

# Preventive Action

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## Lung Cancer Claims Analysis

By Joseph F. Putz, LHRM, Risk Management Consultant

Recently the Physician Insurers Association of America (PIAA) released a study on lung cancer claims, which was undertaken to better understand the allegations behind these claims and determine what could be done to improve diagnostic techniques, communications, and follow up.

In the 2005 PIAA study, Radiologists were most often the specialist named for failure to diagnose, a marked change from previous studies where Internists were most often named. (See table on page 2.)

The most common reason for a delay in diagnosis was communication, a common issue in many malpractice

cases. Communication problems were evenly split between communication issues with the patient and communication problems with another physician or medical professional. While the study cited multiple reasons which contributed to the delay in diagnosis, more than 56 percent identified communications as central to the delay.

The 2005 study showed that patients commonly presented to physicians with no marked symptoms indicative of the disease, and that the physicians didn't find any symptoms that pointed to the disease. The absence of pronounced symptoms is notable because 85 percent of the patients reported smoking histories that averaged 39 pack years (number of packs per day multiplied by number of years smoked). Patients who smoked received indemnity payment amounts that averaged 8 percent more than those patients with no smoking histories.

Although females reported fewer pack-years overall, the average payment made to a female patient with a smoking history was 53 percent higher than that paid to a male smoker. Females in the current study



were 2.5 years younger than males (56.0 years versus 58.5 years.)

The PIAA study confirms the difficulties which are present in diagnosing lung cancer. The presenting symptoms are often subtle and confusing, complicating the diagnosis. Often, a delay of more than a year in the diagnosis prevents a full recovery.

At present, there is no agreement in the medical literature on the most reliable method to make a lung cancer diagnosis, nor does routine screening provide much help. While patients contribute to the development of this disease in a large percentage of cases, healthcare professionals must be diligent in communicating and documenting patient histories, symptoms and observations.

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## Reducing Risk When Treating Non-Compliant Patients

By Sandra Strickland, RN, MSN, Risk Management Consultant

In primary care, the most frequently misdiagnosed conditions resulting in claims are breast cancer, acute myocardial infarction, diabetes, lung cancer, pulmonary embolus, appendicitis, colon cancer, and meningitis<sup>1</sup>. A predominant root cause of misdiagnosis is the non-compliant patient. To reduce your exposure in treating non-compliant patients, it is vital to identify high-risk patients, inform patients of the urgency of diagnosis and treatment, the consequences of their failure to comply, and document the process.

### 1. Identify High Risk Patients

A physician's risk exposure increases when encountering patients with complaints of breast mass, pain, rash, or discharge; chest pain, shortness of breath, cough or hemoptysis; unexplained weight loss and fatigue, excessive thirst and urination; abdominal pain, change in bowel function, new diagnosis of anemia, especially with a family history of colon or rectal cancer; or severe headache with neck stiffness. These complaints and symptoms are indicative of the most commonly misdiagnosed conditions. Extra care and attention should be taken to appropriately assess and evaluate, diagnose, treat and follow-up with patients with these symptoms.

### 2. Educate and Inform

Communication is essential in evaluating, diagnosing, and treating your patient. It is important to inform the patient of the potential diagnoses, the diagnostic procedures indicated, and the importance and urgency of following your recommendations and advice. The patient should understand what diagnostics, procedures, or treatments are needed, the timeframe for completion, the rationale, and the consequences of non-compliance or delayed compliance. The physician also has the duty to communicate with the patient regarding any non-compliance issues and to determine and attempt to resolve with the patient the reasons for non-compliance. Should you continue to treat the patient, it is important to re-address compliance issues and continue offering diagnosis and treatment recommendations to the non-compliant patient.

### 3. Document

Each discussion – face to face or by telephone – regarding diagnostic and treatment options should be documented. The documentation should include your communications to the patient regarding the importance and urgency of compliance, as well as the consequences of failure to comply. A certified letter to the patient is often helpful in stressing the importance of your recommendations and also provides proof that the patient received the communication. Your continuing follow-up and discussions regarding non-compliance should also be documented. Frequently the patient will allege that he or she was unaware of the severity or importance of complying with recommendations, and documentation of these discussions is the most effective legal defense in these cases.

As a last resort, you may find it necessary to terminate your relationship with patients who are consistently non-compliant and prevent your delivery of the standard of care or the level of care to which your practice is committed. To avoid allegations of abandonment, first ensure that the patient is not in an acute or unstable episode of illness. Secondly, the patient must be given written notice of the dismissal. A certified letter, stating the need to obtain the services of another physician, the reason for the termination, and the provision of emergency care for a period of time (usually 30 days) is strongly recommended.

<sup>(1)</sup> Physician Insurers Association of America. *Risk Management Review-Combined Specialties*, 2005 edition.



### What is the legal definition of "supervision"?

The definition of supervision varies greatly in both Florida statutes and Administrative Codes. The scope of collaboration is determined by the context of the clinical setting, patient acuity and medical condition, type of healthcare provider, professional licensure, and even duration of clinical practice and employment.

### Is a "time out" process required before surgical procedures?

Yes. In Florida, the time out procedure is required by law. Florida Administrative Code 564B8-9.007 requires the surgical team to pause prior to initiation of the

surgery or procedure to confirm the side, site, patient identity, and surgical procedure. The notes of the procedure must specifically reflect when the time out was completed and which personnel on the surgical team confirmed each item.

### Which drugs can a prescribing PA write prescriptions for?

Under current Florida law, a PA may not write prescriptions for controlled substances, anti-psychotics, general anesthetics, radiographic contrast materials, and parenteral injectables except for insulin and epinephrine. Only a PA with a current license with approved prescribing privileges can write prescriptions in Florida.

### If you get served with a subpoena – but no court order – can you still disclose protected health information under HIPAA privacy rules?

Yes, according to the HHS Office of Civil Rights – as long as you meet one of these criteria:

1. When you are neither a plaintiff nor a defendant in litigation, you may disclose PHI if you have made reasonable efforts to notify the individual whose PHI will be disclosed; or the party seeking the PHI has made similar efforts – and provides

documentation proving that it provided the individual enough details and time to file objections to the disclosure. Otherwise, qualified protective court orders for the information should be sought.

2. If you are a party to a legal proceeding, such as a defendant in a malpractice action or a plaintiff in a suit to obtain payment, you may use or disclose PHI as part of your healthcare operations. However, you must make reasonable efforts to limit such uses and disclosures to the minimum necessary to accomplish the intended purpose.

### 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.



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.

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Lung Cancer Claims by Physician Specialty PIAA Lung Cancer Study, 2005						
	# Claims	% of Claims	Avg. Patient Age	Avg. Indemnity	Total Indemnity	% of Indemnity
Radiology	74	27.6%	56.6	\$328,038	\$24,274,807	32.3%
Internal Medicine	45	16.7%	55.6	\$404,157	\$18,187,043	24.2%
Family Practice	45	16.7%	56.5	\$212,737	\$ 9,573,164	12.8%
Other Surgical Spec.	13	4.8%	57.9	\$ 28,077	\$ 365,000	0.5%
Pulmonology	12	4.4%	53.8	\$279,708	\$ 3,356,499	4.5%
General Surgery	11	4.1%	60.4	\$158,409	\$ 1,742,499	2.3%
Cardiology	8	2.9%	67.8	\$233,188	\$ 1,865,500	2.5%
Emergency Med.	6	2.2%	56.6	\$120,833	\$ 725,000	1.0%
Vasc.& Thor. Surg.	4	1.4%	50.5	\$443,231	\$ 1,772,925	2.4%
Other NonSurg. Spec.	12	4.4%	49.8	\$229,750	\$ 2,756,999	3.6%
Physician group/corp	24	8.9%	54.5	\$261,927	\$ 6,286,249	8.4%
Hospital	14	5.2%	57.9	\$297,304	\$ 4,162,250	5.5%

## Do I Really Have to Sign It?

Failure to sign off on dictation is a frequent finding during FPIC's physician office surveys. This practice can create a significant risk exposure. Every day, physicians are barraged with requests for sign-offs. The hospital wants them and your office wants them. The hospital part is fairly easy. Medical record departments flag your charts for missing signatures when your patient's record reaches them. Your signing off makes for a completed hospital record. You agreed to abide by their rules when you became a member of the medical staff. If you don't comply, you could lose privileges. Why should your office be any different? Remember, you are still creating a legal document. Every provider should sign off on his or her entries into the charts. That includes your office clinical staff. When staff take phone messages or make any other entries in the record, they should be signed. Dictated entries may be problematic from the sign-off perspective. Many providers don't want to go back and initial them and rely on the "dictated but not signed" designation. From a defense perspective, a dictated entry that no one has verified for accuracy of the transcription and/or dictation leaves significant opportunity for risk exposure. There is concern that plaintiff attorneys can use unsigned dictation to attack the physician's credibility, specifically attacking with an, "If you didn't sign it, how do we know it's accurate?" Furthermore, claims often arise years after care was provided. Suppose you review your chart in preparation to deny or defend the claim only to find there is an error in the dictation. Depending upon the significance of the error, your defense strategies may be weakened. Is it worth the risk? Take a few moments and review the dictation. Add your initials to verify accuracy. It is best to review and sign off soon after the dictation is completed. The next best opportunity is when you review dictation prior to providing care at your patient's next visit. Sign off then. It only takes a moment and could make the difference between easily dismissing allegations and a protracted malpractice case defense.

## Florida Supreme Court Allows Lawyers To Avoid Contingency Fee Caps

The Florida Supreme Court ruling in December allows attorneys to avoid the voter-approved cap on attorney contingency fees in medical malpractice cases. Limits on such fees were established last year under Amendment 3, however, Florida lawyers have been side stepping them by permitting clients to waive their rights to fee-limits. The unanimous ruling ordered the Florida bar to draw up new rules to clarify when and how lawyers can bypass the fees.

## Congress to Tackle Medical Liability in 2006

According to Senate Majority Leader Bill Frist, medical liability reform will be on the Senate's agenda in 2006. Speaking before the American Academy of Family Physicians (AAFP) Board of Directors, Frist said he planned to begin moving pending legislation on medical liability through the Senate as soon as Congress had acted on tort reform legislation affecting the asbestos industry. He told the Board he first wanted to "de-link" a lot of the issues that have been hanging onto medical liability legislation and that have been giving legislators cover for not voting on reform proposals. The AAFP Strike Force on Medical Liability recommended that the Academy back legislation that would cap noneconomic damages in medical malpractice cases; support the Fair and Reliable Medical Justice Act (S. 1337), which would fund studies of alternative judicial and extra-judicial systems; advocate eliminating contingency fees in medical liability cases; and support constituent chapters

that are advocating liability reform. Unfortunately, the task force recommended that the Academy support caps not to exceed \$500,000 instead of the cap which has proven to be effective in California and Texas: \$250,000. (*American Family Physician*, 11/17/05)

## Health Records of Hurricane Evacuees Go Online

In a move that basically turns HIPAA on its head, the federal government is making medical information on Hurricane Katrina evacuees available online to doctors. This marks the first time private records from various pharmacies and other healthcare providers have been compiled into centralized databases. Doctors in eight shelters for evacuees can go online to search prescription drug records on more than 800,000 people from the flood-racked region. Officials hope to soon add computerized records from Medicaid in Mississippi and Louisiana, Department of Veterans Affairs health facilities, laboratories, and benefits managers. The records are one step in reconstructing medical files on more than 1 million people disconnected from their regular doctors and pharmacies. Though the immediate focus is on urgent care, participants in the effort say the disaster demonstrates a broader need to computerize individual health records nationwide and make them available throughout the medical system. Privacy advocates fear the data could be exploited by hackers, companies, or the government. (*Washington Post*, 9/14/05)

## CASE SUMMARY: Protection Against Non-Compliant Patients

This case involves a 55 year old obese male referred to a gastroenterologist by his primary care physician with a two month history of painless lower GI bleeding with no change in bowel habits. The patient underwent colonoscopy on March 13, 2003. The procedure could not be completed due to improper preparation of the patient and was rescheduled for the following day. However, small bleeding external hemorrhoids were identified. The patient failed to return to the outpatient surgical center the following day. That same day the gastroenterologist spoke with the patient by phone to encourage the patient to have a repeat colonoscopy following additional preparation on the following day or, as a lesser option, be scheduled for a barium enema. The patient elected to have a barium enema instead of the recommended colonoscopy. The barium enema was interpreted and reported as normal in March and the patient was given a hemorrhoid care sheet and advised again to have re-examination of the colon. In April, the gastroenterologist again strongly advised the patient to follow up with additional testing, which was scheduled for the following week. Again, the patient failed to show for this appointment. The appointment was rescheduled for May and the patient "no showed" again. The patient was called regarding the missed appointment and the urgency of having the colonoscopy repeated. However, the patient stated that he was doing better and declined further follow-up. The gastroenterologist advised the patient to follow up with his primary care physician. Three months later the patient underwent colonoscopy when his symptoms returned. He was diagnosed with a 3 cm infiltrating mass in the sigmoid colon. The patient's attorney filed a notice of intent against the gastroenterologist alleging failure to diagnose colon cancer. An immediate response was filed, rejecting the claim. Based on the gastroenterologist's documentation of the patient's non-compliance (and expert testimony regarding the disease progression), the claim was withdrawn.

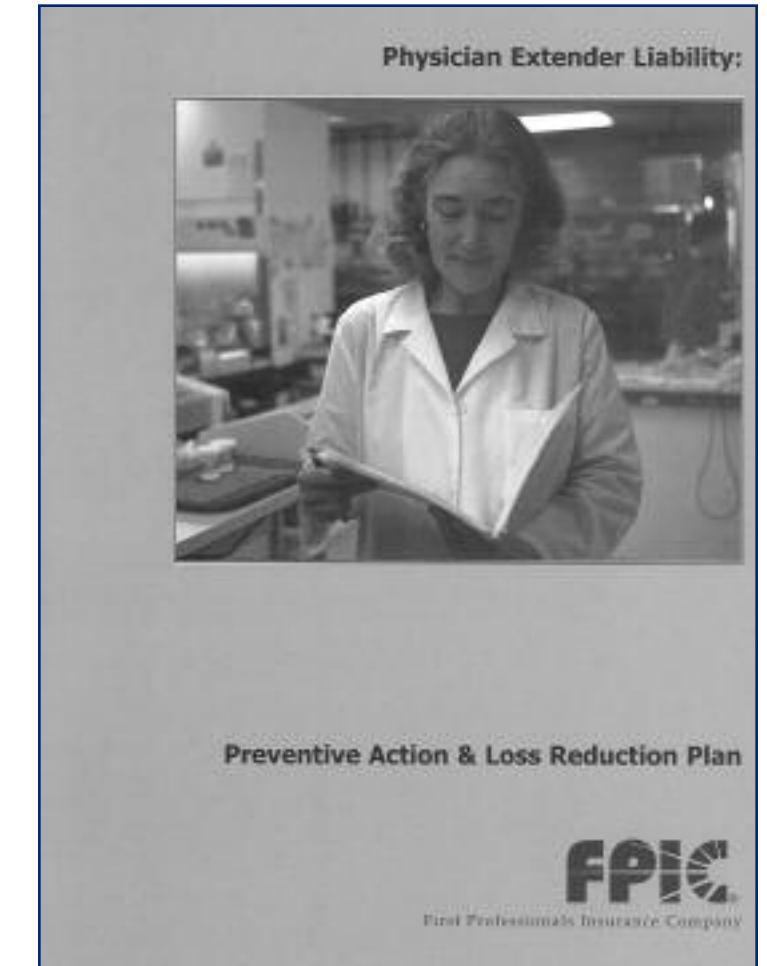
## Risk Management Products & Services

### Physician Extender Liability: Prevention Action & Loss Prevention Plan

This risk management reference tool is designed to help physicians understand the commonly used theories of liability for which they are held accountable for the negligence of others. The various types of physician extenders increasingly utilized in healthcare delivery are defined. Applicable Florida statutes and Administrative Codes are cited. The booklet contains a specific risk management plan of action pertaining to the use of physician extenders together with model protocols and templates – all designed to reduce physician liability.

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. Such products and services are available at no cost to our policyholders.

To obtain this or any risk management reference materials, contact the Risk Management Department at 800-741-3742, ext. 3016, or rm@fpic.com. These materials are also available to download on the FPIC risk management website at [www.firstprofessionals.com](http://www.firstprofessionals.com)



## Risk Management Guidelines: Physician Extenders

In tandem with the increasing use of physician extenders is the spiraling frequency and severity of medical malpractice claims against physicians attributed to physician extenders. Most malpractice claims attributed to physician extenders can often be traced to clinical and administrative factors that are easily identified and remedied:

- Assumption of too much responsibility
- Inadequate physician supervision
- Absence of written protocols
- Deviation from written protocols
- Failure and delay in seeking referral or physician collaboration