QUALITY IMPROVEMENT AND RISK MANAGEMENT

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QUALITY IMPROVEMENT AND RISK MANAGEMENT

- Estimated that medical errors – 8th leading cause of mortality and responsible for between 44000 and 98 000 hospital deaths annually (Kohn et al, 1999)

- Challenge for every Physician is to better understand the nature of risk :
  - In Medicine
  - The liability system that must judge responsibility and resolve disputes about untoward outcomes

QUALITY IMPROVEMENT AND RISK MANAGEMENT

-The need to practice a reflective style of medicine that seeks continual improvement

- Compelling evidence that more malpractice is committed than recognized, litigated or compensated (Locallo et at, 1991)

DEFINITIONS

RISK REDUCTION MANAGEMENT : Preventative Management

NEGLIGENCE : Not a willful action. Could be done due to error – but could be compensatable

MALPRACTICE : Willful action. Malicious action. Action with intent to cause harm

“Error done intently is willful and hence – malpractice”

ELEMENTS OF MALPRACTICE

Most malpractice suits against Physicians involve claims of

negligence rather than breach of contract.

ALL 4 ELEMENTS

- **Duty**
- **Breach of Duty**

ELEMENTS OF MALPRACTICE

- Damages
- Proximate Cause

All 4 elements must be proved for plaintiff to prevail in malpractice

ELEMENTS OF MALPRACTICE

- DUTY

-A doctor has a duty to exercise reasonable

care when undertaking the treatment of a patient.

- Doctor patient relationship

ELEMENTS OF MALPRACTICE

- Limits placed on doctors right as to who to treat.
  - ✓ Cannot abandon an established patient.
  - ✓ Cannot refuse treatment to a patient who has reasonably relied on the doctors apparent willingness to treat all comers (eg. Emergency Department in a General Hospital that advertises its emergency services)
  - ✓ When doctor wants to terminate a relationship. 30 Days considered customarily reasonable.

ELEMENTS OF MALPRACTICE

- **Legal Obligations**
  - ✓*Outside Health Care settings* eg. Automobile crash
  - ✓*Telephonic advise*

    Beware even if you have not met patient (a Dr patient relationship may be in force)

    - "Curbside consults" with another colleague (beware if this informal advice finds its way into medical records)

ELEMENTS OF MALPRACTICE

The existence of a Doctor – patient relationship is not dependent on whether a doctor charged or was paid for the service, but rather on whether the doctor had an impact on the patient's medical care and outcome

BREECH OF DUTY

Although doctors are not guarantors of perfect results they are required to perform at a "LEVEL EQUIVALENT" to that of a similarly situated clinician.

A patient cannot usually proceed with an allegation of malpractice, unless an expert witness (Dr) is willing to testify on behalf of the plaintiff that the defendant (Dr) failed to meet the "Standard of Care" and is therefore in breach of duty to the patient .

BREECH OF DUTY

"Standard of Care" is defined as the degree of skill, care, and judgment that the average physician would exercise given the same or similar circumstances and the state of medical knowledge at the time.

In the case of ‘Hall v Hillburn (466 50 2d 856,1985) (Backen, 1995)

“*A doctor defendant may be measured not only against whether a reasonable Dr would have managed the problem in a similar manner but also against whether a reasonable doctor would have referred the patient* (Selby et al, 1992)

DAMAGES

Plaintiff must prove that damages (an injury or loss) resulted from the Dr's negligence.

An emerging trend in recent years has been the allegation that the plaintiff suffered a "*loss of chance*" (Schoenberger, 1985)

Eg. : A doctor failed to diagnose a problem early, even if the diagnosis is eventually made, the theory is that the patient would have had a better opportunity for survival with an earlier diagnoses and this lost opportunity constitutes an injury.

DAMAGES

- Allegation of inadequate informed consent. Some cases award damages where no medical negligence was found, but the doctor failed to obtain adequate consent from the patient or guardian.

PROXIMATE CAUSE

Plaintiff must prove “Negligent performance of Doctors was the proximate cause of patients injury. Plaintiff must show that doctors negligence was the “Cause in fact” of the alleged injury.

Two formulas can be used to demonstrate cause in fact :-

1. “But for” – the injury would not have occurred but for the negligence or
2. “Substantial factor” when several factors exist (eg. Patient failed to keep the appointment and dr misread the radiograph) and the doctor’s error was a substantial factor in the resultant injury.

PROXIMATE CAUSE

Examples of Negligence and Causation

- A hemostat unintentionally left behind in the abdomen. Doctrine of “res ipsa loquitor” (‘the thing speaks for itself) is invoked and no expert testing is required.

- A smoker at the first visit had an abnormal chest x-ray and hip pains that 2 months later diagnosed as Metastatic Bronchogenic Carcinoma

PROXIMATE CAUSE

- Recently courts have found that 2 months delay in diagnosis caused a “Loss of a Chance” which may be compensated.
- This even when the change for survival was less than 50% at the first visit, if the delay in diagnosis was negligent was reduced by some amount whatever chance the patient had, the patient may be able to recover. Expert witnesses are easily available to **Litigants**.

EMERGING QUALITY INITIATIVES

- Malpractice claims often reflect low frequency events that have high severity outcome for patients (Couch et al, 1981)

- The emergence of new quality initiatives that emphasizes continual improvement holds promise for improving patient outcomes and reducing malpractice and reducing malpractice risks (Granville et al, 1999)

EMERGING QUALITY INITIATIVES

- The individual doctor is best able to reduce the risk of malpractice litigation by practicing :-
  - Personable high quality medicine
  - Stays focused on individual patients needs
  - Keeps current with changing medical science
  - Continually applies scientifically validated standards of care
  - Maintains a sense of partnership and communication with the patient

EMERGING QUALITY INITIATIVES

- Keeping the focus on ***Quality Care*** is ultimately more effective than practice ***Defensively*** to avoid a law suit.
- A conscientious doctor will practice "Reflective Medicine" :-
  - Remain mindful of medicine ability to do harm
  - Monitor a patients progress
  - And strive to maintain therapeutic and effective rapport with the patient

METHODS FOR EVALUATING AND IMPROVING THE PROCESS AND OUTCOME OF MEDICAL CARE

- Incident reporting systems
- Generic outcomes screen (outcomes such as maternal deaths are always reviewed)
- Clinical indicators (Specific indicators eg. Postoperative infections)

ELEMENTS TO CONSIDER WHEN EVALUATING QUALITY OF CARE

1. Process the Dr used (eg. Test ordered, procedures performed)
2. Outcome achieved (eg. cure, improvement, death)
3. Quality of medical records (eg. Whether another doctor is able to continuing ongoing care based on available documentation

ELEMENTS TO CONSIDER WHEN EVALUATING QUALITY OF CARE

4. Use of a consistent and logical approach with each patient, and the patients satisfaction with care
5. Peer review process having other Doctors review the quality of their care. In this way doctors can gain additional insight into their own effectiveness.

ELEMENTS TO CONSIDER WHEN EVALUATING QUALITY OF CARE

"Regardless of the approach used doctors should view the process of ongoing review of the quality of their care as a necessary part of good medical practice."

LEADING ALLEGATIONS

Doctors are sued most often for failure to diagnose.

- Errors in diagnosis
- No medical misadventure
- Improper performance
- Medication errors
- Failure to supervise or monitor case
- Failure/delay in referral or consultation
- Not performed
- Performed when not indicated or contraindicated
- Failure to recognize a complication of treatment
- Delay in performance

LEADING ALLEGATIONS

The leading conditions for failure to diagnose suits are :

- Myocardial infarction, acute
- Malignant neoplasms of the female breast
- Appendicitis
- Malignant neoplasms of the bronchus and lung
- Malignant neoplasms of the colon and rectal region
- Brain disorders, including lumbago and sciatica
- Pregnancy
- Pneumonia

ERRORS IN DIAGNOSING

A doctors best defence will be to provide a consistent and systematic approach
with patients, a well documented medical records,
and appropriate referrals to consultants.

Other common pitfalls include:

- Negative electrocardiograms/cardiac enzymes
- Evaluation of chest pain
- Failure to recognise pulmonary emboli
- Blood gas study
- Delayed surgical response
- Abdominal pain
- Hemorrhoids inpatient older than 40
- Bowel cancer
- Chest radiograph (eg. Smoker, asbestos worker) who has persistent pneumonia

FOUR C's RISK MANAGEMENT

- **Compassion**

It is tempting as one listens to a patient's woeful tale, to condemn a previous doctors suboptimal care. Caution should be exercised before commenting on another caregiver until all the facts have been reviewed.

- **Communication**

In addition to informing patients and their families, doctors should endeavour to inform fellow doctors, nurses and other providers.

FOUR C's RISK MANAGEMENT

- **Competence**

Is determined by training and expertise as well as by the doctors ability to perform at that moment (eg. Not impaired by intoxication or distracted by personal problems). When confronted by an emergency, doctors should perform to the best of their abilities and, if necessary, transfer the patient or consult with another doctor.

FOUR C's RISK MANAGEMENT

- **Charting**

Approximately one third of malpractice cases are lost because of an inadequate record. Long after memories have faded, the record can serve as a doctor's friend or foe when asked to serve as a witness to the doctor's action. The record must be legible, accurate, consistent, timely, objective and completed and timed. Changes in the record must be obvious, with no attempt at concealment. Eg. An incorrect phrase should have a single line drawn through it and the correction should be initialed.

CONCLUSION

The Physician has no absolute protection against a Medical malpractice suit. Compassionate, competent, conscientious physicians can diminish, but not eliminate, the risk of a suit. Practicing reflective medicine can reduce patient injury and dissatisfaction, and it can represent the best prophylaxis against malpractice litigation.

"An ounce of malpractice prevention is worth a ton of money" (Massanari, 1987)