

# Preventive Action

The Quarterly Risk Management Newsletter for Policyholders of APAC

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## Disclosing Unanticipated Outcomes and Medical Errors

**Physicians may be uncertain of how to proceed when faced with the dilemma of disclosing an unexpected outcome to a patient. Unfortunately, people often mistakenly equate unanticipated outcomes with medical error. However, more frequently, the unanticipated outcome is a consequence of the patient's medical condition or an inherent complication associated with the treatment. The current litigious environment may cause the physician to be reluctant not only to discuss unanticipated outcomes, but especially medical errors. In fact, it is often this reluctance and failure to communicate that forces patients or family members to seek legal action in order to obtain answers to their questions.**

When a patient experiences an unexpected outcome or is harmed by a medical error, the health care team may fail to acknowledge the event and refuse to discuss it. They are fearful that furnishing information about the event is tantamount to admitting liability. Absent communication and answers to their questions, the patient and family become increasingly suspicious and distraught

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until the distress eventually turns to rage. Often, it is this rage that forces the patient to retain an attorney to supply the missing answers and seek compensation.

Studies have shown that patients and family members are less likely to sue when information is provided and an apology offered in response to a negative outcome. Increased communications have been shown to enhance the physician-patient relationship in these situations. In addition to the ethical duty to inform patients of negative outcomes and offer appropriate treatment options, Florida law (FS 456.0575) requires health care providers to disclose adverse outcomes that result in serious harm.

Important points to remember when disclosing a medical error or adverse outcome are:

- Prepare for the discussion. Consider having support persons on hand. Arrange for a private setting to conduct the discussion.
- Provide a prompt, factual description of events. Don't speculate as to the cause if the cause has not been determined. But, do not delay initiating communication until all the facts are known. Inform the patient and family they will be advised as soon as more information becomes available and then follow-up.
- A sincere apology or statement of regret that the patient experienced a negative outcome is appropriate. Do not assign or assume guilt or blame.
- Discuss the effect the event may have on the immediate and long-term status of the patient.
- Discuss the interventions that have been initiated and any future

interventions that may be indicated.

- Conduct an evaluation of the event. Relay to the family that a full evaluation of the event will be made and that they will be advised of the outcome of the investigation as appropriate.
- Provide ample time and opportunity for the patient's and/or family's questions and concerns to be addressed.
- Reinforce applicable points made during the informed consent discussion.
- Maintain continued communications as facts become evident.
- Document the discussion, including the date and time of disclosure, who was present, a summary of what was discussed, and what questions were raised.
- Seek legal or risk management guidance when necessary.

Patients who have been engaged in a thorough informed consent discussion are less likely to become suspicious or confrontational when faced with an adverse outcome. Prior informed consent may make the disclosure process less fearful for the physician as well, since it sets the foundation for discussion.

The three primary goals of appropriate disclosure are to avoid the conflict of an adversarial approach that puts patients and attorneys against healthcare providers in lengthy litigation, to improve physician-patient communications, and to improve the delivery of medical care and patient safety by openly evaluating and addressing unanticipated outcomes.

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For comments, questions, or to obtain additional copies contact the APAC Risk Management Department at 866-294-6014, ext. 3016, or rm@apac.com.

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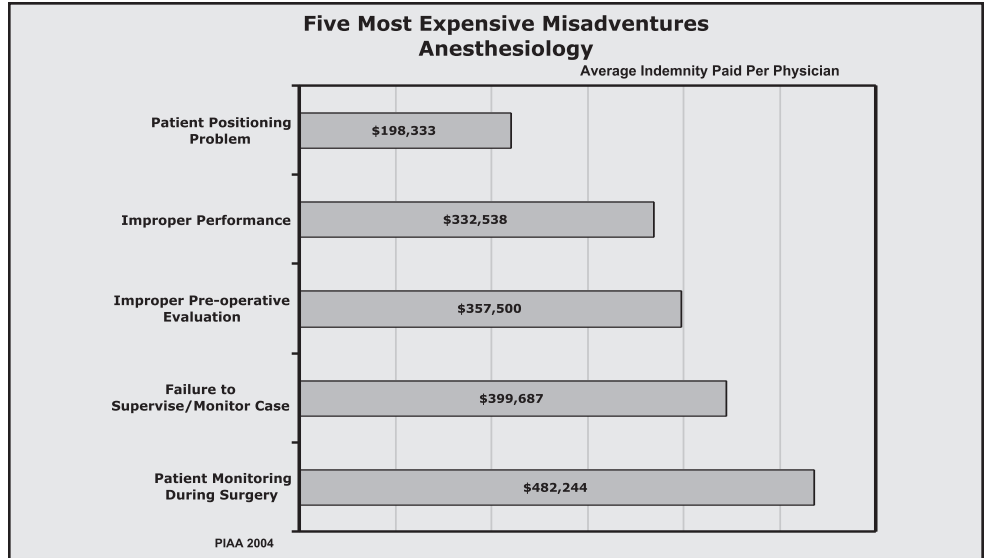
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## APAC Risk Management Bulletin

### **SUBJECT**

Verification of tracheal intubation

### **OBJECTIVE**

Implementation of loss prevention measures designed to reduce claim frequency and severity.

### **CONCLUSION**

There are many methods available to verify tracheal tube placement, all of which can fail under certain circumstances. However, when verification methods are used properly and in conjunction with conscious attention to clinical signs, they are effective in differentiating esophageal from tracheal intubation.

### **DISCUSSION**

A study of closed claims conducted by the ASA found that a majority of adverse respiratory events was caused by inadequate ventilation, esophageal intubation, or difficult tracheal intubation. There are several methods to verify tracheal intubation, and these can be divided into three groups; traditional clinical signs, tests based on the anatomic differences between the esophagus and trachea, and tests based upon physiologic differences.

The traditional clinical signs (none of which is foolproof) include:

- Visualization of the tube passing through the cords
- Observation and palpation of chest movements
- Auscultation of breath sounds
- Epigastric auscultation and observation for abdominal distention
- Combined auscultation of epigastrium and both axillae
- Reservoir bag compliance and refilling
- Reservoir bag movement with spontaneous ventilation
- Sound of expelled gases with sternal compression
- Water vapor condensation within the tube

Tests using anatomic differences include transtracheal illumination, cuff maneuvers and neck palpation, chest x-ray, self-inflating bulb, and fiberoptic bronchoscopy. These, too, are not totally foolproof.

Testing based upon physiologic differences such as capnography and pulse oximetry, while often considered the gold standard for verification of tracheal intubation in surgical settings, can be less than perfect. For example, oxygenation prior to intubation can extend the time period before a drop in saturation is noted.

All of the methods listed are useful in verifying tracheal intubation. An awareness of the limitations of each as well as close attention to all of the clinical signs facilitates verification of proper tracheal intubation and thus mitigates adverse respiratory events.

# Most Prevalent Procedures – Anesthesiology Claims

Nationwide malpractice claim data compiled by the Physician Insurers Association of America (PIAA) indicate that the most prevalent procedures in anesthesiology malpractice claims that were closed in 2003 are:

- General anesthesia
- Epidural/caudal anesthesia
- Operative procedures on the spinal cord and spinal canal
- Diagnostic interview, evaluation, or consultation
- Prescription of medication
- Spinal anesthesia
- Physical therapy and rehabilitation procedures

Anesthesiology ranks 7<sup>th</sup> in terms of the total indemnity paid for claims closed in 2003. The payment ratio for the specialty is approximately 3% higher than that of all medical specialties. According to the Florida Office of Insurance Regulation, the average loss paid in anesthesiology for closed claim year 2003 was \$289,057 per physician.

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## HIPAA Privacy and Security Rules – Compliance Tools

APAC has developed simplified HIPAA Privacy and Security Rule material to help clarify the Rules and assist in compliance measures. The reference packet includes an overview of the Privacy Rule, risk management guidelines, a patient education brochure and website references. It also contains those forms and templates that are necessary for HIPAA compliance, including a model Business Associate Agreement.

To obtain these compliance tools, contact the risk management department at 866-294-6014, ext. 3016 or email [rm@apac.com](mailto:rm@apac.com). The reference packet can also be downloaded from the APAC risk management web page at [www.apacinsurance.com](http://www.apacinsurance.com)



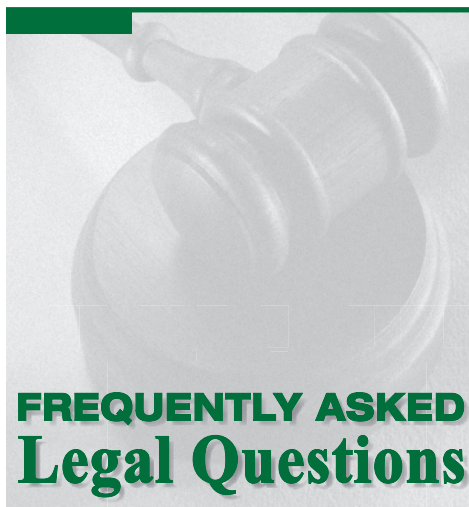
### **LOSS PREVENTION**

A labor epidural was administered to a 31-year old female who underwent an unremarkable vaginal delivery. However, immediately postpartum, the patient complained of paresthesia of both lower extremities. Multiple charting entries referred to “post-epidural neuropathy”. A diagnosis was made of femoral nerve injury, secondary to positioning of the patient’s legs during delivery. The use and type of stirrups was not documented. Although medical experts could defend the anesthesiologist’s administration of the epidural, they could not support a causation defense given the inability to ascertain if femoral compression occurred during delivery. The anesthesiologist’s failure to properly document positioning, including the use of stirrups, necessitated settlement of an otherwise medically defensible case.



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**What is the HIPAA Security Rule?**

Security standards that were developed to protect electronic health care information. The Security Rule adopts a set of national standards for safeguards to protect the confidentiality, integrity, and availability of protected health information. With the exception of small health plans, all covered entities must comply by April 20, 2005. Small health plans have until April 20, 2006.

**Does HIPAA Privacy Rule compliance establish Security Rule compliance?**

No. However, many of the requirements set forth by the Privacy

Rule satisfy those required by the Security Rule in terms of a covered entity having in place appropriate administrative, physical, and technical safeguards for the protection of protected health information. However, the Security Rule contains 18 security standards that must be implemented. Moreover, there are 42 implementation specifications that are either required or addressable. If implementing a specification is not reasonable and appropriate, the covered entity must document why, and must implement an equivalent alternative measure that is reasonable and appropriate.

**Does a physician have the right to have legal counsel present when being deposed?**

Yes. A deponent has the right to legal counsel at the time of deposition. Always contact APAC's Claim Department or Risk Management Department before providing a deposition in order to determine if legal counsel is necessary and if an attorney will be assigned to represent you at the deposition.

**What is meant by the legal term 'discovery'?**

Pre-trial devices that are used by one party to obtain information about the

case. Forms of discovery include depositions, written interrogatories, production of documents or things including medical records and personal records. Discovery could also include physical and mental examinations, requests for admission, and information necessary to support a claim for damages.

**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. Clarify the timeframes of the specific record retention laws in the state in which you practice.