PIAA Releases National Closed Claim Data
by Barbara Rose, Senior Risk Management Representative

The information that follows is a summary of nationwide medical malpractice claim data from member companies of the Physician Insurers Association of America (PIAA).

Physicians in internal medicine ranked second and general and family practitioners third in the number of malpractice claims reported from 1985 through 2000 according to the most recent update of PIAA’s Data Sharing Project. Obstetricians/gynecologists ranked first in the number of malpractice claims.

A decade ago, PIAA identified improper performance, diagnostic error, failure to monitor the case, and medication errors as the most prominent “medical misadventures” for all specialties combined. The list in the latest report is basically the same. What has changed is the average indemnity (payout). Primary care physicians have been especially affected. Average claim payments increased from $150,011 in 1995 to $270,460 in 2000.

PIAA defines primary care physicians as internists, family and general practitioners, pediatricians, and gynecologists. Among these physicians, the most often cited misadventure is diagnostic error. Second is “no medical misadventure” which means a doctor has been named in a suit but there is no allegation of inappropriate medical conduct on his/her part. This category includes those allegations against an entity, such as the clinic or practice in which a physician is a partner, associate or employee.

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The medical conditions that most often resulted in claims against primary doctors were, in order of total claims, myocardial infarction, cancer of bronchus and lung, breast cancer, colon and rectal cancer, and diabetes. Cases closed in 2000 alone reflected changes to this list.

The most often cited procedures resulting in claims were the diagnostic interview, evaluation or consultation followed by prescription of medication, general physical exam, failure to render care and injections/vaccinations.

Primary care physicians have an ever expanding myriad of responsibilities and claims can develop both as a consequence of doing something wrong or an omission such as failure to do routine annual screening. “Primary care physicians must stay abreast of current practice standards in order to minimize liability. As patient care standards shift, so will the patterns seen in morbidity, mortality, and eventually medical malpractice claims.”

Sources
2. PIAA Research Notes: Primary Care Managers Focus on Internal Medicine and General and Family Practice. Winter 2002.

Top 10 conditions in suits against primary care physicians 1985-2000

<table>
<thead>
<tr>
<th>Condition</th>
<th>Closed claims</th>
<th>% closed w/payment</th>
<th>Average payout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI</td>
<td>1,432</td>
<td>39%</td>
<td>$193,439</td>
</tr>
<tr>
<td>Cancer of bronchus and lung</td>
<td>894</td>
<td>36%</td>
<td>$171,565</td>
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<tr>
<td>Breast cancer</td>
<td>829</td>
<td>43%</td>
<td>$190,252</td>
</tr>
<tr>
<td>Colon and rectal cancer</td>
<td>707</td>
<td>43%</td>
<td>$222,335</td>
</tr>
<tr>
<td>Diabetes</td>
<td>613</td>
<td>33%</td>
<td>$120,087</td>
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<tr>
<td>Abdominal/pelvic symptoms</td>
<td>521</td>
<td>23%</td>
<td>$201,818</td>
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<tr>
<td>Pneumonia</td>
<td>531</td>
<td>28%</td>
<td>$141,734</td>
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<tr>
<td>Chest pain (not further defined)</td>
<td>476</td>
<td>29%</td>
<td>$197,101</td>
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<tr>
<td>Appendicitis</td>
<td>500</td>
<td>37%</td>
<td>$65,040</td>
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<tr>
<td>Hypertension</td>
<td>457</td>
<td>30%</td>
<td>$180,922</td>
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Closed in 2000

<table>
<thead>
<tr>
<th>Condition</th>
<th>Closed claims</th>
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<th>Average payout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI</td>
<td>34</td>
<td>39%</td>
<td>$265,173</td>
</tr>
<tr>
<td>Chest pain (not further defined)</td>
<td>30</td>
<td>37%</td>
<td>$304,727</td>
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<tr>
<td>Abdominal/pelvic symptoms</td>
<td>29</td>
<td>17%</td>
<td>$124,250</td>
</tr>
<tr>
<td>Obesity</td>
<td>26</td>
<td>0%</td>
<td>$0</td>
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<tr>
<td>Back disorders *</td>
<td>19</td>
<td>37%</td>
<td>$152,143</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>19</td>
<td>37%</td>
<td>$43,333</td>
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<tr>
<td>Soft tissue disorder</td>
<td>18</td>
<td>28%</td>
<td>$265,000</td>
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<tr>
<td>Color and rectal cancer</td>
<td>18</td>
<td>50%</td>
<td>$338,519</td>
</tr>
<tr>
<td>Diabetes</td>
<td>17</td>
<td>53%</td>
<td>$397,500</td>
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<tr>
<td>Injury to multiple body parts</td>
<td>17</td>
<td>35%</td>
<td>$67,961</td>
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</tbody>
</table>

* including lumbago and sciatica

Top 10 procedures in suits against primary care physicians 1985-2000

<table>
<thead>
<tr>
<th>Condition</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic interview, evaluation or consultation</td>
<td>15,159</td>
<td>27%</td>
<td>$167,370</td>
</tr>
<tr>
<td>Prescription of medication</td>
<td>6,012</td>
<td>39%</td>
<td>$118,699</td>
</tr>
<tr>
<td>General physical exam</td>
<td>3,096</td>
<td>30%</td>
<td>$182,294</td>
</tr>
<tr>
<td>No care rendered</td>
<td>1,644</td>
<td>10%</td>
<td>$95,895</td>
</tr>
<tr>
<td>Injections and vaccinations</td>
<td>1,506</td>
<td>38%</td>
<td>$139,253</td>
</tr>
<tr>
<td>Diagnostic radiologic procedures excluding CT scan and contrast</td>
<td>1,135</td>
<td>44%</td>
<td>$158,551</td>
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<tr>
<td>Diagnostic procedures involving cardiac and circulatory functions</td>
<td>997</td>
<td>37%</td>
<td>$218,300</td>
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<tr>
<td>Misc. manual exams and non-operative procedures</td>
<td>906</td>
<td>43%</td>
<td>$181,616</td>
</tr>
<tr>
<td>Diagnostic procedures of large intestine</td>
<td>489</td>
<td>37%</td>
<td>$160,529</td>
</tr>
<tr>
<td>Misc. non-operative procedures</td>
<td>459</td>
<td>31%</td>
<td>$63,262</td>
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Closed in 2000

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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic interview, evaluation or consultation</td>
<td>339</td>
<td>30%</td>
<td>$276,053</td>
</tr>
<tr>
<td>General physical exam</td>
<td>183</td>
<td>26%</td>
<td>$370,413</td>
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<tr>
<td>Prescription of medication</td>
<td>162</td>
<td>28%</td>
<td>$215,996</td>
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<tr>
<td>Injections and vaccinations</td>
<td>47</td>
<td>40%</td>
<td>$405,377</td>
</tr>
<tr>
<td>Misc. manual exams and non-operative procedures</td>
<td>44</td>
<td>48%</td>
<td>$234,568</td>
</tr>
<tr>
<td>No care rendered</td>
<td>34</td>
<td>3%</td>
<td>$130,000</td>
</tr>
<tr>
<td>Diagnostic radiologic procedures excluding CT scan and contrast</td>
<td>30</td>
<td>33%</td>
<td>$130,450</td>
</tr>
<tr>
<td>Diagnostic procedures involving cardiac and circulatory functions</td>
<td>28</td>
<td>54%</td>
<td>$336,283</td>
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<tr>
<td>Diagnostic procedures of large intestine</td>
<td>20</td>
<td>50%</td>
<td>$190,500</td>
</tr>
<tr>
<td>CT scan</td>
<td>17</td>
<td>47%</td>
<td>$163,422</td>
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</table>
risk management 101

Don’t be a sitting doc
by Jane Mueller, Vice President, Risk Management

The health care industry is the target of outside organizations as never before. Pressure from third party payors, government agencies and large employers to provide cost effective and quality care are some of the many reasons physicians and administrators should implement a risk management program. Additionally, physicians increasingly find they are the target of plaintiff attorneys hoping to bag their limit in contingency fees from settlements or jury verdicts in medical malpractice cases.

The majority of medical malpractice claims can and should be avoided. It does not require evolutionary changes or that you elevate yourself to a higher standard of care. The public is largely unaware that approximately 80% of medical malpractice claims nationally are closed with no indemnity paid. TMLT closes approximately 87% of claims with no indemnity payment. Implementing basic risk management techniques and systems will decrease the risk of a liability claim and improve the defensibility of those who are involved in litigation.

The following risk management strategies will facilitate the practice of safe, quality medicine and help maintain a standard of care to which physicians have always been held accountable. These areas consistently rank among the top five concerns when defending a claim.

Medical records documentation

When involved in litigation, documentation can be your best ally or your worst enemy. Juries typically believe physicians when appropriate information is documented in the medical record. Conversely, a physician’s credibility is challenged when essential elements of the patient encounter are absent or incomplete. Following these guidelines can strengthen defensibility.

- Documentation of each patient encounter should be complete. According to AMA guidelines, documentation should include:
  1. chief complaint and/or reason for the visit and, as appropriate, relevant history, examination findings and prior diagnostic test results
  2. assessment, clinical impression or diagnosis
  3. plan of care, follow-up visits and/or referrals
  - Do not make any additions, deletions, or any other type of alteration to the medical records. Anything added to a previous note is considered a late entry. If you need to elaborate or clarify a previous note, the note should say “LATE ENTRY” and be dated. The relationship to a previous note should be explained, such as “addendum to note of 8/23/2000,” or “see 2/15/2000 note.” The reason for the late entry should be explained. A late entry should appear in its normal chronological position in the chart, not squeezed into space near the previous note. After-the-fact entries may be viewed as alterations to the medical record and damage the credibility of the physician.
  - How late is a late entry? Once a note is finished, anything else is a late entry. When in doubt, a late entry that is clearly identified and properly referenced is always preferable to adding anything to an existing note.
  - Blank lines or large blank spaces in the medical record may invite some individuals to make changes or additions to a note. It is wise to protect your medical documentation from such alteration by not leaving blank lines or by marking through spaces in a manner that prevents alteration.
  - Illegible handwriting in medical records is a common weakness, and the documentation can be subject to broad interpretations of actual meaning as well as the quality of patient care.

Physician-patient relationship

The physician-patient relationship is the result of a contract, express or implied, between physician and patient that is voluntary and arises when a patient requests and is supplied medical information and/or treatment. Generally, once established, the physician-patient relationship continues as long as medical treatment is required, unless the physician or patient terminates it. Advice given during a telephone conversation or casually at a social gathering may be construed as establishing a physician-patient relationship.

- Create policies and procedures regarding the acceptance of new patients. Educate your staff and ensure they adhere to these policies. Communicate to staff the dangers of trying to accommodate walk-in patients.
- Physicians need to follow a process of proper documentation and adequate notice when deciding to terminate the physician-patient relationship. Where appropriate, physicians should verbally advise the patient of the decision and document this in the record. In every case, the physician should send a letter by regular mail and also by certified mail, return receipt requested, with the notice. Refer the patient to the county medical society or their managed care organization for a list of physicians. It is not advisable to refer patients to specific physicians. Enclose an authorization for release of the medical record and advise the patient to designate his/her new physician as soon as determined, sign the form and return it to your office. Place a copy of the letter in the patient’s record.
- When terminating a physician-patient relationship, the patient should be given a reasonable amount of time to find a new physician. The time limit for finding a new physician will depend on several factors, such as physician specialty, size of community, and availability of other practitioners. The current physician should remain available for acute and emergency care until the patient finds a new physician.
- When deciding whether or not to terminate a physician-patient relationship, consider the patient’s medical status and needs. For example, pregnant patients, patients in a post-op recovery period and patients undergoing a continuous course of treatment, might need assistance in making sure continuity of care is not disrupted.

Informed consent

Texas recognizes that consent for treatment must be obtained and that such consent be “informed.” By statute, the process of obtaining informed consent is a non-delegable responsibility of the physician.

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Primary care

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• Even minor procedures carry the risk of an unexpected outcome. A separate consent form is not required by law for procedures not on the Medical Disclosure list. However, a protocol should be written to either use a consent form for minor procedures or document the informed consent discussion with the patient as well as the patient’s understanding and consent to do the procedure.

• Be aware of the timing of a signature when obtaining informed consent. Patients can contend their mental status was impaired when they consented. When obtaining consent in a hospital, try to make sure the consent was not signed 15 minutes after a mood-altering medication had been given.

• Document the patient’s mental acuity at the time of the risk/benefits discussion or when obtaining informed consent. A brief note reflecting that the patient was awake, alert, participated in the discussion and asked appropriate questions could protect against allegations of failure to obtain informed consent.

• Consider including on your informed consent form a statement that the patient fully comprehends the risks of the procedure and is not subject to any medication, illness or other impairment which might affect the patient’s ability to comprehend. Include any family members who witnessed the discussion.

• Supply patients with supplemental information about a procedure, such as a brochure, and document the receipt of the brochure by the patient. Ensure all the information made available to your patients fairly and accurately portrays the risks of the procedure.

• A patient’s decision to decline treatment, evaluation or testing should be documented in the patient record. “Informed refusal” should be obtained with respect to any treatment or procedure, which could have either diagnostic or therapeutic consequences. “Informed refusal” should be obtained in writing or at the very least, a note in the chart should be made. The documentation of informed refusal should contain:

  1. description of the treatment offered
  2. the reasons the treatment was offered
  3. the potential benefits of the procedure
  4. a statement that the patient has been informed of the risks in not accepting the treatment
  5. a clear statement that the patient has unequivocally and without condition declined the treatment
  6. reasons the patient refused treatment

**Health information release**

• With few exceptions, health care information should not be released without a valid authorization signed by the patient or a subpoena signed by a judge.

• Document each release of medical information in the medical record.

• Medical information should only be faxed for urgent or emergent care. If you do fax health information, identify who will receive the information and relay when you will send the fax so the person will be available to secure the fax. Use a fax cover sheet indicating the need to maintain confidentiality. Avoid faxing sensitive health information such as HIV, mental health or alcohol/drug abuse records.

**Additional considerations**

• Notify the TMLT Claim Operations Department immediately if you receive a notice or subpoena which involves the delivery of medical care as an issue in a claim where you may be the defendant.

• Design a tickle file or a log of patients referred for tests, appointments with other physicians, etc., in order to identify those that are not completed in the time frame scheduled.

• Give patients a return appointment as a method of determining that orders were followed. For “no show” patients, develop a protocol to contact the patient and document your conscientious efforts to determine why the appointment was not kept. Triage the patient conditions, and if of a serious nature, call again, document again and then send a certified letter with your concerns. Place a copy of the letter in the patient record.