

Preventive Action

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ALABAMA

Statute of Limitations

All actions against healthcare providers must be commenced within two years after the act or omission giving rise to the claim provided that if the cause of action is not discovered and could not reasonably have been discovered within the two-year period, then the action may be commenced within six months from the date of such discovery, or the date of learning of facts that would reasonably lead to such discovery, whichever is earlier. (Ala. Code SS 6-5-482.) Although this statute of limitations is subject to tolling for minority or disability, in no event may an action be brought more than four years after the act or omission, except that a minor under age four at the time of the act or omission accrues has until their eighth birthday to commence an action.

A wrongful death action must be brought within two years after the descendant's death (Ala. Code SS 6-2-38 and 6-5-410) and is not subject to any tolling provisions and applies in wrongful death cases even if the cause is medical malpractice. *Cofer v. Ensor*, 473, So. 2d 984; *McMickens v. Waldorp*, 406 So. 2d 867.

GEORGIA

The Right to Know Act of 2001

Georgia's *Right to Know Act*, which became effective 4/11/01, requires the Composite Board of Medical Examiners to create a physician profile for every licensed physician. Profiles, which must be completed and available to the public by July 1, 2002, include:

- Core Information – related to education, specialty, board certification, length of time in practice, primary location of practice, hospital privileges, status of participation in Medicaid, and availability of translating services;
- Criminal felony convictions;
- Restrictions on hospital staff privileges based on character or competency;
- Malpractice awards; and
- Board Actions

Only disciplinary actions and malpractice payments occurring after April 11, 2001, must be included in the profile. A statement warning against the presumption of medical negligence or malpractice will accompany disclosures of malpractice actions. Under the Act, physicians are required to display a "Declaration of Patient Rights" that must contain specified language regarding the process for filing a grievance with the Board. It must also contain the phone number and address of the Board. The Act also states that patients have the right to information regarding the estimated charges for a routine office visit, routine treatments, and lab tests prior to receiving treatment. Monetary penalties for non-compliance are assessed daily by the Board and each violation of the Act becomes a part of the physician's profile. Any person has the right to receive a Physician's Profile from the Board without the knowledge of the physician. Requests for profiles are kept confidential.

FLORIDA

Office Surgery Rules

The First District Court of Appeals in Florida recently reversed an Administrative Law Judge and upheld the Board of Medicine's rules imposed on physician office surgeries. The Court held the following rules valid:

1. Physicians performing Level II Office Surgeries must have a transfer agreement or medical staff privileges with a nearby hospital.
2. Physicians performing Level III Office Surgeries must have hospital staff privileges, Board Certification, or comparable background, training, and experience.
3. Level III Office Surgeries must have the administration of anesthesia performed by an anesthesiologist.

OHIO

New Fee Schedule for Copying Medical Records

Recent legislation in Ohio sets forth a fee schedule permitting the right to charge for copies of medical records. A physician may charge:

- \$15 for a records search fee;
- \$1 per page for the first 10 pages;
- 50 cents per page for pages 11 to 50;
- 20 cents per page for pages 51 and higher; and actual postal costs when mailing copies.

In the case of electronic records, the actual cost of making copies may be charged as well as actual postage costs when mailing the copies.

Exceptions to the right to charge for copies include those records furnished to the Bureau of Workers' Compensation, which must be provided free of charge.



What is the effective date for the new HIPPA privacy rules?

Although the HIPPA Privacy Rule became effective April 14, 2001, it has not been finalized and will be the subject of future updates anticipated through the fall of 2002. Physicians and dentists covered by the new rule must comply by April 14, 2003.

Does state or federal law set forth a specific manner in which obsolete patient records must be destroyed?

No. However, patient records must be destroyed in a manner that protects patient confidentiality. The best way to dispose of records is by shredding, mutilation, or similar protective measures. If arrangements are made with third parties or entities for the destruction of patient records, a written agreement should be obtained clearly obligating the entity to safeguard confidentiality as well as indemnify and hold harmless you and your practice from any breach of confidentiality for which they are responsible. Before destroying records, confirm the timeframes of the specific record retention laws in the state in which you practice.

What is a deposition?

A deposition is testimony given under oath before a court reporter. Depositions are important in the preparation of a case for trial. Depositions also freeze testimony and can be used to impeach your credibility if you deviate from them later. They are used to discover facts of the case and to uncover additional witnesses.

Depositions are also used to narrow the issues of the case. Failing to appear for a deposition subjects you to the potential to be held in contempt of court. Always consider exercising your right to legal counsel before providing deposition testimony.

Does the physician-patient relationship end at the time insurance coverage expires or a managed care plan terminates?

No. Once established, the physician-patient relationship does not end merely because insurance is no longer available or a change in managed care coverage occurs. A physician's responsibility to the patient continues unless and until the patient severs the relationship or the physician provides proper notification to the patient of the intent to withdraw from providing further care and treatment. Furthermore, the physician's responsibility to treat the patient may extend until the patient becomes medically stable. Always seek legal or risk management guidance before terminating the physician-patient relationship.

*By Cliff Rapp, L.H.R.M.
 Vice President, Risk Management*

Spiraling increases in the frequency and severity of malpractice claims attributed to factors other than medical negligence necessitates that physicians and their staff implement effective risk management practices. A two-pronged approach must be taken: initiation of loss prevention measures necessary to deter lawsuits before they are pursued and adherence to risk management practices designed to defeat the unavoidable claim.

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Allegations involving diagnostic error continue to remain a leading cause of lawsuits against physicians and among the most difficult to defend. However, the type of medical condition, modality of treatment, and practice environment often determines loss exposure. Ironically, those factors have little, if anything, to do with physician competency or the level of care rendered.

An essential but often overlooked risk management technique is effective communication. Recent studies reveal that between 60-90% of a physician's clinical time is spent communicating with patients. Communication is both an art and a science. It is also a powerful motivating factor upon which malpractice claims are pursued and avoided. Inadequate, inappropriate, or ineffective communication increases the chances of diagnostic error, non-compliance, poor medical outcome, and the likelihood of being sued. Conversely, effective communication improves diagnostic accuracy, enhances patient decision-making, and increases the likelihood of adherence to therapeutic regimens. By establishing realistic expectations, non-meritorious claims can be avoided and patient satisfaction levels greatly increased. Essential for physician-patient rapport, good communication prevents erosion in the physician-patient relationship, a

significant challenge since the advent of managed care.

Ever emerging creative legal doctrines and not medical error often serve as the predicate for negligence claims. Fortified by requirements set forth by federal and state law, allegations entailing lack of informed consent continue to lower the threshold in tort necessary to bring legal action. Consequently, physicians who fail to appreciate the distinction between such legal doctrines as *formal* consent and *informed* consent do so at their own peril.

"Practicing to the standard of care does not fully insulate a physician from the increasing chances of being sued for malpractice...."

Although written and verbal communications have traditionally been the primary method of disseminating healthcare information, the Internet opens new avenues for providing information and communicating with patients. In tandem with the potential benefits of electronic communications are sobering legal concerns that can be neutralized with applicable risk management practices.

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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.

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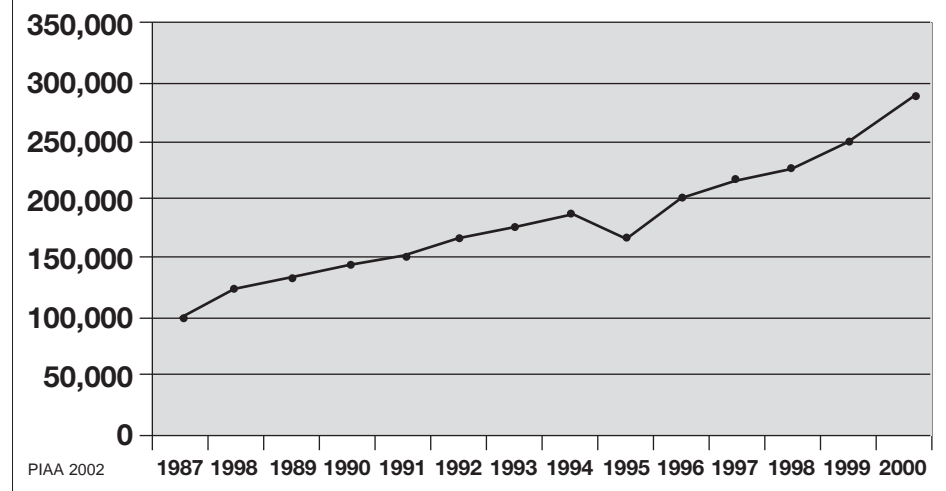
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Average Indemnity Payment: National



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Practicing to the standard of care does not fully insulate a physician from the increasing chances of being sued for malpractice or confronting allegations of fraud and abuse. Under broadened federal regulations, mere coding oversight or billing error can trigger investigative nightmares and result in civil damages, penalties, and criminal sanctions. Initiating a voluntary compliance plan is an essential

preventive measure, easily accomplished with a modicum of risk management savvy. Physicians can significantly reduce their liability exposure, eliminate intimidation by the legal system, utilize the tort system to their advantage, and increase the odds of defeating non-meritorious claims and suits. However, to do so, risk management is a necessity.

Preventing Medication Errors

By Cliff Rapp, L.H.R.M., Vice President, Risk Management

The Harvard Medical Practice Study (MPS) was the first of its kind to attempt to quantify the number of adverse events that occur in medical encounters. According to the MPS, nearly a fifth of patient injuries are attributed to medication error. The 1999 publication of the Institute of Medicine (IOM) report, "To Err is Human," cites medication error as the leading cause of medical injury.⁽¹⁾ Other studies estimate the cost of drug-related morbidity and mortality to exceed \$136 billion.⁽²⁾ Notwithstanding any controversy surrounding these reports is the undisputed increase in frequency of medical malpractice claims resulting from medication errors. In terms of an iatrogenic injury, medication errors are among the most difficult to defend. Ironically, they are also the most preventable type of malpractice claim.

Etiology of Medication Errors

Most medication errors are attributed to:

- Faulty prescribing, monitoring, and refilling practices;
- Improper documentation;
- Inadequate communication, primarily telephonically; and
- Inappropriate formularies.

Common Causes of Error

Errors in transcription and verbal orders are among the most common causes of medication error. Inadequate staffing, multiple prescriber/single patient, failing to record allergies and inadequate drug history are other frequent causes of error.

Common Drug Classes

The four major drug classes involved in medication error claims are analgesics, antibiotics, psychotropics, and cardiovascular drugs.

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Common Prescribing Errors

The most frequent prescribing errors entail:

- Wrong dose;
- Wrong dosage form;
- Route;
- Frequency; and
- Contraindication.

Prevalent Drug Type

In terms of malpractice claim frequency, the most prevalent drug type entails anticoagulants, particularly blood-thinning drugs with a narrow therapeutic index. Potassium chloride is another drug commonly encountered in medication error claims. The primary issue from a liability standpoint frequently arises from inadequate monitoring of the patient.

(1) PIAA Medication Errors Symposium White Paper, Physician Insurers Association, Rockville, MD. April 2000

(2) Classen, D.C.; et.al. "ADVERSE drug Events in Hospitalized Patients." JAMA. 1997, 227:301-6

A Reference Tool for Risk Management

The FPIC Risk Management Department has recently completed an extensive revision of the publication entitled "A Reference Tool for Risk Management." This version of the book has been enhanced with the addition of several new topics, including *Legal Issues and Concerns, HIPPA, Fraud and Abuse, Running a Medical Office Practice, and Incident Reporting*. This enhanced book contains many forms and templates that can be used in your practice environment.

"A Reference Tool for Risk Management" is currently available as a bound printed book. CD-ROMs should also be available shortly. To request a complimentary copy of "A Reference Tool for Risk Management", contact the FPIC Risk Management Department:

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Risk Management Guidelines: Preventing Medication Errors

PRESCRIBING POLICIES

- Exercise caution prescribing medications when on call
- Verify medication history for new patients
- Do not permit unlicensed staff to dispense or furnish medication
- Implement dispensing protocols
- Do not casually delegate refill authority
- Do not refill or re-prescribe drugs prescribed by another physician
- Conduct a medical exam before prescribing controlled drugs
- Ask pharmacists to repeat the prescription or refill order when calling in the order
- Become familiar with the indications, contraindications, dosage, and side effects of medications prescribed
- Avoid medical abbreviations on the telephone such as: "t.i.d." –vs– "three times a day"
- Use standardized language
- Document patient non-compliance

CHARTING DEFICIENCIES

- Utilize a medication control record – ideally affixed to the inside cover of the patient's chart
- Avoid ambiguity in charting notations – be specific
- Prevent illegible handwriting and abbreviations
- Document your medical rationale when prescribing
- Differentiate similar name or sounding drugs, newly marketed medications, and trade names:
 - Celebrex (arthritis)
 - Cerebyx (seizures)
 - Celexa (depression)

DANGEROUS ABBREVIATIONS

- "Q.D." –vs– "QID"
- Units abbreviated as "U" mistaken for an "0"
- Failure to include a leading zero preceding a decimal: "0.5"
- Using a trailing zero after a decimal "5.0" misinterpreted as "50" mgs

ALLERGY IDENTIFICATION

- Review incoming hospital summaries or consultation reports
- Update the patient history
- Periodically ask patients about their medications or food allergies and document their response
- Document medications prescribed by other physicians
- Retake an allergy history when prescribing new drugs

Medication Alert

OxyContin – FDA Warnings

Because of the ongoing problems of OxyContin abuse and diversion, a "black box warning" has been added to the labeling of OxyContin. This new warning is the strongest type of warning for an FDA-approved drug and is intended to alert prescribers to the potential for misuse, abuse, and diversion. The label warns that fatal respiratory depression may occur in patients not previously exposed to opioids. Additionally, the label warns that ingestion, in any form other than swallowing the whole controlled release tablet, may lead to rapid absorption of a potentially fatal dose of oxycodone.

Lawsuits entailing OxyContin have spread to numerous states. A Florida pain management physician was convicted on four counts of manslaughter, five counts of unlawful delivery of controlled substances, and racketeering. Physicians in California and a second Florida physician may face charges of manslaughter or first-degree murder in overdose deaths of patients treated with Oxycodone. [Many physicians worry that the verdict sets a very strict standard of liability for deviations in proper behavior by patients and that patients with legitimate analgesic needs will suffer.](#)

Risk Management Guidelines:

- Physicians are advised to carefully assess patients, including the patient's abuse potential, and to educate and counsel patients who may be candidates for OxyContin.
- Counseling should include warnings about the potential for abuse and overdose fatalities.
- The assessment and counseling should be documented in detail. Many pain management physicians obtain a written contract with patients prior to prescribing an opioid.
- Patients should be re-evaluated periodically to determine compliance with prescription protocols and to assess the abuse potential.
- Documentation should also include the patient's continued compliance and understanding of OxyContin warnings.
- Prescriptions should be limited with no refills available until the patient is re-evaluated.

- Careful record-keeping of refills should be maintained so that compliance with administration schedules may be monitored.

Lupron Investigations

In a recent record-breaking settlement, a pharmaceutical company agreed to pay \$875 million in criminal and civil charges for the sale and marketing practices of Lupron. Legal claims included conspiracy to defraud Medicaid, conspiracy to violate the Prescription Drug Marketing Act, and violations of federal anti-kickback statutes. The manufacturer was charged with giving physicians expensive trips; free consulting services and medical equipment; and forgiveness of debts. Five physicians were also charged with conspiracy to receive excessive Medicare reimbursement for Lupron. ***

The Department of Health and Human Services Office of the Inspector General (OIG) has expanded its work plan to include investigation of the business practices of pharmaceutical companies and drug reimbursement. [The efforts of the OIG have spread beyond investigating drug manufacturers to targeting individual physicians and medical groups.](#) OIG agents may contact any physician who has received 50 or more free samples of Lupron from the

manufacturer. Agents may appear unannounced and frequently physicians do not stop to consider their legal rights before responding to investigators' requests. Contact FPIC to determine if your professional liability policy affords defense coverage for the investigation before participating in the investigative interview or process. The following guidelines may assist physicians in the investigative process:

- Address the agent in a professional manner. Determine the reason for the visit and obtain supporting documentation from the agent (identification, subpoena, or other paperwork related to the official nature of the investigation).
- Communicate your intent to cooperate fully and your need to arrange for the care of the patients in your office. Request an opportunity to consult with your legal advisor prior to the initiation of the investigation.
- Request that your attorney be allowed to arrange a mutually convenient time for conducting the investigation.
- Respond cautiously. Remember any questions from the investigator are for the purpose of determining potential violations of law. Do not answer questions indiscriminately.



LOSS PREVENTION

Consider the case of a 75-year-old female with a history of high blood pressure and Bell's Palsy who presented to her internist with complaints of a swollen tongue and swelling to the left side of her face. The internist prescribed Prednisone to help reduce the swelling of the patient's tongue. Two weeks later the patient returned to the internist and was prescribed Zestoretic to control her blood pressure. Six weeks later the patient was admitted to the hospital in acute respiratory failure and anaphylactic shock. The patient brought action against the internist for negligently prescribing the Zestoretic and failing to diagnose her adverse reaction to the medication. Defense experts were unable to defend the internist for the use of Zestoretic, a combination drug including both an Ace inhibitor and diuretic, which was contraindicated in light of the patient's initial hypertension. Experts also criticized the internist for allowing the patient to be on Maxide in conjunction with the Zestoretic.

Consequently, the case was forced to settlement, necessitating an indemnity payment on behalf of the internist in the amount of \$205,000.