RISK MANAGEMENT AND PREVENTION

The Insurance/Claims Management Division of the Office of General Counsel is responsible for administration of the UAMS physician’s liability program. The primary responsibility of the Division is to reduce the risk of claims and lawsuits involving UAMS faculty and staff. In reality, there is no way to totally eliminate the possibility of a suit but there are many things you can do that will substantially improve the chance of successful defense in the event you are sued. Your cooperation and support are essential for a successful program.

It is not possible to provide a complete discussion on any given topic contained in this guide but this will provide you with a handy reference to many issues associated with our program and your practice of medicine. The Insurance/Claims Management staff or members of the Office of General Counsel are available for consultation on any of the issues contained in this guide. In addition, staff is available to give presentations on any risk management or medical/legal issue that may be of interest to you or your department.

Our normal office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday and we can be reached at 614-2082 or 614-2077. There is voicemail service in the event we are out of the office or you call after normal office hours. In addition, we can be reached by cell phone (350-6845) in the event the situation demands immediate attention at times other than during normal office hours.

RISK MANAGEMENT

Our primary focus is to assist healthcare providers reduce the potential of malpractice claims while maintaining the provision of high quality patient care. This mitigation differs from defensive medicine in that it is not just a set of strategies for preventing claims but also works in the best interest of the patient and the provider. It is not limited to but certainly stresses good rapport and communication between the provider and the patient, good documentation of the communication, obtaining informed consent, and reporting problems to the Insurance/Claims Management Division.

You have the responsibility of reviewing and following your own department’s policies, procedures, and protocols as well as those of the University Medical Center. Unfamiliarity with these policies can create liability situations and is not an excuse for failure to comply with the approved policies of the department or institution.

Risk identification and analysis is performed through patient complaints, sentinel events, medical record reviews, and reports from clinical departments. Loss prevention involves continuous educational and orientation programs for medical staff, residents, students, nurses, and other health care providers; policy review and development; compliance with local, state and federal regulatory risk management requirements and JCAHO risk management related standards; support to the Corporate Compliance Officer and the HIPAA Officer; participation in committees; development of mechanisms to assist patient and families following an adverse event; response to patient/family complaints and support to the medical staff and high risk areas.
COMMUNICATION
An open line of communication between the patient and health care provider is a key factor in reducing lawsuits. Studies have shown that patients who have good rapport with their physicians file fewer lawsuits. The basic premise is that people generally do not sue friends or those who they trust and respect.

The health care provider who communicates effectively with his/her patient is less likely to produce the kind of surprise that sparks most lawsuits. A patient is inclined to forgive mistakes made by someone who clearly demonstrates an earnest concern for their well-being.

In addition to effective verbal communication with the patient, the physician must also document effectively. What the physician communicates into the medical records will stand as testimony if his/her actions are later contested.

From the risk management standpoint, medical treatment is what the physician does for a disease and medical care is what the physician does for the patient. A major step toward the prevention of malpractice suits begins with the realization that a patient expects care, not just treatment...and care requires effective communication.

CONFIDENTIALITY
The information disclosed to a physician during the course of the relationship between the patient and the physician should be held confidential to the greatest extent possible. The physician should never reveal confidential communications or records without the express consent of the patient. Confidentiality is a term we usually use to express protection of information or records but it means so much more.

Examinations must be humane, discreet, reasonable, and decent, exposing only the body parts under examination. Access to a patient’s body or medical information must be limited to the primary health care team involved in the care and treatment of the patient. This information or access may be granted to others, such as consultants, medical students, and chaplains, with the patient’s express consent.

Practices such as examining patients in the presence of unidentified students and others and/or discussing the care and treatment of a patient with parties not directly involved in the care and treatment of the patient should not be permitted unless the patient has been informed and consent obtained.

There are situations in which medical information and records are released to non-health care providers without the necessity of obtaining the patient’s authorization. This includes release to government agencies, the health department, and insurance companies who pay for services rendered. If there is any doubt about whether or not to release information or medical records you should contact the Risk Management Department, the Medical Records Department, the HIPAA Office, or the Office of General Counsel prior to releasing the information in question.

One final note on confidentiality focuses on a situation somewhat unique to teaching facilities. In most hospitals, a patient has one primary treating physician, the various nurses, and perhaps a consultant or two. In our facility, the patient not only has the primary treating physician and the nurses but also has a host of residents and medical students involved to some extent. It is part of the training process for physicians, residents, and students to discuss the patient’s condition and treatment options however, many times these discussions take place in hospital
corridors, elevators, and other public places. Every health care provider must remain alert to their surroundings and avoid breaching confidentiality inadvertently in public places. Hallways, elevators and cafeterias are not the best place to discuss a patient’s condition, course of treatment, prognosis, test results, etc.

DOCUMENTATION

The patient’s medical record always becomes a focal point anytime there is a question regarding the care and treatment rendered. It is important that the medical record be kept accurately and timely.

The medical record serves three primary purposes: 1) to insure quality patient care and communication to other health care providers treating the patient; 2) to provide documentary evidence of the patient’s course of illness and treatment; and 3) to facilitate review.

One often thinks of the medical record as a means of protecting the hospital or providing a defense in a medical malpractice action. However, the purpose of the medical record is not to protect or to provide a defense. The purpose of the medical record, as it pertains to risk management, is to preserve the truth. In reality, a complete and accurate medical record will protect the legal interests of the patient, the hospital, and the responsible practitioner. The medical record will provide a justifiable defense if one exists or will indict the responsible party if there is no justifiable defense.

What Should be Documented in the Medical Record?

There are no clearly defined guidelines as to what should or should not be documented in the medical record. There are, however, certain minimum requirements on what generic information should be documented. These include:

1. identification data
2. medical history
3. physical examinations
4. diagnostic and therapeutic orders
5. appropriate consent
6. clinical observations
7. reports of procedures
8. results of tests
9. conclusions at the termination of care

It is recommended that in addition to these minimum requirements, other significant items should become part of the medical record. Keep in mind the old adage “If it hasn’t been documented, it hasn’t been done.” With this in mind, anything related to the care and treatment of a patient or the patient’s conditions that the physician considers or does during the course of treatment should be documented. It should be pointed out that the obligation to document the treatment rendered and the patient’s response to the treatment is a positive one rather than a negative one. In other words, only acts of commission should be documented, not acts of omission.
For example, if a given unit is understaffed on a given day and appropriate care could not be rendered to all patients, it would be inappropriate to record “All primary care was not rendered due to 1:12 nurse ratio.” The absence of documented care would establish what was and was not done and there is no need to highlight what was not done by making an entry to that effect. The hospital has established avenues of reporting that can be used to address quality of care concerns. It is important that quality of care issues be brought forward so that steps can be taken to address the area of concern and the practitioner is encouraged to utilize these reporting avenues rather than “venting” in a patient’s medical record.

Often, a patient’s degree of mobility, appetite, orientation, mental attitude, and degree of independence will influence the scope of care being rendered. For this reason, it is important that the physician record what he or she sees, hears, smells, and feels.

Examples:

1. Sees- bleeding, pallor, deformities, drainage, urine color, etc.
2. Hears- patient complaints, moaning, breath sounds, etc.
3. Smells- alcohol on patient’s breath, malodorous drainage, fecal odor, vomitus, acetone breath, etc.
4. Feels- motion at fracture site, firm, hot, area of induration, crepitus of subcutaneous emphysema, etc.

Documenting Complications or Mishaps

Medication errors, conflicts with doctors’ orders, unexpected outcomes, and complications occur from time to time even with efforts to provide the best of care. It is important that these events be documented and addressed in the medical record.

Entries in the medical record that address these types of events should be made in a factual manner without being judgmental or placing blame. Keep the entry objective and describe the event, the evaluation of the patient following the event, and whether or not the event resulted in any injury to the patient. If there was some injury to the patient, the documentation should describe the injury and what course of treatment will be followed to address the injury. The complication or injury should be addressed in subsequent notes until it is resolved. If the event did not result in an injury to the patient, this should also be included in the note. Again, the physician should be careful not to contribute their own judgmental comments, witticisms, conclusions, or other prejudicial remarks.

Late Entries or Addendum

The patient’s medical history, clinical record, order sheet, and discharge summary are usually accomplished in a sequential manner. These notes should contain relevant observations and information regarding the patient’s condition and course of treatment.

The contemporaneous entry of information in the medical record is important. The greater the delay between the evaluation/treatment/procedure itself and the dictation of the report or entry of the note, the greater the risk that the lapse of time will adversely effect the credibility of the report. Every effort should be made to avoid “late” entries of this nature.

Upon occasion, however, the physician may feel that he or she does not have adequate time, while on the job, to prepare a thorough and detailed note as to all that took place in reference
to the care and treatment of a patient during a specific visit. This may be particularly true when there has been an incident that may give rise to legal exposure. When an event occurs that the physician feels may give rise to some legal exposure, he or she is inclined to maintain his or her own personal notes which elaborate upon the medical record. Since malpractice cases are often initiated and pursued after many months or years have passed since the care and treatment was rendered, personal notes are invaluable to refresh memories but it should also be recognized that the need for personal notes belies the completeness of the medical record. It should also be noted that personal notes are not protected from discovery and may have to be turned over to the plaintiff attorney upon request.

If time does not permit complete documentation contemporaneous with the event or treatment, the physician should prepare a brief note at the time and then prepare a supplement to the medical record as soon as possible. As pointed out earlier, documentation in the medical record should be objective and not contain personal judgments or prejudicial remarks. With this in mind, if there is an event which the physician feels may give rise to some legal action, personal notes regarding impressions, personal observations, or opinions about the patient may need to be recorded outside of the medical record in order to refresh memories about items not necessarily related to the condition of the patient and the care provided. Again, keep the note factual and objective. Do not impose your personal judgment or lay blame. Simply write enough to refresh your memory in the event you are asked to recall details.

**Errors in the Medical Record**

Errors inevitably occur in any medical record. They may be minor errors in transcription, inadvertently omitted test results, physicians’ orders, other information omitted, or deliberate falsifications.

First, deliberate falsifications must be avoided at all costs. This will most likely lead to allegations of a cover up which will, at best, create a prima facie case of negligence. This will also have significant impact on the credibility of the provider.

Effort should be made to avoid other types of errors. However, in the event an error occurs, they can be corrected legally by following the following procedure:

1. The person who made the incorrect entry should be the one to correct the error.
2. *The original entry should not be obliterated, deleted, or erased.* Simply add the correction to the record with reference to the incorrect information or note.

**INFORMED CONSENT**

Consent is permission, agreement, and acceptance as to opinion or course of action. It is an act of reason, accompanied with deliberation, the mind weighing as in a balance the good or evil on each side. It is an act unclouded by fraud, duress, or sometimes even a mistake.
There are several different kinds of consent. There is implied consent, consent in an emergency, express consent, etc. We will focus on express consent since this is usually the type of consent we think about and refer to when we discuss informed consent.

Informed consent is a process through which the treating health care provider discloses appropriate information to a patient (or the patient’s authorized representative) about a proposed treatment or procedure so that the patient can make an informed decision about whether to accept or refuse the proposed plan of care.

Who Can Consent?

Competent Adults: A competent adult may give, withhold, or revoke consent for himself. Any patient may refuse to give consent to treatment for himself. A spouse may not give, withhold, or revoke consent for the competent patient unless legally authorized to act on behalf of the patient.

Incompetent Adults: An incompetent adult may not give consent for himself. There are exceptions to this general rule but the exceptions are so rare that they will not be discussed in this manual. Risk Management, Ethics, or General Counsel should be consulted prior to proceeding with care and treatment on a patient of unsound mind when substituted consent is unable to be obtained.

Minors: In Arkansas, a minor is a person under the age of eighteen (18) years. A minor may not give, withhold, or revoke consent for himself except under certain circumstances. As a general rule, a health care provider must obtain consent of the minor’s parent or guardian before proceeding with non-emergency treatment of a minor.

There are, however, certain circumstances under which a minor may consent to treatment without parental consent. A minor may consent to treatment for himself/herself if:

1. The minor is married (this does not include divorced or widowed minors if they are living with their parents; or
2. The minor is emancipated (for purposes of consent, an emancipated minor is one who does not live with or receive financial support from their parents; or
3. The minor is seeking treatment for a venereal disease or birth control; or
4. The minor is seeking treatment in connection with pregnancy or childbirth (this does not include the unnatural interruption of the pregnancy); or
5. The minor is incarcerated in the Department of Correction or the Department of Community Punishment; or
6. The minor is not emancipated but is deemed by the physician to be of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedure.

Substituted Consent

In the event the patient is unable to consent to treatment for himself or herself, whether due to their age, physical, or mental state, consent for treatment may be obtained from another who is legally authorized or empowered to give such consent. For purposes of this section, substituted consent is used in those cases where the patient is “of unsound mind”. Of unsound
mind, for purposes of this section, means and includes the inability to perceive all relevant facts related to one's condition and proposed treatment so as to make an intelligent decision based thereon, regardless of whether the inability is only temporary or has existed for an extended period of time or is due to natural state, age, shock or anxiety, illness, injury, drugs or sedation, intoxication, or other cause of whatever nature. It is important to understand that “of unsound mind” as used in this section does not require an adjudication of incompetency.

Substituted consent may be obtained from any one (1) of the following:

1. A person designated in writing as a durable power of attorney for healthcare or a person designated as a health care proxy;
2. A court appointed guardian or custodian;
3. NOTE: Court appointed guardians or custodians may NOT consent for sterilizations, abortions, psychosurgery, removal of bodily organs, experimental treatments, or the withholding of life-saving treatment for an incompetent or maltreated adult without a court order unless such treatment is necessary to alleviate a life-threatening condition.
4. A surrogate who has been designated by an adult patient to make healthcare decisions if the patient becomes incapacitated;
5. NOTE: A patient may inform the attending physician of the surrogate designation orally or in writing. Any such designation MUST be documented in the medical record. The surrogate’s decision-making authority shall become effective only if the patient loses decision-making capacity.
6. If no alternate decision-maker has been designated by the patient, the attending physician may designate a surrogate.
7. NOTE: In choosing a person best qualified to serve as a surrogate, the physician should consider the individual’s (a) ability to make decisions according to the patient’s wishes or best interest, (b) frequency of contact with the patient before and during the illness, (c) care and concern exhibited for the patient, (d) availability and willingness to serve. The surrogate does not have to be a relative of the patient but consideration will be given to:
   a. Spouse (unless legally separated)
   b. Adult child
   c. Parent
   d. Adult sibling
   e. Any other adult relative
   f. Other adult caregiver or friend
8. A surrogate designated by the attending physician shall be noted in the patient’s medical record and the designated surrogate shall remain in effect only for the duration of the hospitalization.
9. In the event there is no one eligible to serve as a surrogate decision-maker or if the designated surrogate is not available, the attending physician may make health care
decisions for the patient in consultation with the Ethics Consult Service and a second physician who is not in a supervisory or submissive role to the attending physician.

10. Consent may be obtained through a court order under certain circumstances. Risk Management or General Counsel should be contacted if the need for court-ordered consent arises.

Consent in an Emergency

An emergency, for purposes of this section, is defined as a situation wherein, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain consent would reasonably be expected to jeopardize the life, health, or safety of the person affected or would reasonably be expected to result in disfigurement or impaired faculties.

In the event of an emergency as defined above and the patient is unable to give, withhold or revoke consent, and there is no one immediately available authorized to give consent, medical or surgical care can be instituted without consent.

The use of this type of consent requires a judgment call by the physician. For example, a minor child presents to the emergency room after sustaining a fall. The child is diagnosed with a fractured femur that will require surgical intervention. The parents are not available nor is anyone authorized and empowered to give consent. At the time of the initial presentation, there is not immediate threat to life or limb so an “emergency” does not currently exist. Treatment is delayed in an effort to obtain consent. Time may well become a factor. The physician must remain aware of the patient’s condition and, if consent cannot be obtained in a timely manner, the patient’s condition may develop into an “emergency” requiring surgical intervention before consent can be obtained.

Elements of Informed Consent

The courts are eminently clear that the responsibility to obtain informed consent from a patient clearly remains with the physician and this responsibility cannot be delegated. The task of obtaining informed consent from the patient can be delegated but the responsibility cannot. Within our institution, it is strongly recommended that the physician who is going to perform the procedure obtain informed consent.

The physician obtaining consent from the patient should explain the nature of the procedure, treatment, or disease. The patient should be informed about the expectations of the recommended treatment and the likelihood of success. This is not to imply any guarantee of success be given to the patient but some indication of the likelihood of the expected outcome. The patient should be informed about the particular known inherent risks and possible complications that are material to the informed decision. Finally, the patient should be informed about reasonable alternatives that are available and what the probable outcome would be with one of the alternatives or in the absence of treatment.

The mere signing of the consent form constitutes only some evidence of a valid consent. The best evidence that informed consent was obtained is by a properly completed and signed consent form and an accurate narrative by the attending physician in the patient’s chart.

The corollary to the doctrine of informed consent is “informed refusal”. When a patient (or the surrogate) rejects proposed treatment, he should be advised in a discreet, professional manner
of the consequences of the refusal. Keep in mind, however, that it is the patient’s right to refuse treatment even if the physician believes the decision is irrational. Consent obtained by fraud or under duress is not valid consent. In the event the patient rejects treatment, the physician must honor the refusal of consent. Again, appropriate documentation is essential in this situation and, if possible, the physician should have the patient sign a statement indicating the patient’s refusal of recommended treatment.

**Court Ordered Consent**

Consent may be given by the court where an emergency exists, there has been a protest or refusal of consent by a person authorized and empowered to do so, and there is no other person immediately available who is authorized, empowered, and capable of consent.

The court may grant consent provided the patient is:

1. a pregnant female in the last trimester of pregnancy;
2. a person of insufficient age or mental capacity to understand and appreciate the nature of the proposed treatment and the probable consequences of refusal;
3. a parent of a minor child, provided the court finds that the life and health of the parent is essential to the child’s financial support or physical or emotional well-being.

In the event there has been refusal of consent and the physician feels action should be taken, the physician should contact the General Counsel, Risk Management, or the hospital administrator on duty who will determine whether or not a court order should be sought.

**Police Orders**

Upon occasion, a physician may be in a situation where the police bring in a person and request tests or procedures be performed. There is no case law on this subject in Arkansas at this time. However, the physician should be advised that many procedures or tests require consent from “one authorized and empowered to do so” and the police were not in the list of those authorized to give substituted consent. The decision to allow tests or procedures remains with the patient or, if the patient is unable for whatever reason, the decision remains with one authorized and empowered to give consent on behalf of the patient. In other words, the police have no authority to consent on behalf of a patient and the policy on obtaining consent must be followed.

There are some minor exceptions to this general position. For example, if the police have an individual in custody and request a blood alcohol test, this test can be run at the police officer’s request.

**Areas Not Discussed**

The area of informed consent and refusal to consent is much too broad to be discussed in its entirety here. There are special consent issues surrounding some religious groups (i.e. Jehovah’s Witness), there are special situations in which the patient may have prepared a living will or advanced directive which could take precedence over next-of-kin consent if the patient is unable to consent or refuse to consent for himself; there are situations in which the patient may have refused to consent but the medical situation has changed significantly since the
refusal. If time allows to seek answers to specific situations, assistance is available through the Risk Management Department, Hospital Administration, Ethics, or the General Counsel’s Office.

**MALPRACTICE INSURANCE**

Medical malpractice (medical professional liability coverage) insurance is provided to all faculty members and house staff members involved in the clinical care of patients. The coverage afforded the faculty and house staff at UAMS is written on a claims-made basis. With the standard claims-made policy, coverage begins on the date the individual physician is initially insured under the policy and coverage ends the day the policy is canceled. In other words, the policy will respond in the event a claim or suit is made only if the policy is in force. If the policy (or coverage) is terminated, and a claim or suit is made after the termination date, the policy will not respond even though the event occurred while the policy was in force. It should be noted, however, that the insured has the option of purchasing what is known as “indefinite reporting period coverage” or “tail” at the time the policy or coverage is canceled. By purchasing “tail”, the physician has the right to report claims or suits that are brought after the policy was canceled but that stemmed from events occurring while the policy was in force.

The policy under which the physicians at UAMS are covered acts a little differently than the standard claims-made policy. Under our policy, if an individual physician (faculty or house staff) leaves UAMS, the “tail” is provided at no cost to the individual physician. The individual physician still has the right to report claims or suits that may be brought due to events that occurred while employed by UAMS.

The coverage afforded to faculty and house staff is for UAMS approved activities only. The policy is not intended to and will not respond for “moonlighting” activities. If there is a question about whether or not a particular activity is UAMS approved, the question should be directed to the Insurance/Claims Management Division of the Office of General Counsel or the Department Chair.

Claims brought under the policy may be settled out of court prior to the initiation of suit or suits may be settled prior to trial but only with the written consent of the insured or, upon rare occasions, as directed by the UAMS.

**Reporting Procedures**

The Insurance/Claims Management Division of the Office of General Counsel encourages any physician to freely communicate any concerns regarding the care and treatment of a patient including unexpected outcomes, errors, or any medical/legal event. If you have reason to believe a malpractice claim might occur due to some event, REPORT IT. The phone number for the Department of Insurance/Claims Management Division is 614-2077 or 614-2082. Information you should have available includes the name of the patient, the medical record number, physicians involved, and the nature of the event causing concern.

In the event you receive a letter threatening suit or suit papers, you should contact the Insurance/Claims Management Division immediately. In the event you are served with suit papers, you will have only twenty (20) days in which to have an Answer filed with the court so time is of the essence.
Subpoenas, Claims, and Suits

Physicians find themselves involved in the legal arena for a variety of reasons, not all of which are medical malpractice. Contact could be made in a variety of ways. The physician might be contacted by an attorney who simply wants to “discuss” the care and treatment rendered. Do not enter into conversations with attorneys regarding patient care matters without first checking with the Insurance/Claims Management Division or the Office of General Counsel. Revealing sensitive patient information to unknown individuals, regardless of who they say they are, can constitute a breach of patient confidentiality. In addition, answering an attorney’s questions out of context can work against your interest.

If you receive a subpoena demanding your presence for a deposition or trial testimony, you should notify the Insurance/Claims Management Division or the Office of General Counsel immediately. Most depositions can be conducted at a time and place convenient to you and we can help guide you through the process. In addition, if there is need to retain an attorney for you, the Insurance/Claims Management Division can help make those arrangements.

If you receive suit papers, it is imperative that you contact the Insurance/Claims Management Division at 614-2082 immediately so that an attorney can be retained and an Answer filed within the twenty (20) day period as described in Arkansas law. Failure to file an answer timely subjects the defendant to a default verdict.

For any questions or when in doubt, contact the Insurance/Claims Management Division of the Office of General Counsel at 614-2082 or 614-2077.