We are a company built by doctors, for doctors. We are on a mission to relentlessly defend, protect, and reward doctors who advance the practice of good medicine. When one of our own is attacked, we take it personally. Speaking loudly and clearly for tort reform, we are your voice. We are committed to protecting doctors. We loathe litigation, so we work hard to reduce risk. We are devoted to rewarding doctors. We are more than an insurance company. We are The Doctors Company.
The greatest problem with communication is the illusion that it has been accomplished.

George Bernard Shaw
Objectives

- Review litigation trends for hospitalists
- Discuss frequency and severity issues identified in hospitalist malpractice claims
- Present case study examples to illustrate how communication can impact the hospitalists’ quality of care and patient outcomes
- Recall communication techniques to improve the transfer of critical information among providers
Hospitalists

- The fastest growing specialty—1,000 in mid 1990’s to over 28,000 today
- Percentage of internal medicine physicians practicing as hospitalists went from 5.9 percent to 19 percent in 2006

Issues Faced by Hospitalists

- Care provided to higher acuity and complex patients
- Absence of established physician/patient relationship
- Limited or no past medical history available
Issues Faced by Hospitalists (continued)

- Work load—multiple patients/shifts
- Limited orientation to hospital infrastructure
- Follow-up issues
  - Post discharge care
  - Diagnostic test results during hospitalization
Issues Faced by Hospitalists (continued)

- Limited professional interaction with outpatient providers
- Lack of standardized handoff procedures
- Poor communication among care team
  - Especially during transfer of care
Common Claims and Injuries

- Death
- Nerve damage
- Amputation
- Aggravated/worsened condition
- Hemorrhage
- Infarction
Major Allegations for Hospitalists

- Failure to diagnose
- Improper management of treatment
- Failure to treat
- Improper performance of procedure
- Delay in diagnosis
- Failure to monitor patient’s status
Hospitalist Claim Issues

- **Clinical Judgment**
  - Lack of or inadequate assessment
  - Failure to establish a differential diagnosis
  - Failure/delay in ordering a diagnostic test
  - Failure to report an abnormal finding
  - Selection and management of therapy
  - Narrowed diagnostic focus
Hospitalist Claim Issues

- **Communications**
  - Among providers
  - Between patient/family and provider

- **Clinical Systems**
  - Critical information not available when needed
  - Failure/delay in reporting findings or revised findings
  - Lack or failure in patient follow-up systems

- **Documentation**
  - Insufficient or lack of documentation
Handoff Communication Issues

- Communication breakdowns
- Lack of continuity of care
  - Handoff called “the Achilles heel” of the hospitalists’ model
- Lack of follow-up
- No definitive team leader

ECRI 2002 “Hospitalists”, Pg 7
Vulnerable Handoff Moments

- Physician admits patient to the care of a hospitalist
- Hospitalist goes off duty
- Patient is transferred to a consultant
- Patient is transferred to another unit
- Patient goes for testing
- Patient is discharged from the hospitalist care
Human Factors Affect Handoffs

- Fatigue
- Distractions–information overload
- Reliance on memory
- Cognition–anchoring to a particular diagnosis
- Conflict with patient/family
Case Study #1

- 40-year-old female, admitted under hospitalist service over the weekend
  - C/o chest pain, shortness of breath, and heart palpitations
- 20-year smoker, history of chronic bronchitis, asthma, allergic rhinitis, mitral valve prolapse, panic disorder
- Chest x-ray: 2 cm nodule in right upper lobe
- Diagnosed with and treated for bronchitis
Case Study #1 (continued)

- Patient was told she has “something in her lung”
- An order was written for a pulmonary consult
  - Pulmonologist deferred the consult until Monday
- Patient discharged home w/o consult obtained
  - Hospitalist wrote order, “discharge home, to f/u with PCP”
  - Nurses did not communicate consult not done over weekend
- PCP did not receive copies of medical record or CXR report
Case Study #1 (continued)

- Patient seen by PCP for three-week history of pleuritic pain and cough
- Repeat CXR showed 3 cm lesion in right upper lobe
- Non-small cell cancer, stage 3B
- Patient treated but expired 10 months later
Case Study #1 Discussion Points

- What are the difficulties in defending a case where there are several potentially culpable physicians (hospitalist, primary care)?
  - Finger pointing

- What if plaintiff sues only one of the potentially culpable parties?
  - File a third party complaint adding the other physicians?
  - Simply try to point to the empty chair?

- What are patients’ responsibilities if they are told of an abnormal result?
Avoid Communication Exposure

- Communication of abnormal findings
  - Communication between hospitalist and pulmonologist
  - Communication between nurses and physicians
  - Communication between hospitalist and PCP
  - Communication with patient
Documentation Issues

- **Document notification to the PCP**
  - Clinical impressions
  - Diagnoses
  - Treatment
  - Discharge plan
    - Includes recommended follow-up
- **Document notification to the patient**
  - Abnormal findings
  - Required follow-up
  - Written discharge instructions
Case Study #2

- 33-year-old female to ER c/o two-day history of swelling in R index finger–swelling up to elbow
  - Lower arm with erythema, exudate and pain
- Patient with drug abuse history
  - Toxicology screen: + for opiates, amphetamines, benzodiazepines, and marijuana
- WBC 18,900 with slight left shift
- Diagnosis: Severe cellulitis/lymphangitis with abscess
Case Study #2 (continued)

- Admitted to medical floor; under care of hospitalist
  - Started on antibiotic and pain medication
  - Blood/wound cultures negative
- Seen on daily basis—was on Dilaudid for pain control
- Two days later:
  - Patient c/o increased pain—hospitalist ordered Vicodin
  - Dilaudid discontinued due to patient over-sedated
Case Study #2 (continued)

- **Third day:**
  - Seen by hospitalist (no time documented on note)
    - Documentation: erythema and edema improving
    - Patient c/o pain: no new pain med ordered
  - Patient continued to c/o pain
    - Hospitalist called–no new orders given
- **Patient left AMA**
Patient presented to another ER later that day with c/o pain, difficulty extending finger
- X-ray: large amount of soft tissue swelling
- Seen by hand surgeon: cellulitis/tenosynovitis, need for I & D

Patient ultimately lost finger

Experts critical of delay in going to OR (after two days)
- No ortho or hand surgeon consult

Hospitalist stated patient refused surgical consult
- No documentation of this in the medical record

Progress notes do not match—hospitalist noted improving daily
Case Study #2 Discussion Points

- What are the difficulties in defending a case where there are several issues, such as standard of care and documentation?
  - Settlement considerations – why or why not
- What about the lack of a formal consult and the physician’s testimony that the patient refused?
  - Informed refusal
- Physician responsibility for patient that leaves AMA
Case Study #2 Patient Safety Issues

- Human factors
  - Diagnosis and treatment affected by emotional reaction to patient
  - Possible drug-seeking behavior
- Communication with and documentation on patient leaving AMA
Case Study #3

- 8:00 AM patient had EKG done in the ER
  - Read by ER physician as non-specific ST changes
- Patient admitted for observation
- 4:00 PM cardiologist read EKG
  - Read as total heart block, possible MI
- Call from cardiologist to hospitalist, left message to call back
  - No communication documented about this call
- Patient discharged home in 12 hours
Case Study #3 (continued)

- After discharge that evening, hospitalist saw over-read, called the primary care
  - Hospitalist stated that primary care physician said he would follow up the next day
  - Primary care physician stated he told the hospitalist to have the patient return to the ED immediately
  - No one called the patient or family
- Patient found dead at home later that day
Case Study #3 Discussion Points

- Are there documentation issues that enter into the defense of this case?
  - Hospitalist physician likely has some documentation of call
  - PCP at home, probably no documentation
  - Does the hospitalist physician’s documentation make it more difficult to defend the PCP?

- Would the hospitalist be found liable for not calling the patient?
Case Study #3 Patient Safety Issues

- Communication failures may be system issues
- Communication of over-reads, lab results, test results after discharge
How to Enhance Hospitalist Communications

- **Organize communications:**
  - What is important to communicate?
  - Who needs to know what information?
  - When should communication occur?
  - How should the information be transmitted?
  - Is there an opportunity for the receiver of the information to ask questions?
  - How can you validate communication was successful?
Recommendations

- **Standardized protocols/procedures**
  - When need to transfer care to another provider
- **Involve physicians in development of protocols and procedures**
Read Back/Repeat Back

For verbal/phone orders and reporting critical results

- Method:
  - The individual receiving the information
    - Writes down the complete order or test result, or
    - Enters it into the computer
  - The individual receiving the information
    - *Reads back* what has been written
  - The individual who gave the order
    - Verifies the correctness
SBAR Communication

**Situation:**
- What is happening at the present time?

**Background:**
- What are the circumstances leading up to this situation?

**Assessment:**
- What is the problem?

**Recommendation:**
- What should be done to correct the problem?

**Repeat back:**
- Repeat back the plan of care
SBAR+R Example

**S** = “Dr. Smith, this is Mary at General Hospital calling regarding Mr. Cook in 212. His temperature is up to 103.5.”

**B** = “He is POD #2 S/P right knee replacement.”

**A** = “The wound is red; pulse is up to 115 from baseline of 80; his pain level has increased to 9/10 despite increasing his Vicodin dosing to ii tabs Q4.”

- Specific numerical values are given in the assessment

**R** = “I would like you to come see him. When can I expect you?”

- Asking for a specific time frame

**R** = “I will be there in 15 minutes, I am in the PACU.”
Safer Handoffs

- Redundancies
- Checklists
- Read-backs
- Include the patient
- Standardization
- Procedures
- Information sharing
Mission Statement

Our Mission is to advance, protect, and reward the practice of good medicine.

For further Patient Safety information, please visit our web site at:
www.thedoctors.com