

Exam Documentation: Adopting a Risk-Management Mindset

Satellite Conference
Thursday, August 4, 2005
2:00-4:00 p.m. (Central Time)

Produced by the Alabama Department of Public Health
Video Communications Division

Faculty

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Objectives

- Identify examples of medical negligence.
- Identify 10 most effective interventions to reduce malpractice vulnerability.
- List the most frequent complaints voiced by patients in regards to improving patient relationships and communication.
- Discuss good bedside manner and how to improve technique.
- Identify conditions with high malpractice risk.
- Understand best practice when documenting assessment data and the importance of including various components of the patient interview in the written patient record.

IF IT'S NOT
WRITTEN, IT DID
NOT HAPPEN!!!

Documentation

- Good medical care
- Ensuring quality of care
- Meeting state licensure requirements
- Achieving payment for care
- Managing risk

Documentation

Documentation

Documentation

- The chart, friend or foe?
- First checked

GOAL

Prevent the Plaintiff Attorney's Interpretation

What is the Diagnosis?

- Nursing student note mentions "unusual vessels with inflammation".
- Proctored nurse practitioner indicates part of lesion "not visible".
- Supervising nurse practitioner describes lesion as "visible through all dimensions".

Key Points

- "Teach" documentation.
- Always read every entry.
- Correct entry appropriately.

Prevent the Plaintiff's Attorney's Interpretation

- Absence of charting
 - Absence of treatment
- Time gaps
 - No one bothered to contact the patient
 - Patient was never told to return
- Missing tests, pictures
 - Lab test/procedure was not performed
- No consultation notes
 - No consult requested

Prevent the Plaintiff's Attorney's Interpretation

- Disagreements in the chart or countermanding orders
 - Someone deviated from the standard of care
- Inconsistent entries
 - No one read the entire chart before treating the patient

Best Practice Encounter Note

- Legible
- Timely
- Eliminate abbreviations and acronyms
- Decision Specific
 - Convey relevant, objective, accurate info
 - Subjective conjecture or opinion inappropriate
- Reasonable treatment
- Planned follow-up
- Identifiable instructions

Why Do Health Care Providers Get Sued?

- Poor or unexpected outcome
- Anger
- Lack of Communication
- "Jousting"
- Team bickering
- System failures

Factors Prompting Families to File Malpractice Claims Following Prenatal Injuries

Dissatisfaction with communication after birth

- 70% - Not warned about long term neurodevelopmental problems
- 48% - Physician attempted to mislead them
- 32% - Doctors didn't openly talk to them
- 13% - Felt doctors did not listen to them

Hickson, et al. JAMA Nov :2330, 1994

Patient Satisfaction Problems

- Communication failures
- Poor patient/staff/doctor interaction
- Lying or covering up
- Conflicting information
- Lack of information on transfer
- Breaching a confidence

Pichert, Miller, et al JQI, 1998



Communication

- Not trained
- Worried to upset patient and family
- Worried about blame
- Lack of communication may prompt litigation

EMORY HEALTHCARE
THE EMORY CLINIC, INC. EMORY UNIVERSITY HOSPITAL

COMMUNICATION - A CHALLENGE FOR PHYSICIANS

The outcome of the first round of Press Ganey patient satisfaction surveys confirmed what our patients have been articulating for some time: our communication with them and - by extension - among ourselves and our staff need to improve. Enhancing and developing our communication skills can have profound implications for outcome satisfaction, medical-legal risk reduction, and our financial success. This is particularly true given the present level of general dissatisfaction with the healthcare industry.

The Do's of Communication
We urge that you take a few extra moments to be warmer and more receptive to your patients as you go about your duties in patient care. Ms. Susan Hart, Director of Patient Relations for Emory Healthcare's Office of Risk and Insurance, suggests the following measures to improve communication and satisfaction:

- Review the medical record before entering the room
- Call the patient by name and acknowledge the presence of their family members
- Introduce yourself and all members of the team
- A hand shake or pat on the shoulder helps to establish the bond
- Sit down - a five minute seated visit is perceived by patients to be much longer than one in which the physician stands
- Try to appear relaxed, maintain eye contact
- Explain your treatment plan and what the patient may expect

Follow Up Communication
Beyond the patient's original diagnostic or therapeutic encounter, follow-up communication is essential to the continuity of care and to general satisfaction with that care. To this end, it is wise to:

- Explain the diagnosis in layman's terms to the patient and key family members
- Review test results - give the patient a copy
- Follow up treatment discussions with a brief letter
- Encourage questions, do not discourage them
- Urge patients to call from home with pressing questions - leave a message: "I'll return your call within 24 hours"
- Return phone calls promptly and conscientiously

Problem Behaviors Which Impair Communication and Elevate Patient Satisfaction
Certain behaviors impair communication and heighten patients' concerns for their care. The negative messages communicated by these behaviors are easily intended by even the most conscientious of physicians. However, sensitized patients and their families quickly perceive your signals. Some of these behaviors and their apparent messages include:

- Looking at your watch - *I'm too busy to bother with you*
- Interrupting the patient encounter to take phone calls - *This call is more important than you are!*
- Referring to the patient as a case or diagnosis - *You are just a number*

COMMUNICATION - A CHALLENGE FOR PHYSICIANS



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Problem Behaviors Which Impair Communication and Diminish Satisfaction

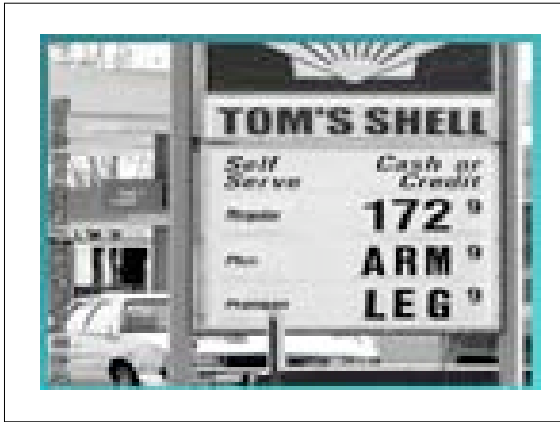
- Looking at your watch - I'm too busy to bother with you.
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LISTENING

"I know you believe you understand what you think I said, but I am not sure you realize that what you heard is not what I meant"

– Anonymous, Wolf & Marznik, Perceptive Listening (1992)

How you Handle a Bad Situation Defines the Situation



How Do You Address Bad Outcomes?

- Be honest
- Be sensitive
- Be available
- Be smart
- Don't cover up
- Encourage family involvement

Poor Communication Strategies

- Standing
- Use of technical vocabulary
- Domination of the conversation
 - Fails to acknowledge the patient
 - Not intended
 - Doctor isn't listening
 - Helpful to health professional



Good Strategies

- Empathetic
 - Convey support and compassion
 - Listening
 - Affirm patient's feelings
 - Silence
- Lead by the patient's agenda
- Informed consent

Good Communication

- Posture
 - Sitting
 - Appropriate body language/ tone
- Words to use and NOT to use



JACHO – July 1, 2001

"...patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes."

» JACHO std RI.1.2.2

Disclosure of Unanticipated Outcomes

- Disclose outcome
 - May not want to use the “e” word
 - Follow hospital/institution policy
 - Non-cooperation clause
- Sincere apology
- Assure changes to prevent future occurrences
- Team must work together
 - Agreement
 - Don’t criticize
- Document/Preserve evidence

Who Should Disclose?

- Attending physician/nurse
- Another physician/nurse
- Executive administrator
- Hospital risk manager
- Hospital medical director
- Primary communicator

Disclosure

- Avert lawsuit
- Helpful in defense

Dealing with the Angry Patient

- Maintain your cool
- Avoidance and denial do not help
- Keep your voice low and moderate
- Open body language
- Ask for more information until all questions exhausted
- Keep patients communicating with you

Why Health Care Providers Get Sued?

- Poor or unexpected outcome
- Anger
- Lack of Communication
- “Jousting” & Team bickering
- System failures

- 43 year old presents for annual check-up.(1) Requests general exam as not feeling well and is mildly febrile. CBC ordered (2) → significant neutropenia.(3) Patient treated symptomatically and recovered.(4) Patient returned for repeat visits for routine care over the next 28 months.(5) Patient later determined to be HIV positive.(6)

Primary Obstetric Allegation

- Brain damaged infant
- Stillbirth/Neonatal death
- Maternal injury - minor/major
- Other infant injury - minor/major
- Failure to diagnose
- Maternal death
- Informed consent

Primary Gyn Allegation

- Patient injury - major/minor
- Failure to diagnose
- Abortion related
- Informed Consent
- IUD related
- Patient death

Common Themes

- Skepticism about possibility of breast cancer in young women.
- Complete reliance on negative mammograms.
- "System" failures.
- Inattention to medical history.
- Failure to diagnose recurrent disease.

Case Studies

- 41 year old patient complains of breast mass.
- Documentation indicates only patient to return in 4 weeks.

Major Principles

- Accuracy
- Comprehensiveness
- Legibility
- Objectivity
- Timeliness

SOAP

- Subjective
 - "Quotes"
 - Capacity
- Objective
 - Chaperones
 - Avoid judgments
- Assessment/Opinion
 - Rule out or likely
- Plan
 - Follow-up
 - Referral
 - Access
 - Agreement

Comprehensiveness

- Identification
- Current condition
- Past medical history
- Past surgical history
- Family history
- Social history
- Medications
- Physical examination

Comprehensiveness

- Counseling and education
- Disposition
- Patient correspondence
- Advanced directives

Preventive Maintenance

- History
- Self Breast Examination
- Clinical Breast Examination
- Mammography

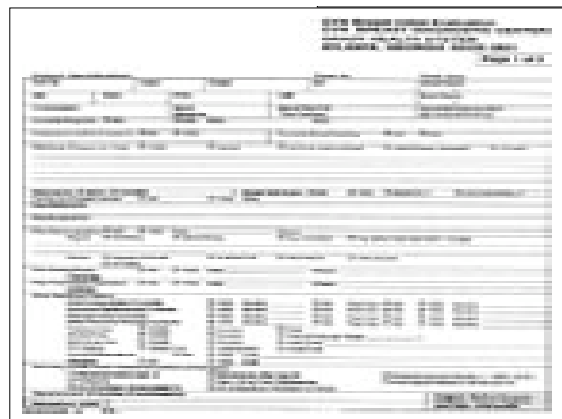
RISK FACTORS

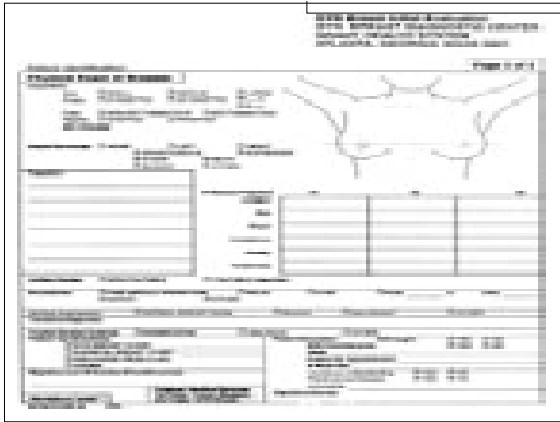
- Age
- Ethnicity
- Family history
- Reproductive factors
- Exogenous hormone use
- Benign breast disease
- Dietary factors
- Lifestyle factors
- Environmental exposures
- Genetic factors

High Risk Factors for Breast Cancer

Age: older
Race: white
Age at birth of first child: 30+
Postmenopausal body build: obese
Age at menarche: early
Age at menopause: late
Family history of breast cancer: first degree relative, especially premenopausal bilateral breast cancer
History of breast disease: atypical hyperplasia, previous breast cancer in one breast
History of other cancers: ovarian or endometrial cancer

O'Grady LF, et al. A Practical Approach to Breast Disease. Little, Brown and Company, New York, 1995





- Subjective: 41-year-old white female states, "I felt a lump on my right breast yesterday." Lump is nontender without pruritus, bleeding or nipple discharge. No associated fevers, chills, fatigue, weight change, hot flashes, back or joint pains. No personal or family history of breast cancer. Menarche at age 13, mother of three, first born at age 22, all breast fed to age 1 without problems. Normal LMP three weeks ago, contraception via condoms, infrequently performs BSE, drinks three to five cups of coffee daily, nonsmoker. No other concerns today.

- Objective: Chaperoned exam by nurse A.C. BP, 120/70; P=66; RR=14; T=99.2 oral; weight=138 lbs. Lungs clear bilaterally, Heart RRR, no palpable vertebral tenderness or spinal deformity. Breast without skin color or texture change, no retractions. Left breast without nodularity or expressed discharge. Right breast with 1.5 cm, mobile, smooth-bordered, rubbery, nontender lesion at 10 o'clock. No other lesions. No nipple discharge. No axillary lymphadenopathy bilaterally.

- Opinion: Right breast lump. Specific diagnosis unclear. History and exam favor fibrocystic change. Rule out malignant involvement.
- Options: Reviewed observation with re-examination through full menstrual cycle vs. ultrasound with possible biopsy. Symptomatic treatments reviewed including caffeine reduction and hormonal stabilization with OCPs.

- Advice: Advised ultrasound characterization now with possible follow-up investigations including biopsy and/or excision. Tripartite nature of breast cancer reviewed. Encouraged annual screening mammography and reviewed its diagnostic limitations. Instructed BSE. Reminded patient she is due for lipid profile.
- Agreed Plan: Patient chooses ultrasound now. Radiology appointment scheduled. She understands need for close follow up and states she'll keep appointments. Recheck in one week. Dictated in patient's presence.

- Breast mass diagnosed as fibroadenoma in 40 year old woman
- Mam and US c.w fibroadenoma
- Patient returns with metastatic carcinoma

Comprehensiveness

- Identification
- Current condition
- Past medical history
- Past surgical history
- Family history
- Social history
- Medications
- Physical examination

Comprehensiveness

- Initial assessment and reassessment
- Results
- Operative reports
- Procedure notes
- Consultant reports
- Informed consent

What Does "Informed Consent" Mean?

- Signing the consent form
- Telling the patient the relevant facts
- "You can die from breast cancer if its not detected early"
- "You can die from having your tubes tied"

Informed Consent?

- Process of providing information
 - Answering questions
 - Obtaining consent
 - Documentation
 - Good medical care
 - Legal defense
 - Consent form cannot replace the personal exchange

Informed Consent?

- Reasons why particular course of treatment
- Risks and benefits of treatment
- Alternatives to treatment
- Comprehension
- Update as circumstances change

Goals

- Adequate understanding
- Free from coercion
- Ability to choose between alternatives
- Ability to refuse
- Lack of deception as to purpose/nature

Assessing Patients' Capacities to Consent to Treatment

- Communicating choices
- Understanding relevant information
- Appreciating the situation and its consequences
- Manipulating information rationally

» Applebaum NEJM 319(25):1635

Issues

- "Signing the paper"
- Language Barriers
- Health Literacy
- Religious/Cultural barriers
- Financial interests/incentives
- Patient Autonomy
- Intentional tort

Comprehensiveness

- Counseling and education
- Disposition
- Patient correspondence
- Advanced directives

Skepticism about Possibility of Breast Cancer in Young Women

- 1-3% of all female breast cancers occur in women younger than 30 years
- 5% occur in women younger than 35 years
- 10% occur in women younger than 41 years
- Dismissed as Fibrocystic Condition

Bland, K The Breast 87:1607, 2004

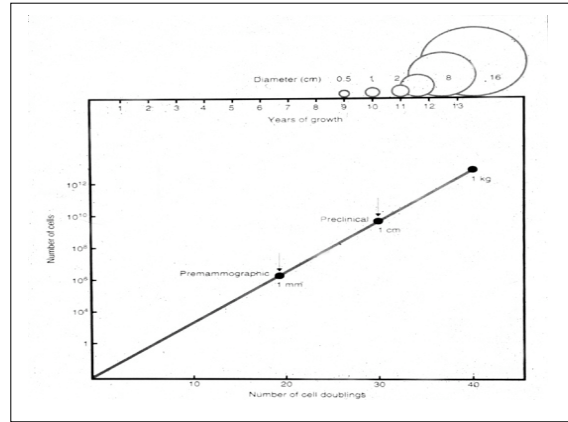
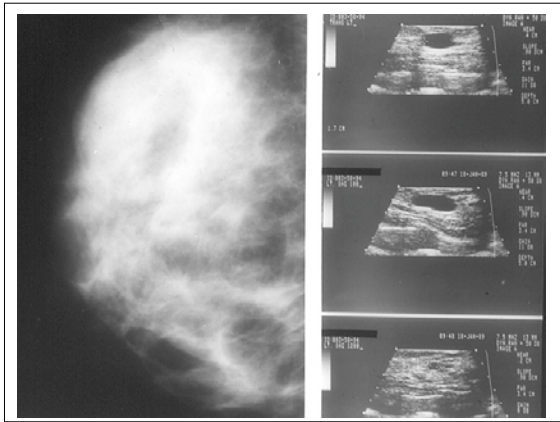
- Reassurance
 - Inappropriate in face of a persistent mass
 - False negative rate of mammography is 10-15%
 - Palpable mass despite a negative mammogram, requires further evaluation

Lower Accuracy of Mammography

Women with:

- Dense breasts
- Implants
- Fibrocystic condition
- Prior breast surgery
- On HRT

» Mandelson MT. JNCI 92:1081, 2000
» Rosenberg RD. Radiol 209:511, 1998



NATIONAL HEART, LUNG, AND BLOOD INSTITUTE NATIONAL INSTITUTES OF HEALTH

THE WOMEN'S HEALTH INITIATIVE

NEWS FLASH--Early Stopping of Estrogen plus Progestin Trial

WOMEN'S HEALTH INITIATIVE

Does breast or ovarian cancer run in your family? You can reduce your risk. We can help.

BRACAnalysis®
Be Ready Against Cancer.

Even if it runs in your family, cancer doesn't have to be inevitable. BRACAnalysis® is a blood test that can provide answers about your risk of hereditary breast and ovarian cancer. After BRACAnalysis®, you and your doctor can discuss effective options and steps you can take to reduce your cancer risk. Your results are kept confidential, and most health insurance plans provide coverage for testing.

If you answer "yes" to either of the following questions, you may benefit from BRACAnalysis®.

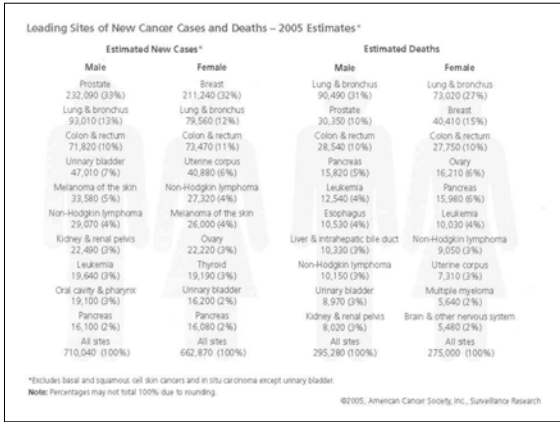
- Have you had breast cancer before age 50 and/or ovarian cancer at any age?
- Has anyone in your family (mother's or father's side) had breast cancer before age 50, ovarian cancer at any age or male breast cancer at any age?

Find out more about BRACAnalysis® and hereditary breast and ovarian cancer.

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730 Alabama
 2570 Florida
 15%
 4017 California
 1120 Georgia
 2760 New York

- ### Objectives
- Discuss the common theories of failure to diagnose
 - How to document to avoid future litigation
 - Review mammography screening guidelines and BIRADS categories

- ### ACOG Professional Liability Survey
- Pregnancy
 - Ectopic Pregnancy
 - Failure to diagnose cancer

TABLE 87-1 Top Three Errors in Diagnosis Resulting in Claims for Medical Malpractice by Physician Specialty

General surgery	Breast cancer, appendicitis, spinal fracture
Family practice	Myocardial infarct, breast cancer, appendicitis
Internal medicine	Lung cancer, myocardial infarct, breast cancer
Obstetrics/gynecology	Breast cancer, ectopic pregnancy, pregnancy
Radiology	Breast cancer, lung cancer, spinal fracture

Table created from data compiled in the Physician Insurers Association of America (PIAA) Data Sharing Reports, Executive Summary (1995, 2001) Washington, DC, PIAA, 1995, 2001.

TABLE 87-2 Most Prevalent Conditions Resulting in Claims of Medical Malpractice

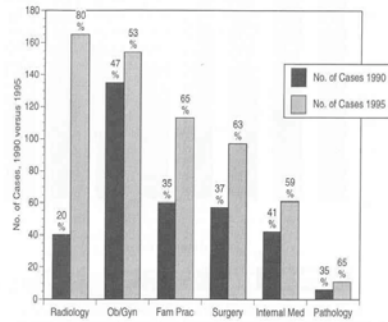
CONDITION	n	AVERAGE COST PER CASE
Breast cancer	3370	212,894
Brain-damaged infant	3308	487,839
Pregnancy	2656	159,922
Acute myocardial infarction	2336	180,506

Data from Physician Insurers Association of America (PIAA) Data Sharing Reports, Executive Summary (2001).

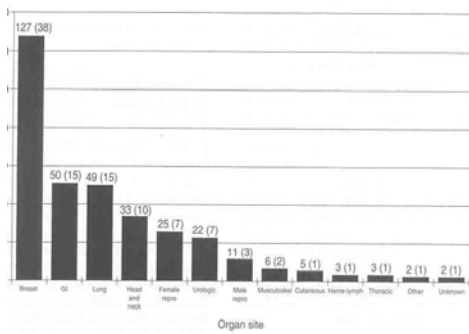
TABLE 87-3 Most Expensive Conditions to Indemnify for Medical Malpractice

CONDITION	n	TOTAL PAID (IN \$ MILLIONS)
Brain-damaged infant	3308	754.2
Breast cancer	3370	295.8
Acute myocardial infarction	2336	155.9
Pregnancy	2657	122.4

Table created from data compiled in the Physician Insurers Association of America (PIAA) Data Sharing Reports,



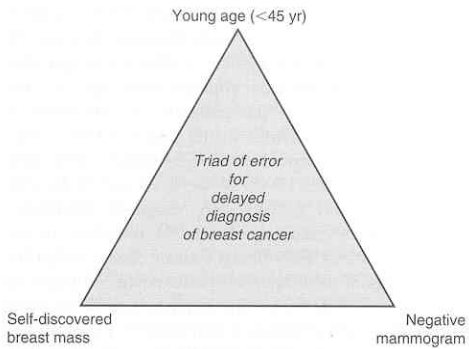
Data from Kern KA. Arch Surg 129:397, 1994



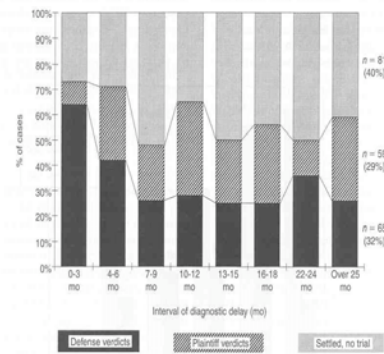
Data from Kern KA. Arch Surg 129:397, 1994

Common Themes

- Skepticism about possibility of breast cancer in young women
- Complete reliance on negative mammograms
- "System" failures
- Inattention to medical history
- Failure to diagnose recurrent disease



Bland KI The Breast 87:2003



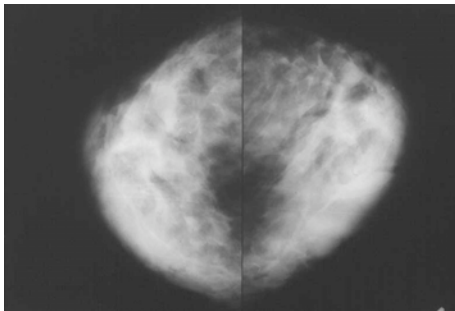
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Case Study

- 43 year old patient notes breast lump
- Examined by two healthcare providers –
 - ill defined margins



- Negative mammogram
- Multiple visits for unrelated gynecologic condition
- Lump enlarging over 2 1/2 years per patient
- Repeat breast exam lump unchanged in size

- Repeat mammogram negative
- Routine annual exam - "puckering" of skin
- Stage III Breast Cancer

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"System" Failures

- Insufficient procedures to assure follow up
 - Patient did not keep appointment
 - Patient did not follow for mammogram
 - Patient did not come back for results
 - Patient did not follow with Surgeon
- Mammogram/Lab report not reviewed
- Lack of communication amongst medical team

Patient Did Not Keep Appointment

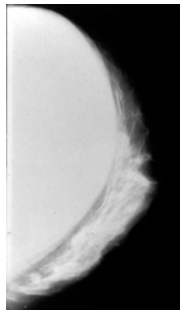
- Seen by Plastic Surgeon – lump diagnosed
- Several visits – Patient expressed concern
- Follow up visit in three months – patient returns 1 year
- Cancer diagnosed
- Decrease in chance of survival from 42% to 33 %

Key Points

- Always document planned follow up and reasonable treatment plan
- Document refusals and noncompliance with treatment
- Maintain copy of all initialed records

Case Study

- 39 year old patient undergoes breast augmentation by plastic surgeon
- Postoperative "hardening" in right breast



- Seen on several visits over 3 years
- Visits Ob/Gyn in interim for annual exam
- Notes "hardening" but orders no diagnostic tests
- "Did not feel it was his responsibility"

General Risk Management

- Choose a "captain" for medical team
- Sufficient systems in place for follow up
- If it can be measured, it is a "lump"
- Watch descriptive terms
- Always have a plan/reason
- Informed Consent
- Discuss cancer diagnosis after "cooling off" period
- Discuss with other family members and record

General Risk Management

- Strict adherence
- Foster better physician/patient relationship
- Mitigate against increased damages

Common Misconceptions

- Mass you are examining is the mass the patient is concerned regarding
- Negative exam means a lesion is not present
- Negative mammogram means a nonmalignant mass
- We have "microscopes" in our fingertips
- No family history, No breast cancer
- Patient will not

Caveats of Treatment

- Make sure the patient's concern is your concern
- Make sure the patient is comfortable with the diagnostic plan
- Record the history, examination and plan
- Avoid "Lesion", "Mass", "Thickening"
- Assure follow up of missed appointment
- Document, Document, Document
- Refer, Refer, Refer

TABLE 86-2 Reasons Underlying Diagnostic Delay^a

REASON	%
Physical findings fail to impress physician	35
Failure to follow-up in a timely fashion	31
Negative mammogram report	26
Misread mammogram	23
Failure to do a proper biopsy	23
Delayed or failed to consult	16
Failure to react to mammogram	12
Other health problems	11
Repeat examinations failed to impress clinician	11
Failure to order mammogram	11
Communication failure	11
Poor clinical examination	10

Bland KI The Breast 87:2004

Screening Guidelines for the Early Detection of Breast Cancer, ACS 2003

- Women ages 20-39
 - CBE every three years
 - BSE monthly.
- Women 40 and older
 - Annual mammogram
 - Annual CBE
 - Monthly BSE

BIRADS

Breast Imaging Reporting
And Data Systems

BIRADS Assessment Categories

Category

- 0 Incomplete
- 1 Normal
- 2 Benign
- 3 Probably benign
- 4 Probably Malignant
- 5 Malignant
- 6 Proven Malignant

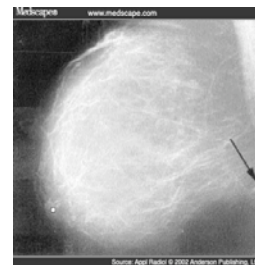
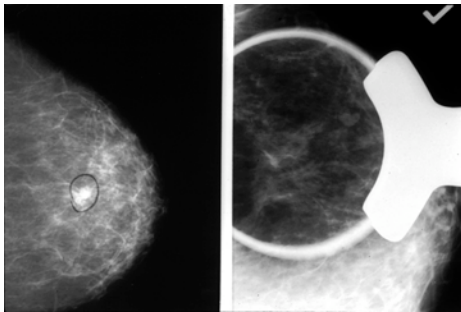
Category 0

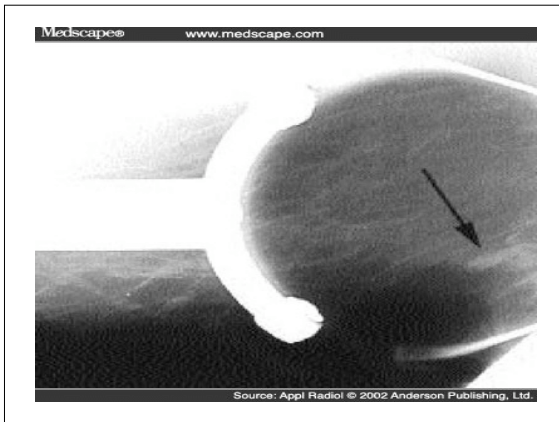
- Incomplete
- Needs additional imaging evaluation and/or prior mammogram comparison

Additional Evaluation

Usually screening situation

- Spot compression
- Magnification views
- Special views
- Ultrasound
- MRI





Category 3

Probably benign

- (Excludes palpable findings)
- <2% risk of malignant transformation
- Expect stability
- Short-term follow up 6, 12, 24, 36 months
- Biopsy possible

Pearls of Wisdom

- Biopsy must be performed on patients with a dominant or suspicious mass despite mammographic findings
- Mammography is never a substitute for biopsy because it may not reveal clinical cancer
- Ultrasound is the primary imaging method in younger women with dense breast
- Ultrasound is primarily for detection of nature of lesion rather than cancer

Diagnostic Errors

- Failing to:
 - examine a breast containing an obvious tumor while treating the patient for an unrelated disease
 - during palpation of the breast, to feel the tumor that the patient/another physician had discovered
 - recommend a referral, biopsy/excision
 - determine the cause of a nipple discharge

Diagnostic Errors

- Mistaking a carcinomatous tumor of the breast for a breast infection/benign lesion
- Relying on
 - negative aspiration biopsy
 - negative mammography
- Disregarding
 - a definite retraction sign
 - a history of acute and sharp pain

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Implementing and maintaining effective patient tracking and follow-up systems
- Establishing and following clinic policies and procedures Improving patient relationships
- Establishing effective communication with patients and families
- Improving medical record documentation
- Avoiding disagreement among health care providers

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Following applicable practice guidelines
- Hiring qualified staff and supervising them
- Maintaining patient confidentiality
- Avoiding medication errors

A LIFE IS NOT IMPORTANT
EXCEPT IN THE IMPACT
IT HAS ON OTHER LIVES

Jackie Robinson

Thanks to:
John Banja
Larry Wagner
Laura Dean
Department of Ethics in
the Health Professions
Emory Risk Management Department

Conclusion

- Common themes in failure to diagnosis breast cancer
- Mammography screening guidelines
- Understand provider obligation to obtain informed consent/refusal
- Identify how to set realistic expectations and help patients understand risk
- Documentation, documentation, documentation

Upcoming Programs

For a complete listing of all upcoming programs
www.adph.org/alphn