Shoulda, Coulda, Woulda

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"Shoulda, Coulda, Woulda. It's so easy in the past tense." - Sarah Dessen

Contrary to popular belief, all medical negligence claims do not start and end with a physician or even a licensed healthcare provider. You may be thinking – “what are you talking about? Only a physician or healthcare provider provides medical care.” You are absolutely right. However, non-medical or non-certified office personnel and office systems account for a growing number of professional medical negligence claims and lawsuits.

Just as we all learned in school, every story needs five elements- who, what, when, where, and how. A medical practice needs much the same. Straight forward, organized, and effective office systems need to be in place. As an example, one important system that should be implemented is tracking: tracking what has been done and what’s next to be done. A medical office needs a systematic way for handling patient labs, specimens and diagnostic test results. Once a test is ordered, then what? How and when will a provider review and sign off on the test results? Does the patient need to follow-up? Was the patient notified (of normal and abnormal findings)? Were the results and patient notification documented?

Failure to implement office protocols could lead to a delay in diagnosis or treatment, treatment options and even the ultimate outcome of patient care. Rarely are errors in patient care the result of any one isolated action or inaction. It often has nothing to do with a provider’s lack of knowledge or diagnostic ability. Rather, errors are often the result of poorly designed, ineffective or non-existent office protocols.

Through the years, we have seen many instances where, had there been an office system in place, there would not have been a plaintiff nor a defendant because an incident would not have occurred. For instance in the case of a Mr. Sharpe [1], a 75 year old male who underwent a kidney biopsy for hematuria and suspected kidney cancer, there was no office system in place to track the specimen. The normal procedure was for the specimen to be reviewed for adequacy, separated into two vials, and given to an employee for further processing and transport to the pathology lab. Somehow, the specimens went missing. It was later learned that the vials were placed in a biohazard bag, the pathology lab courier arrived and the specimens were put in the transport bag along with numerous other specimens. The courier recalled putting the bag on the counter on arrival to the pathology lab. The bag was unpacked at the pathology lab, but the specimen in question was never logged and processed.

The physician office staff was not able to retrace their steps to determine if the specimen was logged in, given to the courier for transport to the pathology lab, or received by the pathology lab, because there was no documentation of such. No one knew what happened. Upon the internal investigation, the original specimen container (before the frozen section was prepared) was the only evidence of the specimen. Unfortunately, the specimen could not be found. This left Mr. Sharpe with no other alternative but to have a second biopsy, despite having a very complicated recovery from the initial biopsy due to other health challenges.

It was unknown how the error occurred. Did the physician's staff not hand the specimen off for proper submission to the pathology lab? Did the employee not properly hand over the specimen to the pathology lab courier? Or did the error occur at the lab? While all regretted this unfortunate occurrence, this reactive posture became the perfect time for the physician, hospital, and pathology lab to all review policies and procedures related to chain of custody for specimens.

How does the physician's office ensure a report has been received and reviewed by the provider? While all office systems are important for minimizing risk of error, clearly, a simple tracking protocol would have outlined – (1) who the specimen was given to; (2) what that person does with the specimen; (3) when the specimen is sent to the pathology lab; (4) how the specimen is sent; and (5) where the specimen was sent (most important if multiple labs are used for different types of specimens). Well- established systems by both the physician's office and pathology lab may have prevented this scenario.

In addition to a tracking protocol, it is recommended that you have an office protocol for appointment scheduling, follow-up appointments, missed appointments, patient referrals, communicating test results, prioritizing test results, proper referrals, discharged patients, documentation, refilling prescriptions, telephone procedures, answering service, patient portals, emailing, and texting PHI, mobile devices, and all other office functions involving patient care. You and your staff should be properly trained to follow these office protocols consistently without fail. Otherwise, too much is left to individuality and personal judgment call. The potential for the patient to "fall through the crack" is too much of a risk. (Related: See "An Analysis of Pathology Closed Claims" from the January 2017 issue of The Sentinel)

Once office protocols have been implemented, it is imperative to periodically perform an assessment of said system(s). You must ask if a particular protocol is still effective. Have personnel changed, requiring additional training? Are all lab and diagnostic vendors electronically interfaced with your electronic health record system? If not, is there a separate tracking system for those that are not? Is it the most efficient means to achieve the goal? Keep in mind, just because you are not aware that there has been an incident or mishap, does not necessarily mean there does not need to be an improvement. Some risks are not worth taking.

The rule of thumb should **not** be "no news is good news." Advising patients to "call if you have not heard from us" allows your patients to serve as a safety net in the event of a

system failure. The mode of operation should be proactive rather than being only reactive after an error has occurred. Otherwise, the focus is then on the past and you become a victim of the dismissive expression of “shoulda, wouda, couda,” which are often useless excuses for regrets, mistakes, and missed opportunities. Do not wait until something happens to take a pause to reflect, inspect, and adjust. Shouldas, couldas, and wouldas don’t count.

[1] All names have been changed
