A review of SVMIC Family Practice claims from 2011 – 2015, where a loss was paid on behalf of an insured, reveals that failure to diagnose and lack of proper staff supervision were the primary allegations asserted in lawsuits. Most typically, the diagnostic errors were not the result of lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph at the right illustrates, were a product of poor documentation, communication breakdowns and poorly designed or ineffective systems. Medication errors were also present in the cases reviewed.

1 The analysis did not include claims that resulted while the family practice physician provided OB or ER care or as a hospitalist or surgeon.

**DOCUMENTATION ISSUES**
The importance of maintaining a well-documented medical record is vital from both a patient care and a risk management standpoint. As the graph above illustrates, documentation issues were a factor in 43% of claims paid in Family Practice. Of those, 81% involved inadequate documentation which negatively impacted our ability to defend the provided care. Most often there was a failure to completely document patient and/or family history; details of the physical exam; rationale for the diagnosis and treatment plan; patient education; telephone calls; and recommendations for screening tests. Additionally, a number of the cases involved electronic health records where the use of templates to auto-populate information resulted in inaccurate or conflicting information appearing within an office note. There were instances where the use of templates and “copying and pasting” resulted in records that appeared virtually identical from visit to visit which gave the impression that an individual assessment may not have been completed at each visit.

**MEDICATION ISSUES**
Medication errors were present in 32% of the reviewed cases. Roughly two-thirds of these involved administration, monitoring and wrong dose issues. Because many of these cases involved clinical staff, they likewise involved associated claims of failing to properly supervise.

Many of the administration error cases involved steroid injections. In one example, the patient experienced an indentation and fat necrosis at the injection site after having received a Kenalog injection in the right hip. There was no documentation that the injections were administered, and likewise, no evidence that there was any discussion of risks with the patient. Further, there were no office policies and procedures regarding safe practices for administering injections.

An example of failing to monitor medications is illustrated by the case involving a 93-year-old patient on Coumadin for chronic atrial fibrillation. Upon receiving a report that the patient’s INR level was elevated, her FP properly elected to suspend the Coumadin until the INR level returned to normal. Rather than making it clear in the record that he intended to resume the Coumadin once her labs were within normal limits, he documented only to “discontinue Coumadin.” He ordered a follow-up INR which was received the next day by the APN and was within normal limits. However, when the APN
reviewed the chart, she observed the “discontinue Coumadin” order so did not advise the physician of the new report. The patient developed a blood clot the next day and died from complications two days later. This case not only involved an indefensible failure to monitor and follow-up on relevant test information but also a documentation error that resulted in miscommunication between providers which led to patient harm.

**COMMUNICATION ISSUES**

Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient’s perception of the quality of care. Of the claims reviewed, 25% involved communication breakdowns. A significant portion of these involved physician-to-patient breakdowns due to a failure to properly educate and obtain informed consent regarding addictive medication therapies or high-risk medications. Other cases reviewed involved breakdowns in communication between physicians. A case in point involved a 43-year-old male who was admitted for a lumbar laminectomy with fusion. After admission, he was evaluated for medical clearance for surgery by his FP who, suspecting the possibility of diskitis, ordered a sedimentation rate and c-reactive protein, which were both elevated. He included diskitis in his differential diagnosis, but he did not directly communicate the elevated lab results to the surgeon or to the patient. The patient proceeded with surgery as planned, which was uneventful. The patient later developed intradiscal abscesses which required both pain management and additional surgery. He was ultimately left disabled and impotent. The FP came under scrutiny for failing to directly communicate the pre-op test results and his suspicion of diskitis to the neurosurgeon.

**SYSTEMS ISSUES**

Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanism alone. Of the claims analyzed, 19% involved a systems breakdown which resulted in diagnosis delays. The majority of these involved failing to take proper action on abnormal test results. A classic example involved a 58 year-old smoker who presented with complaints of pain in the right axilla for two months. Her FP sent her for a chest x-ray and a bone scan. The x-ray showed a 1.2 cm opacity in the right lung apex, and the radiologist recommended a repeat study in two months. The patient was never notified of the test result, and no further action was taken by the FP (the reason for this is not clear). Roughly a year and a half later, she presented with complaints of continual shortness of breath for four months. She was again sent for a chest x-ray. The report showed a right upper lobe abnormality, but it was filed in the record by a staff member without the physician reviewing or acting on it. Two months later the patient returned with a respiratory infection, shortness of breath and wheezing. At that point, the earlier report was discovered, and the patient was sent for a CT which showed a malignancy. The patient had surgery, but the cancer metastasized. She died two years later.

Other system errors noted in the case reviews involved issues with telephone call and appointment handling. One example involved a 33-year-old male who presented to his FP with a six-day history of headache, nausea and photophobia. His physician diagnosed viral illness and admitted him for rehydration, antibiotics, and anti-emetics. He was discharged home but continued to experience headache and fever off and on for three weeks. The patient's wife called the office on a Friday afternoon and explained that the patient’s headache pain and nausea had worsened. The FP called in a prescription for Phenergan and instructed the wife to call back on Monday to schedule an appointment. He did not document the details of the conversation in the chart, and the level of concern and severity of symptoms relayed by the wife was disputed during trial. The wife called the office on Monday and relayed the patient's history and asked that he be seen that day because he was experiencing worsening symptoms. A scheduling employee advised that the earliest the patient could be seen was Wednesday. When the patient presented Wednesday, he appeared extremely ill. The FP performed a lumbar puncture which revealed cryptococcal meningitis. He was admitted, but died despite aggressive treatment.
• Document clearly, completely, and accurately, making sure to include a comprehensive medical, family and psychosocial history; the chief complaint or purpose for the visit as expressed by the patient; all relevant positive and negative clinical findings; the differential diagnosis; your final diagnosis or medical impression; the decision-making process for the clearly defined treatment plan; and return-to-clinic instructions.

• Document all recommendations for diagnostic and screening tests as well as instances of non-compliance or refusal to follow the recommended treatment plan.

• If using electronic health records, review and correct all documentation that may have auto-populated or been carried over from a previous visit to ensure it is an accurate reflection of the current office visit assessment.

• To help prevent medication errors, update medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits of, and alternatives to, prescribed medications; closely monitor high-risk medications; train staff who are allowed to administer medications to adhere to the “Five Rights” (right patient, right drug, right dose, right route, right time) and appropriate injection techniques.

• Follow the CDC recommendations for multi-dose vials and safe practices for medical injections available at http://www.oneandonlycampaign.org/sites/default/files/upload/pdf/Injection%20Safety%20FAQs_7pages_FINAL.pdf

• Follow the CDC “Guide To Infection Prevention In Outpatient Settings” available at https://www.cdc.gov/hai/pdfs/guidelines/ambulatory-care+checklist_508_11_2015.pdf

• If using advanced practice providers, make sure you examine and comply with pertinent state rules and regulations related to supervision. In most states, proper supervision begins with a detailed protocol which is jointly developed by the supervising physician and advanced practice provider. It is recommended that both parties sign and date the protocol when it is complete. A copy should be maintained on-site and reviewed and updated in accordance with state regulations. Copies of pertinent rules and regulations, as well as sample protocols, may be obtained from the State Board of Nursing, Board of Medical Examiners and State Medical Association.

• Educate patients on the indications, risks, benefits, alternatives, side effects and expected outcomes of recommended treatments. Be sure these discussions are documented in the chart.

• When consulting with a specialist, make sure there is a clear understanding as to who is responsible for the patient’s care.

• When consulted to provide medical clearance to a patient prior to surgery, make sure to directly communicate to the surgeon all relevant or unexpected findings on ordered tests.

• To promote continuity of care, implement a system to ensure abnormal test results are
clearly flagged for follow-up at subsequent visits.

- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it’s important enough for staff to track and for providers to review results.

- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame.

- Staff giving clinical advice should do so pursuant to an approved written protocol. The protocol should be detailed enough to include what clarifying questions the staff should ask in response to various complaints as well as when a patient should be referred to a physician.

- Written procedures should be in place to assist scheduling staff in making appointment decisions in cases of scheduling difficulties.

The office should determine procedures and time frames for scheduling and conducting different types of appointments (new patients, urgent, same day, follow-up, physical exams, ancillary testing, etc.) and implement procedures to meet the defined goals. In the event that a patient feels that his/her problem warrants an earlier appointment, the staff should consult with someone in the clinical department for guidance.

- Clearly communicate with patients when providing medical advice over the telephone. Use the teach-back method to ensure an understanding of the relayed information. At a minimum, the following types of phone calls should be documented in the medical record: All phone calls in which test results are reported to patients; during which the patient is advised to return to the office or go to the emergency room; and during which the patient requests medical advice or prescription refills.