

# Preventive Action

The Quarterly Risk Management Newsletter for Policyholders of FPIIC **Second Quarter 2006**  
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## Reducing Exposure To On-Call Liability

By Sandra Strickland, RM Consultant

*Physicians are becoming increasingly reluctant to take call for hospital emergency departments (ED) citing increased liability risks as the reason.*

Reasons for increased liability include the complexity of the injury or illness of patients being treated in the ED, lack of a pre-existing patient-physician relationship, increased scope of practice by physicians who limit their practice to a sub-specialty but may be required to provide care outside that sub-specialty in the ED (such as a hand surgeon required to respond to an orthopedic case), and the likelihood that the physician-patient relationship established on-call will extend beyond the ED.

To reduce your risk exposure when providing on-call services:

- Acquaint yourself with the Emergency Medical Treatment and Active Labor Act (EMTALA) mandates.
- Review medical staff by-laws to ensure compliance with the duties and responsibilities of on-call physicians, which may vary by hospital.
- Ensure hospitals receive clear posting of your call schedule and contact information to ensure that you receive calls promptly, yet avoid multiple calls when you are not on call. If you utilize an answering service, monitor the quality of the service.
- Ensure appropriate response time (as defined by medical staff by-laws and community standards).
- Listen to and document the complete assessment – ask pertinent questions. If pertinent symptoms are not described ask about their presence. Communicate your initial impression or diagnosis, continued observations and symptoms requiring further actions, your recommended plan of care, recommendations for other referrals as indicated, and any other concerns.
- Discuss plan of care – arrive at consensus.
- Document conversations, including caller, time of call, presence and absence of symptoms, agreed upon plan of care.



- Don't refuse to come to the hospital to evaluate the patient – determine the urgency and an appropriate time frame for your response. Upon evaluating the patient, document the time of your on-site assessment, your findings, and plan of care. Follow through on any pending diagnostic studies.
- Maintain the same degree of follow-up care and treatment as that of established patients.
- Protect against allegations of abandonment. Terminate the physician-patient relationship of on-call patients in the same manner as those of established patients.

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## Physician Case Study

### Subject

Birth injuries continue to be a major contributor to medical malpractice losses. A significant number of birth injury claims are those involving shoulder dystocia. The majority of claims entailing shoulder dystocia arise out of manually assisted deliveries, which account for approximately 43% of all shoulder dystocia claims.

### Risk Management Issues

1. Lack of Informed Consent is a common allegation in shoulder dystocia claims.
2. Failure to offer C-section as a delivery option in the presence of high-risk factors for shoulder dystocia.

### Case Study Analysis

An obstetrical patient presented a picture of high-risk for shoulder dystocia over the course of prenatal care. Throughout prenatal visits no discussion of the option or possibility of need for a C-section was discussed, either according to the patient or documented in the medical record. During the course of vaginal delivery, shoulder dystocia occurred. Delivery was accomplished with excessive traction resulting in a Brachial Plexus injury. Permanent paralysis of the entire arm, hand and fingers occurred.

### Conclusion

Medical experts could not defend the case given the lack of any evidence that the patient's risk factor for shoulder dystocia was discussed at any time during her prenatal course, nor that the option of a C-section delivery was considered, in light of the patient's prior obstetrical course, current macrosomia and likelihood of cephalopelvic disproportion. Consequently, settlement of the case was necessitated in the amount of \$2,375,000. Implementing fundamental risk management measures may have prevented the claim, enhanced its defensibility, and mitigated damages.

### Discussion

*Because shoulder dystocia can occur with even the most experienced practitioners, a well-orchestrated plan of action is necessary to prevent complications, beginning with an accurate prenatal assessment, risk profile and informed consent. Accurate documentation of delivery maneuvers is essential. Shoulder dystocia claims are costly and difficult to defend.*



### whose license the PA is not registered?

No. This is an important consideration when the patients of a physician-partner of the practice are being covered and for those PAs who may take "call" for a supervising physician under whose license they are not registered.

### Is a PA (Physician Assistant) required to maintain a listing of medications prescribed?

Yes. Per current Florida statutes and specifically Florida Administrative Code(s)64B-300.007 and 64B15-6.0037, the supervising physician and prescribing PA shall enter into and keep on file a written agreement outlining which of the medicinal drugs in the formulary that the supervising physician has specifically authorized the prescribing PA to prescribe. It must be signed and dated by all parties and maintained on file for at least five years.

### Are HIPAA compliance mandates anti-electronic?

No. Doctors can communicate via e-mail, the telephone or fax machines. However, they must protect their patients' protected health information while doing so.

### What is arbitration and what benefit does it provide?

Arbitration is the submission of a

dispute to one or more impartial persons for a final and binding decision. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. It is also believed that arbitration panels will help to avoid unreasonable jury wards, thereby further lowering costs. These cost savings would positively impact professional liability rates and the cost and availability of healthcare services.

### Is a specific timeframe set forth when withdrawing professional services to a patient?

NO. Although statutes do not specifically set forth the amount of time a patient must be given, managed care contracts and Provider agreements may contain language that does. Generally, a 30-day notice period is sufficient, however, depending on the circumstances, a lesser time period may be appropriate. If the patient terminates you, there is no further obligation to treat the patient. Always review the language of applicable managed care plans before terminating the physician-patient relationship

### What is 'vicarious liability'?

A term used to describe the imputation of neglect to another person not directly involved in an allegedly negligent act. Generally, the common law test under which vicarious liability is determined is that of direction or control of another's actions.

### What is meant by a 'Root Cause Analysis'?

A widely adopted method of identifying underlying causes of medical error. An effective RCA looks beyond the immediate result and identifies the chain of events or contributing factors which led to the error.

### Can a PA (Physician Assistant) see those patients of a physician under



FPIC publishes *Preventive Action* on a quarterly basis as a service to its policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. FPIC recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions, or to obtain additional copies contact the FPIC Risk Management Department at 800-741-3742, ext. 3016, or [rm@fpic.com](mailto:rm@fpic.com).

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## FPIC Arbitration Program

FPIC offers an arbitration program for Florida physicians. The program was developed as a way to deal with rising court costs and jury verdicts. For participants, any claims that arise will be handled through the process of binding arbitration.

Arbitration is a relatively informal process of resolving disputes that is an alternative to the traditional court system. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. Arbitration panels should also help avoid unreasonable jury awards, thereby lowering costs. These cost savings would then be passed on to physicians.

The process of arbitration is simple; however, all parties agree to give up their constitutional right to have potential malpractice claim(s) resolved in court. Patients and their representatives who have signed the agreement must abide by the decision of the panel of arbitrators. A panel of three arbitrators will review the facts and determine the results. An arbitrator is like a judge, in that he or she listens to the evidence presented by both sides and decides whether malpractice occurred. At the arbitration hearing, each party will be represented by their own attorney,

have the opportunity to present evidence and witnesses, and cross-examine the other party's witnesses. The arbitrators will apply the same law that a court would, but the procedural rules are less formal than a trial. The arbitrators could also award any amount or kind of damages.

FPIC's arbitration program offers two alternative agreements. Both agreements are the same except for one key provision. One agreement requires

patients to sign the arbitration agreement as a prerequisite to future treatment. The other agreement permits a patient to terminate the agreement at any time for a period of 30 days from the date the patient signs the agreement.

The program is complimentary for all FPIC insureds in Florida and includes an

agreement, short video for patients to view, commonly asked questions and answers, and instructions for use. To receive additional information contact, Robert Wortelboer, Esq., General Counsel and Vice President, at 800-741-3742, ext. 3281 or [wortelboer@fpic.com](mailto:wortelboer@fpic.com). The order form, participation agreement, and commonly asked questions can also be downloaded from our website at [www.medmal.com](http://www.medmal.com).

*“Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party.”*

## NEWS ALERTS

### NPDB Decides Against Free Queries for Medical/Dental Boards

The National Practitioner Data Bank has been weighing the option of providing free database queries to state medical and dental boards. A task force collected information from the Federation of State Medical Boards and the American Association of Dental Examiners member boards and evaluated current use of the NPDB query services and potential use if free services were available. Based on the analysis, it was determined that medical and dental boards would not significantly increase their query numbers because, in general, they lack the human and/or financial resources to query on the majority of their licensure applicants — even if there was no fee involved. Additionally, the NPDB must pay for the cost of operations through user fees, so the task force determined that the NPDB would be unable to offer free services to a group of users for an indefinite period of time and remain financially viable. (NPDB, 1/31)

### Track Test Requests

If it's important enough to order a test or consultation, it's important enough to make sure you get a report of the results. Relying on labs or referral physicians to send reports may leave you vulnerable in a failure to diagnose malpractice action. Reports sometimes “disappear.” Commonly used tracking procedures include logging requests and checking them off when reports are received; holding out charts until the report comes back (this works for offices where testing is low volume); and maintaining a tickler file of copies of requests and discarding the copy when results are received. Use the method which works best for your office environment. To close the loop, initial and date all reports to signify that you have reviewed the report. Communicate abnormal results to your patients and chart that the information was relayed. Include follow-up care plans in your note.

### Procedures That Fall Within the “Universal Protocol”

The Universal Protocol and its Implementation Guidelines apply to all operative and other invasive procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room such as a special procedures unit, endoscopy unit, or interventional radiology suite. Certain routine “minor” procedures such as venipuncture, peripheral IV line placement, insertion of NG tube, or Foley catheter insertion are not within the scope of the Protocol. However, most other procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this Protocol.

### Harmful Medication Errors Seven Times Higher in Radiological Services

Rockville, Md., Jan 18, 2006 - The United States Pharmacopeia (USP) today announced that medication errors occurring in radiological services produced the highest percentage of harm—seven times higher than all medication errors studied in the 2000–2004 reporting period, according to the 6th annual MEDMARX® Data Report. From 2000 to 2004, 12 percent of the 2,032 medication errors reported in radiological services resulted in patient harm. This is more than seven times the percentage of harmful errors reported in the 2000–2004 general MEDMARX data set. Radiological services were also more likely to result in the need for additional care and consumption of resources.

Inpatient and outpatient radiological services include the radiology department, cardiac catheterization laboratory, and nuclear medicine. These services involve an increasing number of procedures and tests each year, despite the common misperception that radiology is limited to x-rays. In addition to diagnostic exams, radiological services include procedures such as draining abscesses, inserting gastric feeding tubes, inserting arterial stents, and performing angioplasties. Breakdowns in “continuity of care” contributed to harmful medication errors. Patients often circulate quickly through radiological services without adequate communication between radiology staff and the physicians and nurses who have been providing their care. This breakdown in communication can lead to various errors including patients receiving the wrong drug, the wrong dose of a drug, or not getting the drug at all.

**Reprinted with permission: Sherrie Borden at US Pharmacopeia**

### \$2.9 Million Verdict in Illinois Shoulder Dystocia Case

Two Chicago attorneys have announced a \$2.9 million settlement on behalf of their clients in a shoulder dystocia case that occurred Sept. 19, 1999. The plaintiffs alleged that doctors applied too much pressure to extract an infant girl whose left shoulder became stuck against the pubic bone of her mother. The resulting nerve damage in the child's neck permanently restricted movement of her left arm. Doctors attempted to alleviate the complicated birth by flexing the mother's thighs back onto her abdomen while applying pressure to the mother's belly below the navel, otherwise known as the “McRoberts maneuver.” Defendants in the case were West Suburban Medical Center in Oak Park and the attending physician, who were responsible for the entire amount of the settlement. (*Insurance Journal*, 2/17)

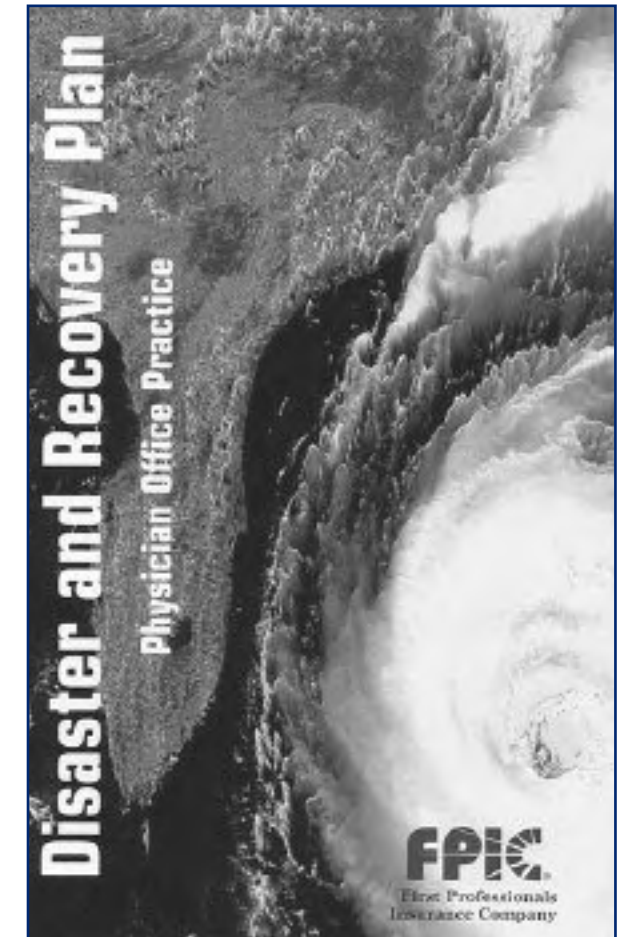
## Risk Management Products & Services

### Disaster & Recovery Planning For Physician Office Practices

Anticipating and preparing contingency plans for coping with natural and manmade disasters can make a significant difference in how well your practice survives. Now is the time to evaluate preparedness procedures, meet with your staff and address these issues. The use of a disaster and recovery plan checklist is an efficient loss prevention measure. An hour or two spent discussing these questions with your staff can help avoid chaos and confusion, reduce your exposure to loss and maintain patient safety if and when faced with a disaster. This booklet contains a model for disaster and recovery planning designed specifically for the physician office. An extensive checklist format covers things from protecting patient records to third-party billing measures - all designed to help mitigate loss and facilitate recovery.

FPIC has available a number of highly effective, risk management products and services. These comprehensive products are designed to avoid claims and disciplinary actions and encourage physician participation. All risk management products and services are available at no cost to our policyholders.

To obtain a copy of the *Disaster & Recovery Plan* or to access other risk management products and services, contact the Risk Management Department at 800-741-3742, ext, 3016 or [rm@fpic.com](mailto:rm@fpic.com). The materials are also available on the FPIC website at [www.firstprofessionals.com](http://www.firstprofessionals.com)



## Risk Management Guidelines: Disaster & Recovery Planning

- Over 25% of businesses that close following a disaster do not reopen.
- 80% of businesses having an extended disaster are out of business within five years.
- 50% of businesses having a disaster without a plan go out of business within two years.
- A private practice is a business and has both tangible and intangible assets.
- Without a pre-defined plan to protect and recover service operations, most practices will be unable to survive a business outage.