Recalls and Cancellations

- Establish a tickler system to track patient recalls. Include the reason for a follow-up visit, and the month/year the recall is due.
- Schedule follow-up appointment before the patient leaves the office.
- Track and document patient no-shows daily. The physician should be informed of all no-shows and instruct staff whether or not to contact the patient to reschedule. Recontact efforts should be documented.
- Be aware of patients who could fall through the cracks, i.e., who cancel without rescheduling. Do not erase or overwrite cancellations and no-shows from either manual or electronic appointment systems (if possible).
- Review, initial and date all consultation reports upon receipt.

  Notify the referring physician if a patient does not keep an important appointment

## Patient Noncompliance

- When you encounter a patient who fails to keep appointments or refuses recommended testing or treatment, maintain an ongoing conversation with the patient and document the following in the patient's medical record:
  1. what the testing/treatment entails,
  2. why you are recommending this course of action,
  3. risks and benefits of the proposed testing/treatment,
  4. risks involved in foregoing treatment, and
  5. any alternatives that are possible.
- Send certified mail (with return receipt) to high-risk patients who do not keep appointments or respond to phone calls to reschedule.
- Document all telephone conversations, including those in which compliance issues are stressed.

## Medications

- Maintain a medication record to track all medications, including dosages, prescribed by you and other providers.
- Develop a list of medications that warrant close monitoring.
- Document all sample medications given to patients.
- To prevent or identify drug toxicity, create a tickler file to schedule patient visits at regular intervals for blood tests or diagnostic exams.
- Review the patient's record prior to prescribing renewals. Sign-off on renewals is recommended.
- Update patient drug allergies at every clinical encounter. Known allergies should be conspicuously flagged.
- Be aware of cross-sensitivities for patients who have drug allergies.

  Ask the patient at every clinical encounter if she/he is taking any new medications, including over-the-counter drugs, vitamins, or homeopathics.
- If the patient is being seen in a specialty clinic such as an anticoagulant clinic, establish communication and clarify roles between the primary care physician and the consultant.

## Telephone

- Provide protocols, education, and guidance for staff who give telephone advice or information.
- Protocols and algorithms for non-clinical staff should delineate questions to ask as well as key signs or symptoms that will alert them to refer the call to a clinician.
- Identify calls for priority follow-up by the physician/clinician. All calls should be reviewed at the end of the day by each provider.
- Document telephone encounters, including date and time of encounter, patient symptoms, any medications prescribed, and any clinical advice rendered. After-hours calls should be documented and entered into the medical record the next day.
- Explain and document when and why a patient should recontact the provider (i.e., if any of the symptoms are persistent, worsening, changing, anxiety provoking, or specific to illness.)
- Use middle initials and date of birth to distinguish patients with the same first and last names.

## Documentation

- Document any conversations regarding home instructions about medications or treatments. Preprinted discharge instructions should be given to patients whenever possible.
- Use a separate consent form for any invasive procedures performed in your office. The consent form should include the nature of the procedure and the risks, benefits, and alternatives to the procedure. Document any consent discussion that you have with the patient in the medical record.
- Review and initial all transcribed notes. Do not use a stamp that states "dictated but not read." It is an expectation that physician notes are reviewed for accuracy.
- Be certain to document no-show appointments and any follow-up efforts on your part, when appropriate, in the patient medical record. Poor quality records imply substandard care.

**Risk Management staff** is available to provide risk management education to clinical departments, hospital departments, medical staff and meetings at any one of the Lifespan affiliated institutions. Foundation requests should be directed to **Peggy Martin**, Sr. Risk Management Coordinator, Lifespan Risk Services.
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# It's Not Too Late: Getting Into Compliance with HIPAA's Privacy Rule

The federal Health Insurance Portability and Accountability Act (HIPAA) — with its very complicated Privacy Rule — went into effect on April 14, 2003, and the devil is in the details. If you haven't as yet, name a member or members of your staff to be your privacy and security officers and to become familiar with HIPAA's requirements (not just those of the Privacy Rule). Since not all the changes to the Privacy Rule are discussed below, refer to the amended version of the Rule that is available at www.hhs.gov/ocr/hipaa.

The following answers to common HIPAA questions may be of assistance as you continue or initiate your Privacy Rule compliance efforts.

*1. Does the Privacy Rule still require that I get patient consent before using or disclosing protected health information for treatment, payment, and health care operations?*

**No —** Patients do have a right to request restrictions on your uses and disclosures for these purposes, but you do not have to agree to the restrictions. In Rhode Island, however — unless one of the exceptions listed in the Confidentiality of Healthcare Communications and Information Act applies, — you may not release or transfer any information relating to a "patient's health care history, diagnoses, condition, treatment, or evaluation obtained from a health care provider who has treated the patient" (i.e. confidential health information) without the patient's consent. The exceptions and definitions under the state law and the Privacy Rule's definitions and categories for uses and disclosures without the patient's authorization are not exactly the same. Care is required to assure that actions permitted by the Privacy Rule do not violate any more protective provisions of the state law.

*2. Is it true that the Privacy Rule prohibits me from telling my patients about alternative treatments or products or services?*

**No —** The revised Rule requires an authorization from patients before you use or disclose their protected health information (including demographic information) for marketing. However, the Rule specifically excludes from the definition of marketing any communication about a product or service that is made for treatment of the individual or for case management or care coordination or to direct or recommend alternative treatments, providers, or therapies.

*3. I have a small office, I outsource my billing and do not use computer records, computerized billing, or any web-based programs for clinical purposes.. Am I correct that HIPAA does not apply to me?*

**Maybe —** At a March 2003, conference, the Department of Health and Human Services made clear that only if you, or your business associate, perform electronically one of the transactions delineated in the Privacy Rule definition of "transaction" are you a covered entity at this time. If your billing company electronically submits bills to payors on your behalf, HIPAA applies to you. And, once you are a covered entity, the Privacy rule applies to all of your patients' protected health information in whatever form. The Security Standard applies to all protected health information which a covered entity electronically maintains or transmits. On the other hand, HHS has clarified that transmissions by paper fax or oral transmissions by telephone are not electronic transmissions and, alone, do not make you a covered entity.

*4. What is a business associate agreement?*

**A business associate agreement is —** the government's means to extend Privacy Rule protections to uses and disclosures by certain persons who are not covered entities. The Rule sets out specific business associate provisions to be incorporated into or addended to the underlying service agreement.

*5. Do I need a business associate agreement with every vendor, contractor, or consultant?*

*—Judith Kapuscinski, JD, MPH, MS*

**No —** A business associate is a person or entity, not a member of your workforce, who performs services or functions identified in and governed by the Rule on your behalf. For example, certain auditing functions or legal services, may establish a business associate arrangement. Risk management services provided by an outside individual or entity, outsourced billing, quality assurance consultants, contract transcription services, answering services, temporary office staff, etc., all may require the use or disclosure of protected health information to perform tasks on your behalf and may trigger the business associate provisions of the Privacy Rule. Other services, for example: janitorial services, ambulance transport, or treatment services, which either are not performed on your behalf or do not require the use or disclosure of protected health information do not establish business associate relationships as defined by the Rule, and no business associate agreement is necessary.

*6. Did all business associate agreements have to be in place by April 14, 2003?*

**No —** If you entered into an agreement prior to October 15, 2002, with someone with whom you now believe is a business associate and the agreement is not modified or renewed before April 14, 2003, you have until the earlier of the next renewal/modification date or April 14, 2004 to enter a business associate agreement.

*7. What is a Notice of Privacy Practices?*

**A Notice of Privacy Practices —** is a document which tells your patients when you may use or disclose their protected health information without their written authorization, explains their rights to their protected health information and how to exercise these rights, tells them what your responsibilities are, and provides information on how they may complain about your practices. Your Notice must address categories of uses and disclosures in the Privacy Rule. Your Notice must inform the client of the most

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protective requirements applicable to the use or disclosure. The Privacy Rule is very specific about what must be in the Notice.

*8. Do I have to give each patient a Notice of Privacy Practices at each appointment?*

**No** — You must give the Notice to the patient at his/her first visit after April 14, 2003. Subsequently, any time you change the Notice, you must make the new Notice available on request. You must post the most current Notice at each service site which you maintain. If you provide the Notice to patients electronically, you also must provide it in hard copy at the patient's request. If you have a web site, your Notice is to be posted on it. You need to maintain copies of your patients' acknowledgments that they have received your Notice or documentation of your good faith efforts to obtain such acknowledgments.

*9. Does the Privacy Rule require me to have a separate set of policies and procedures?*

**No** — The Privacy Rule does require that you have policies and procedures to assure compliance with its provisions. Modification of current policies and procedures, not separate and parallel procedures, may be all that is necessary. If you do not have written policies and procedures, you will need to develop some. Areas to be addressed include patient and third party access to patient records, handling of patients' request to amend their records or for an accounting of disclosures; how information gets faxed; what to do with subpoenas; providing the Notice of Privacy Practices and how to handle patient requests for restrictions on uses and disclosures, and more.

*10. By complying with Rhode Island laws protecting health care information can I assume my office complies with the HIPAA Privacy Rule?*

**No** — Simply stated, you must comply with either the state or federal law that gives the individual the greater access to his/her own health information, and to the law which allows the individual greater control over use or disclosure of that information to others. The state and federal laws are not identical. The definitions of the information protected by the Privacy Rule, Rhode Island's Confidentiality of Healthcare Communications and Information Act, and Rhode Island's Mental Health Act are not the same. The Privacy Rule also has administrative requirements, such as the naming of a privacy officer, provision and retention of Notices, etc. which are not covered in state law.

If you have concerns about your practice's compliance with the HIPAA Privacy Rule, first determine if you are a covered entity. You can find a decision tree tool for this purpose at www.cms.hhs.gov/hipaa/hipaa2. If you are a covered entity, get your infrastructure in place. Name a privacy and security officer, which can be one person, and give him/her the time and resources needed to get you to compliance. Inventory your office practices to ascertain what you are doing to protect personal health information from being used or disclosed by other parties. Prepare your Notice of Privacy Practices. Ascertain with whom, if anyone, you need to have a business associate agreement and then execute one. Modify or adopt office practices to assure compliance with HIPAA requirements. Train your staff.

*This article was prepared at the request of Lifespan Risk Services. It is offered for general informational and educational purposes and is not intended and should not be relied on as legal advice applicable to any specific situation. Ms. Kapuscinski is a private health care legal consultant based in Providence who focuses her practice on healthcare corporate compliance, including HIPAA, and risk management. She may be contacted at jkcorliss@cox.net.*

# Lessons Learned

*—by Peggy Berry Martin, MS, ARM, MEd, Senior Risk Management Coordinator, Lifespan Risk Services*

*The 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, but should have some relevance to situations that you may encounter.*

## Case:

Mr. D. presented to a hospital emergency room (ER) on June 10, 1998. The presenting complaint: blister on his right foot with increased redness and swelling for three days after using medicine for athlete's foot. He had a long history of disability related to alcohol abuse.

Mr. D. was seen there by a fourth year medical student and by Dr. H., an attending physician. He was diagnosed with a fungus and a healing fourth toe ulcer. No testing was done at that time and no dressing was applied. The ER record contains instructions to wash the toe with warm, soapy water daily; wear white socks; and take an anti-fungal medication (Sporanox) for two months. All of the notes in the ER record were made by the medical student including "diminished hair with shiny red skin on the patient's toe," an indication of a more severe problem than a fungal infection. The student also documented the absence of a palpable posterior tibial pulse.

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Dr. H. testified in his deposition that he was called away before he could make any note in the record, and was asked by the medical secretary on June 17 to sign and complete the record. Dr. H.'s addendum differed from the original record in that it contained findings of no pain, red streaks, fever, chills, or visible pus and no claudication. He also documented that a palpable posterior tibial pulse was present. Dr. H.'s addendum includes instructions to the patient to return to the emergency room if fever, redness, or pain developed, and he was to follow-up with a private doctor for a possible circulation problem in his foot. Dr. H. testified that he, personally, gave these instructions to the patient. No written instructions were found in the medical record. At his deposition, Mr. D. testified that he had complained of a cut on his toe when he went to the ER, not a blister. He denied that he used athlete's foot medication.

Mr. D. returned for a second ER visit on June 27, 1998, with gangrene of the toe. He was admitted to the hospital and a vascular surgeon performed a bypass graft and a trans-metatarsal amputation of the right forefoot the next day. After a two-week hospitalization, Mr. D. was transferred to a rehabilitation center, to be followed in the Plastic Surgery Clinic. Mr. D. was discharged with a diagnosis of diabetes, previously unknown to the patient and undiagnosed in the ER. Several years later, the amputation site had not healed and Mr. D. was fitted with a prosthesis.

## Damages:

Less than a year after his initial ER visit, Mr. D. brought suit against the hospital alleging that physicians in the hospital's ER failed to diagnose arterial insufficiency and related diabetes, resulting in amputation of a portion of his right foot.

## Liability:

Physician expert reviews for the defense were not supportive of the care Mr. D. received on his first ER visit. Several stated that a patient with his history should have had blood work done in the ER and a more specific follow-up plan should have been given to the patient in writing and documented in the record. They felt that a Sporanox prescription alone would have required follow-up. One expert stated that further testing and follow-up on the possibility of early gangrene should have been considered.

Since Mr. D. did not have a private physician, initial arrangements with the appropriate clinic should have been made before he left the ER. One review from a vascular surgeon suggested that, with appropriate care on the initial visit, Mr. D. could have been revascularized and his foot saved.

## Outcome:

Due to the confusing documentation and the lack of testing during the initial ER visit, the case was settled in the mid range.

## Risk Management Issues:

### Supervision of medical students:

The attending physician did not write a note in the patient's chart during Mr. D.'s initial visit indicating that he had seen the patient, had read the student's notes, and had formulated a care plan based on his own assessment of the patient. Lack of such documentation makes it difficult to prove that the student was properly supervised by a more experienced physician. The absence of evidence of supervision in the record could be used to argue that the physicians did not take this case seriously, giving this patient a minimal amount of attention that resulted in significant damage.

In this case, the findings and follow-up advice that the attending documented seven days after the visit differed significantly from what the medical student documented at the time of the visit. If the outcome of the examination by the student and the attending had been the same even though in hindsight they were incorrect, the case would have been easier to defend. Well-reasoned and documented clinical judgment that later is found to be erroneous does not by itself constitute negligence.

Cases that reflect inadequate supervision are difficult to defend, absent evidence that proper supervisory procedures were followed. In a teaching environment it is understood students have a responsibility to carefully examine, observe, and record findings. The responsibility of the supervisor (the attending physician in this case) is to review those findings and the corresponding documentation with the student to assure the patient is being cared for properly.

When conflicting findings are documented without evidence that they were reviewed and the conflicting information addressed, the lasting impression is one of inadequate supervision and lack of coordination of patient care.

### Timing and content of the addendum

The addendum written seven days after the patient was discharged from the ER contains information that may not have been given to the patient upon discharge: the need to return to the emergency room if fever, redness or pain developed; and the need to

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# Lessons Learned

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follow-up with a private physician for a possibly serious circulation problem. The content directly contradicts the documentation of the care rendered to the patient at the time of the visit. Without some explanation and resolution of the conflicting opinions and subsequent patient instructions at the time of the patient visit, the addendum appears self-serving and defensive, lessening the credibility of both the documentation and the care of the patient.

Even though the chaotic environment of an emergency department makes contemporaneous documentation difficult, failure to do so can become problematic if adverse events occur. In this case, when the attending read the medical student's note, he would have been wise to call the patient to check on his status rather than writing what he recalled after a week, and hundreds of more patient encounters.

## Capability of patient to understand potential complications:

If the original impression and treatment recommendations of the medical student were considered the plan for the patient, it is questionable whether the patient understood either the possible complications that could develop or the need for diligent compliance and follow-up on his part. The patient, who lived alone, had a history of receiving SSI payments for alcohol-related disability. He did not have a private physician. On this occasion he sought care by walking into the ER. It was clear that the patient was an unreliable reporter and had little or no supports in the community.

Patients with Mr. D.'s circumstances frequently seek care in the ER for what may be determined later as non-emergent care. Even though Dr. H.'s opinion at the time of the exam was that the patient's injury was minor, additional testing may have been indicated based on the social circumstances. Arrangements should have been made for Mr. D. to follow-up with another provider rather than expecting him to follow-up on his own. At the very least, he should have been given written instructions about the importance of follow-up and names and phone numbers to make his own arrangements.

While ensuring comprehension and compliance by every patient who has potentially serious complications is unlikely, providers always have responsibility to make an effort to explain possible negative outcomes, provide written discharge instructions and document the conversation in to patient's record.

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

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