Eaton Rapids Medical Center

ACKNOWLEDGMENT STATEMENT

Risk Management Handbook

By signing below I am acknowledging that I have read and agree to abide by the Risk Management Handbook of the Eaton Rapids Medical Center as well as the policies and procedures pertaining to the Hospital.

Signature:
Print/Type Name:
Date Signed:
Department/Specialty:

Rev. 7/01

I. INTRODUCTION

This booklet outlines the Risk Management program at Eaton Rapids Medical Center and key legal issues health care practitioners face.

II. PROGRAM OVERVIEW

A. THE RISK MANAGER

The responsibilities of the Risk Manager have been incorporated into the job of the Utilization Review Coordinator. For the purposes of this document, the term "Risk Manager" shall be synonymous with Utilization Review Coordinator. The focus of these responsibilities is the coordination of the risk management activities relating to patient safety and quality care. These activities include monitoring claims against the facility, working with defense counsel, managing, analyzing and reporting risk management data, and providing risk education.

Please contact the Risk Manager with questions about the program or problems that are risk related. In the absence of a Risk Manager, please contact the Administrator-On-Call. After hours, contact the House Supervisor.

Eaton Rapids Medical Center's telephone number is (517) 663-2671.

B. THE RISK MANAGEMENT PROGRAM

The Hospital has adopted a multi-disciplinary approach to risk identification, analysis and solution through the Medical Executive Committee. This committee has the responsibility and authority for implementing and maintaining the program by performing the following:

1. Monitoring and evaluating the quality of patient care,
2. Identifying and resolving patient problems, and
3. Reporting all pertinent findings to the Board of Directors.

A network of subcommittees, including all medical committees and departments, all medical staff review functions, and the hospital Quality Improvement committee, perform ongoing monitoring activities and report findings to the Medical Executive Committee (See Policy No. 1.16.04).

III. RISK IDENTIFICATION AND FOLLOW UP

A. OCCURRENCE REPORTING

The clinical Event Notification Report is the most important communication tool used by the Risk Manager. This report allows the Hospital staff to confidentially notify us of any patient or visitor injuries or other events that may impact upon the quality of care that we provide.

Monitoring "incidents" helps to identify problem areas that could affect the quality of care provided (e.g. delays in treatment or services, treatment errors, communication problems, etc.).

Using Occurrence Reports to notify Risk Management of patient injuries or unanticipated outcomes is crucial to our program of "early intervention". This allows the Risk Management staff to assess situations promptly from a liability standpoint, and if necessary, make arrangements for further patient care or treatment.

It is recommended that events be reported whether or not they resulted in injury or whether or not they may result in litigation. Tracking and trending data will help the Medical Executive Committee evaluate incidents and the associated loss potential.

Physicians should not initiate, document or sign occurrence reports. Instead, they should report event directly to Risk Management at extension 420. Physician documentation of **medical assessment** and **treatment** is more appropriately found in the Medical Record. Please let us know by phone whenever incidents occur that may adversely affect patient care.

NOTE: Occurrence Reports must not be copied, placed, or referred to in the medical record. The contents are confidential and may not be revealed to unauthorized individuals outside the Risk Management office. <u>The occurrence should be charted in the Medical Record without reference to the report</u> (See Policy No. 1.16.01).

B. WHAT, TO WHOM and HOW TO REPORT

WHAT: Patient and visitor injuries. General hazards that either have or may result in injuries, or serious events with obvious injuries.
WHOM: Risk Manager
HOW : Occurrence Report (Call Extension 420 or Administrator-On-Call)

WHAT: Employee injuries.
WHOM: Safety Officer
HOW : Incident Report (Cardio-pulmonary Department or Extension 492)

WHAT: Spills and debris in hallway, torn carpeting, loose floor tiles, incandescent lights, etc.
WHOM: Housekeeping and/or Maintenance
HOW : Maintenance Report (Page)

WHAT: Broken or malfunctioning medical equipment, office equipment (except computers), wheelchairs, gurneys, etc.
WHOM: Maintenance and Safety Director
HOW : Maintenance or Malfunction Report (Page)

WHAT: Hazardous chemical spills, asbestos-related incidents, general hazardous or unsafe conditions, noxious fumes.
WHOM: Housekeeping/Safety Officer/Risk Manager
HOW : Occurrence/Variance Report (Page)

WHAT: Broken pavement, structural damage to floors, stairs and walls, outdoor lighting, heating, plumbing, air conditioning, fluorescent light replacement.
WHOM: Housekeeping/Maintenance/Safety Officer
HOW : Maintenance Report (Page)

WHAT: New construction hazards, debris, open or obvious hazards relating to new construction or remodeling projects.
WHOM: Maintenance/Safety Officer/Risk Manager
HOW : Occurrence/Variance Report

WHAT: Angry, unhappy patients, families or visitors.
WHOM: Administration/Risk Manager
HOW : Patient/Staff/Physician Complaint Form (Extension 420 or Administrator-On-Call)

WHAT: Any variance/concern, e.g. break in procedure, quality or safety issues without injury or harm.
WHOM: Risk Manager
HOW: Variance/Concern Report (Call Extension 420 or Administrator-On-Call)

NOTE: *If any of the above occur during evening hours, weekends and holidays, notify House Supervisor. If necessary, the supervisor will contact Risk Management.*

C. OTHER "RED FLAG" EVENTS

1. Medical Record Requests

All Medical Record requests by patients or others which may involve litigation are reviewed by the Risk Manager for possible risk management implications. The attending physician will be notified of any record request from an attorney at the time the record is released (See Policy No. 25.01.01.01).

3. Significant Patient/Family Complaints

Complaints may also give warning of dissatisfaction with care and/or deteriorating relationships with care givers. If coupled with an adverse or unexpected outcome, litigations may result if the complaint is not properly handled. All complaints associated with an adverse outcome should be reported to Risk Management.

D. RISK ANALYSIS

In analyzing the report of an occurrence the Risk Manger will review the following questions:

1) Patient Injury-Is the patient injured? How severely? Is it temporary or permanent?
2) Necessary Treatment - Will the patient's stay be extended, or will additional medical intervention be required?
3) Cost - Will the cost of the patient's stay be increased? Will there be additional medical costs?
4) Is there a breach of the standard of care, threat of suit, negligence?

Based on this review, a follow-up investigation may be required. For those incidents involving patient injury, extended stays, or quality issues, the medical record will be forwarded through the peer review process.

E. CONFIDENTIALITY OF PEER REVIEW DATA

There are several Michigan statutes which both mandate and protect professional review activities within the hospital. Statutes clearly state that all records, data, and knowledge collected for or by individuals or committees assigned a professional review function are confidential, not public information and not subject to court subpoena.

IV. PROFESSIONAL LIABILITY COVERAGE

A. THE HOSPITAL'S PROFESSIONAL LIABILITY INSURANCE COVERAGE

The Hospital is currently insured through the Michigan Hospital Association Insurance Company. They provide claims management and loss control services. Your cooperation with MHAIC representatives will be greatly appreciated should you come in contact with them.

B. PHYSICIAN PROFESSIONAL LIABILITY INSURANCE COVERAGE

All physicians and allied professionals on staff are required to obtain their own professional liability insurance with limits listed below.

Privilege Classification	Minimum Limits
All Practitioners	$200,000/$600,000

In some cases, the Hospital provides professional liability coverage for practitioners because they are employees or contractors of the Hospital. In these cases, the coverage only extends to work performed during the course and scope of their Hospital contract or employment. If you are insured by the Hospital and asked to moonlight, you must verify insurance coverage. To obtain authorization, please submit a letter to Risk Management detailing the types of activities you will be engaged in, how they relate to your Hospital employment or contract, and how long you expect to be working there. You will be notified as to the determination on coverages.

V. RISK ISSUES AND POLICIES

A. THE NATIONAL PRACTITIONER DATA BANK

National Practitioner Data Bank was mandated by the "Health Care Quality Improvement Act of 1986", Title IV of Public Law 99-660, as amended by Public Law 100-177. After three years of discussion and negotiations, reporting began in September 1990.

Who Must Report and What Must be Reported to the National Practitioner Data Bank:

1) Malpractice Payments: When an insurer makes an indemnity payment on behalf of any licensed health practitioner in settlement of a claim or judgment for medical malpractice, it must report requisite data to the National Practitioner Data Bank and to the appropriate licensing board(s).

2) Licensure Actions: State Medical, Dental, and other Health Profession Boards must report to the National Practitioner Data Bank disciplinary actions taken against practitioners.

3) Professional Review Actions/Clinical Privilege Actions: Eaton Rapids Medical Center must report certain adverse actions taken against a practitioner's clinical privileges. These actions based on the practitioner's professional competence or conduct and health profession disciplinary action must also be reported to the HPDRA if the action is related to:

   - Professional incompetence;
   - Change of employee status as a result of disciplinary action; or
   - Suspension of privileges for greater than 15 days.

4) Society Membership Actions: Professional societies must report an adverse action taken against the membership of a practitioner when they reached that action through a formal peer review process and when the action was based on the practitioner's professional competence or professional conduct.

All reports forwarded to the National Practitioner Data Bank by Eaton Rapids Medical Center, for any reason, will be made by the Medical Staff Office.

5) Queries to the National Practitioner Data Bank: Pursuit to the Act, the Medical Staff Office will query the National Practitioner Data Bank under the following circumstances:
   a. Application for membership of the medical staff.
   b. Every two years for any practitioner holding clinical privileges.

All reports received from the National Practitioner Data Bank shall be regarded as part of the practitioner's credentials.

B. MICHIGAN PEER REVIEW ORGANIZATION

The Medicare and Medicaid Programs have contracted with the Michigan Peer Review Organization (MPRO) to perform random chart reviews on selected diagnoses. The reviewer looks at length of stay as well as quality of care. From time to time you may receive a letter from MPRO questioning treatment protocols or length of stay for a particular patient. Each letter allows you an opportunity to respond within a specific time frame.

Please notify the Medical Records Department if you receive a letter. Staff there will be happy to assist in the preparation of a response should one be warranted. Quality Points are assigned for patient care where deficiencies are found. Consequently, these letters must be reviewed carefully. Please note the MPRO has the authority to sanction physicians who accumulate a higher- than-average number of quality points.

Correspondence will be maintained in the physician peer review file as evidence of external quality assurance.

At this writing, MPRO is undergoing changes in its direction through the Sixth Scope of Work. This redesigns the methods used to reform physician practice patterns.

C. INFORMED CONSENT (see Policy 1.40)

1. INFORMED CONSENT-WHY IS IT NECESSARY?

Over the years, courts throughout the United States have repeatedly validated the concept of a person's right of self-determination. The foundation in law of this right can be traced to the tort of "battery", which forbids the intentional touching of someone without his or her permission. An "informed consent" is the direct communication between a physician and patient concerning a course of treatment; it must be based on a clear, concise and factual explanation of proposed treatments, possible outcomes and alternatives to therapy. This procedure shall be followed particularly in circumstances when invasive procedures, high risk therapies/drugs, or experimental treatments are contemplated (See Rules & Regulations T.1.1.)

Patient care is a cooperative venture involving practitioners and nurses. As such, the question as to who has final responsibility for carrying out the consent process often arises. If an action is brought alleging lack of informed consent, the clinician who actually performed the procedure will be the one called upon to show that the consent process was carried out appropriately. Therefore, if the physician relies upon someone else to acquire consent from the patient, the consent form must be reviewed and an informed consent progress note completed which will include asking the patient if there are any further questions.

2. INFORMED CONSENT-HOW MUCH IS ENOUGH?

The extent to which disclosure is sufficient is based upon both the nature of the procedure and its urgency. The law acknowledges that certain situations may preclude disclosure—such as emergencies and "good Samaritan" care—protections are in place to shield the clinician from liability in these cases. In these cases the clinician should document the nature of the treatment, its immediacy and its magnitude. However, for the more common, non-urgent care provided competent adults, valid informed consent must include:

a) Diagnosis or suspected diagnosis,

b) Discussion of the nature and purpose of the proposed procedure or treatment,
c) Risks, consequences or side effects—including the risk of death or serious harm, if applicable,
d) Probability of success,
e) Reasonable alternative treatments or procedures,
f) Foreseeable consequences if the patient refuses the suggested course of treatment,
g) The identity of the treating physician or operating surgeon,
h) The right to refuse treatment, and
i) The right to obtain a second medical opinion.

Documentation of the consent discussion is crucial. Additionally, a handwritten note with both the date and time may make the difference between a defensible case and one that is not. After ensuring that the consent form is signed, a simple progress note entry such as the following will generally suffice:

> "Have discussed with patient the nature of his/her condition. Have discussed risks and possible complications including, but not limited to (List in order of possibility). All questions answered. Patient understands and accepts."

The physician should also document the rationale for treatment regimens which may be regarded as unusual or outside standard practice procedures. Remember, the informed consent process is a dialogue—not a monologue. Never underestimate your patient's desire for information. Do not deliberately minimize or omit significant risks or complications. Do not expect to obtain informed consent by simply answering questions—you must volunteer the information. The informed consent discussion affords an excellent opportunity to establish rapport with the patient by involving him or her in the decision-making process. An investment in time at this point will pay off by strengthening your relationship with the patient while enhancing your protection from liability.

D. COBRA (Comprehensive Omnibus Budget Reconciliation Act)

Anti-dumping legislation, specifically known as Section 1867 of the Social Security Act, was enacted in 1985 to prevent the transfer of unemployed, uninsured and underinsured patients from for-profit institutions to the nearest public facility for treatment. In 1989 the law was amended to include active labor and set forth the policy and procedure requirements for the facility's transfer protocols (See Policy No. 42.05.01).

Federal statutes require the following:

1) Medical screening for all patients presenting for treatment, regardless of ability to pay, to determine if an emergency condition exists.

2) Stabilization of the emergency medical condition prior to transfer unless the benefits of immediate transfer of the unstable patient outweigh the risks of delaying treatment.

3) A physician summary of the benefits and risks of transfer.

4) Documentation that the receiving hospital has space and qualified personnel for treatment and agrees to accept the patient.

5) Copies of all medical records relating to the emergency condition of the patient must be sent to the receiving facility.

6) Adequate equipment and personnel necessary to transfer properly.

7) Posting of on-call physician schedules and retention of on-call schedules for five (5) years.

E. HIV

1. Consent

Informed consent must be obtained prior to HIV testing. The Hospital has developed an HIV consent form for your use which covers all of the elements of a valid consent. Michigan Law (PA488) specifies three instances where consent is not required. They are:

- random testing for research where the individuals will not know the results and where the study is blind.
- accidental exposure of a health care facility worker to the blood and body fluids of a patient.
- the patient is incapacitated and there is no guardian to consent.

2. Confidentiality

Test results may only be disclosed to the patient, public health department, or to health care givers who are directly involved with the patient's care. There are strict penalties for unauthorized disclosure of information regarding HIV infection; this includes notification of spouses. (This area is now receiving attention that may amend notification of third parties.)

F. WITHDRAWAL OF LIFE SUPPORT

Hospital policy and procedure provides that competent patients have the right to accept or refuse medical treatment, including the withdrawal of life support. Incompetent patients have the same rights as competent patients, and such rights shall be exercised through a surrogate or designate. The patient advocate designation is part of the hospital admissions process and such information is also included in the patient information handbook. Difficult decisions such as withdrawing life support are addressed in committees such as an ad hoc Ethics committee to assist in an advisory capacity to patients and families.

G. GENERAL GUIDELINES RELATING TO THE TREATMENT OF INCAPACITATED ADULT PATIENTS

In order to arrive at the appropriate choice of treatments with respect to no-complaint or mentally incapacitated adult patients, the practitioner must strive to decrease the possibility of errors. The first type of error is in preventing adults who appear to be considered incompetent from making decisions about their own lives and bodies. The second is in failing to protect mentally incapacitated persons from the harmful effects of decisions made at a time when they are not competent.

An understanding of the following concepts will aid the practitioner in arriving at the appropriate ethical and legally defensible course of action.

1. Competency

The law presumes that all persons, including those voluntarily or involuntarily treated for mental disorders or chronic alcoholism, are competent to make their own decisions with respect to medical care. Generally speaking, an adult is considered legally competent when he or she has the mental capacity to demonstrate an understanding of his or her actions.

Technically, a clinician cannot declare a patient to be legally incompetent; only a judicial court can. However, a clinician may evaluate a patient's condition to determine his or her mental capacity. The clinical term "incapacity is the rough equivalent to the legal term "incompetence". (A board certified psychiatrist may determine legal competency. Also, two physicians or a physician and a psychiatrist may deem a patient incompetent to make health care decisions.) The following are a few guidelines and principles that are useful in considering the question of a patient's mental capacity:

a. Although ill health, including mental illness and accompanying emotional states (e.g., depression, anxiety, etc.), can impair a patient's judgment, they do not necessarily render him or her incapacitated. Physicians and nurses should assist the patient in coping with or

overcoming the depression, fear or anxiety that is interfering with the decision-making process.

b. A patient's refusal of treatment is not necessarily evidence of incapacity, nor is disagreement with a clinician's assessment of the situation or a lack of confidence in the efficacy of treatment. However, a refusal for psychotic or delusional reasons may cast serious doubt on the patient's mental capacity. Although a patient's refusal of treatment on religious grounds may seem unusual to some, it is not generally held to be an indication of incapacity.

c. Complete mental lucidity or orientation is not necessary for someone to have mental capacity. A patient who periodically wavers in his or her position due to anxiety or other reasons may yet have the requisite mental capacity to refuse treatment and have such refusal respected.

2. Consent

Patients do not automatically give up their right to accept or reject medical treatment simply because they may suffer from varying degrees of mental incapacity. If the patient is unable to make any kind of reasonable judgment due to significant mental incapacity or impairment, a clinician should look to the patient's legally recognized surrogate (conservator, guardian, closest available relative, "advocate" pursuant to a valid Durable Power of Attorney for Health Care) to obtain consent for medical treatment.

NOTE: Failure to obtain consent in accordance with applicable legal standards may result in a charge of battery and/or negligence.

3. Gravely Disabled

A patient is considered incapacitated if, due to a mental disorder or to chronic alcoholism, the patient is unable to provide for basic needs of food, clothing or shelter.

4. Emergency Consent

In the case of a medical emergency (i.e., where treatment appears to be immediately required and necessary to preserve life or to prevent deterioration or aggravation of the patient's condition) and the patient is unable to consent, treatment may proceed without the patient's consent. Such treatment may not extend beyond resolving the immediate condition causing the emergency.

NOTE: As a general rule, if a patient has previously refused specific medical treatment (e.g., a Jehovah's Witness refusing transfusion), such treatment may not be provided even though the patient is currently incapacitated and the treatment could prevent deterioration or aggravation of the patient's condition.

5. Emergency Guardianship

The Probate Code section allows for petitioning the Court to obtain Emergency Guardianship to provide an incompetent adult patient with a course of medical treatment. Such a petition may be utilized only with respect to adult patients without conservators or legal surrogates, who are unable to give informed consent, and only in cases where the patient's condition will become life-endangering or result in serious threat to the patient's health. Contact Administration to process an emergency guardianship should you have a patient in need.

6. Restraints

In general, in acute care hospitals, restraints require the written order from a physician or must be an approved specific protocol. If staff can foresee that a patient' s combative behavior may result in physical injury to either the patient or others, they may employ whatever reasonable methods that may be necessary to prevent such harm, including, but not limited to, physical restraint or sedation. "A hospital must observe a patient's medical progress with the care and diligence foreseeably required by the patient's condition, and promptly employ whatever means is necessary for the patient's safety."

In all circumstances, the reasons for the selection and implementation of any course of treatment must be carefully documented within the patient's record. In all cases, alternative methods to modify the patient behavior must be employed prior to the use of restraints. Restraints ordered by a physician must be time limited and used for safety if other methods have been unsuccessful.

7. Durable Power of Attorney for Health Care-DPOA(HC)

Every competent individual over eighteen years of age may execute a "Durable Power of Attorney for Health Care" that will authorize an "advocate" to make health care decisions on his or her behalf. The DPOA allows the advocate (usually the patient's spouse or close relative or friend) to consent to affirmative medical treatment on behalf of the patient should the patient become unable or unwilling to do so. The advocate may authorize withholding or withdrawing of life sustaining procedures,"...so as to permit the natural process of dying" if there is clear and convincing evidence that the patient has given the advocate authority to make such a decision.

The DPOA must meet certain formal prerequisites in order to be valid. These guidelines are clearly outlined on the form itself. There is no need for the patient to involve an attorney in either the interpretation or execution of the form. Copies of the DPOA may be obtained from Nursing, Admitting, Risk Management, or Social Service. A few points to keep in mind with respect to DPOA's are:

a) Beginning in late 1991, all adult admissions will be asked whether they have DPOA. If not, they will be given information regarding their rights in determining the care they receive under Michigan law. Should they be admitted and wish to execute a DPOA, you and other hospital staff members are prohibited by law from witnessing the document.

b) The DPOA may be revoked or changed by the patient, who is presumed competent to do so unless shown otherwise. The patient should:
   1) Notify the advocate orally or in writing.
   2) Notify the health care provider orally or in writing. If such notification is received, it must be made a part of the patient's medical record and the health care provider must make a reasonable effort to notify the agent.
   3) Execute a new DPOA.
   4) Have named his or her spouse as the agent, but the marriage was dissolved or annulled and the patient has not remarried the same person.
   5) Use any method of communication to notify the facility of his or her intent to revoke.

c) A surrogate is generally authorized by the patient to consent, refuse consent, or withdraw consent to any care, treatment or procedure to maintain, diagnose or treat a physical or mental condition, and to receive and consent to the release of medical information, subject to the stated desires of the principal.

   However, under no circumstances may an advocate consent to any of the following:

   1) Withholding or withdrawing treatment from a patient who is pregnant that would result in the pregnant patient's death.
   2) Continuation, withholding or withdrawal of life sustaining treatment over the objections of the patient.
   3) Withdrawal or withholding of life support without clear and convincing evidence that the patient has given the surrogate that authority.

d) The patient's advocate must accept his or her responsibilities in writing and may revoke his or her acceptance of the designation at any time and in any manner sufficient to communicate the intent to revoke.

8. Guardianships

Guardianships are essentially designed to aid patients who, due to either temporary or permanent mental or physical impairment, lack the capacity to provide for their own needs.

Probate Guardianships: Under provisions of the Eaton County Probate code, guardians may be appointed by the court for adults and married minors who have been determined to be unable to properly provide food, clothing or shelter for themselves and who are substantially unable to manage their own financial resources. For minors who have never been married, courts may appoint guardians. This type of guardianship is generally utilized for individuals who are developmentally disabled, senile, or who have some profound physical disorder.

Each patient retains the right to consent or refuse medical care unless the Court specifically finds that he or she does not have the mental capacity to make such decisions. If this should occur, the court may grant the appointed Guardian authority to consent to and require the patient to undergo required medical care. This specific authority will be explicit in the guardianship referral.

NOTE: The term "legal guardian", is often misunderstood and often a family member or friend will believe they are the guardian when they are not. A legal guardian can only be appointed through a Probate Court hearing. A copy of the court order should be available for review if necessary to document the relationship.

9. Involuntary Transfers

Individuals believed to be dangerous to self, or others, or gravely disabled due to a mental disorder, can be transferred involuntarily to a psychiatric facility for treatment and evaluation for up to 72 hours. If these patients continue to meet the above criteria, they may be held for an additional 14 days, but only after having been given opportunity to admit themselves voluntarily for additional treatment if they have the capacity to do so.

Any patient involuntarily transferred to a psychiatric facility and held beyond 72 hours, has the right to a certification hearing.

All petitions for involuntarily transfers shall be requested through the receiving facility after the Petition and/or Application for hospitalization and the Physicians Certificate has been completed.

VI. RISK CONTROL TECHNIQUES

Although the threat of lawsuits cannot be eliminated entirely, your chances of involvement can be reduced by following the guidelines below. A review of past and present claims shows that, in most cases, personal liability is usually enhanced by failure to recognize and follow any one or more of the following:

A. COMMUNICATION BETWEEN DISCIPLINES

Treatment complications traced back to a failure by staff to communicate significant development in the patient's care or changes in the treatment regimen have become a leading cause of malpractice lawsuits. Consultants should be contacted immediately whenever questions arise that are outside the scope of your experience or training. It is particularly unfortunate when an injury or other event is recognized and has not been brought promptly to the attention of a colleague or qualified consultant. The possibility of human loss in such a case is obvious and the prospect of serious patient injury may be reduced (and legal actions possibly avoided altogether) if these situations are dealt with quickly and appropriately from the start. Do not stand by and assume that it is someone else's responsibility to pass information along.

B. PATIENT COMMUNICATION

A patient's decision to file a malpractice suit is usually an emotional one. Although an unsatisfactory clinical outcome may be a contributing factor, a patient's unfavorable perception of the care they have received may be more often traced to a breakdown in physician-patient communications. An uncaring or unresponsive manner conveyed by doctors and other staff members remains the single most common contributing factor to the cycle of events that leads to malpractice lawsuits. The need to establish good patient rapport cannot be overemphasized (people generally don't sue their friends). A caring, concerned attitude projected by you, and other members of the health care team, can defuse a potentially inflammatory situation. A good "bedside manner" can promote the climate of concerned patient care that almost always results in a patient's positive feelings about the care they have received.

When there is less than optimal outcome, or if a patient suffers an injury, his or her need for physician support is often at its highest. By facing these situations openly and honestly while—at the same time--providing an extra dose of "bedside manner", practitioners can keep the confidence of their patients. The courteous treatment of the patient's family may also improve the overall perception of the quality of care. Establishing good patient relations is not only good medicine, but good business.

VII. CONTACT WITH LEGAL SYSTEM

A. LEGAL CORRESPONDENCE

If you should receive <u>any</u> legal correspondence from patients, attorneys or courts, and the Hospital is named (subpoenas, summonses and complaints, notices of intent to commence litigation, etc.), please let the Risk Management Office know <u>immediately</u>. As we must respond to certain legal documents within defined time limits, our immediate receipt of legal correspondence is important.

B. COMMUNICATION WITH ATTORNEYS

Private Attorneys: Remember, there is no such thing as a "casual" conversation with an attorney preparing a lawsuit. To avoid involvement in litigation not directly affecting you, think twice before getting into conversations regarding patient care matters with attorneys not directly working on behalf of the hospital or yourself. Discussing patient care information with people you do not know—regardless of who they are—could lead to accusations that you violated the patient's right of privacy. Check with the Risk Management Office to find out whether the attorney has been retained by the hospital. If you are a named defendant in a lawsuit, never speak with opposing counsel unless accompanied by your appointed attorney.

Hospital Appointed Attorneys: On the other hand, if you are contacted by an attorney retained by the Hospital, or your insurance company, your complete cooperation is very important. You must, however, notify you own attorney before responding to any questions or comments from hospital counsel.

C. FAMILIARIZE YOURSELF WITH HOSPITAL POLICIES

You have the responsibility to review and follow the Hospital's policies, procedures and protocols. Unfamiliarity with these policies cannot be used as an excuse for not complying with them.

D. THE MEDICAL RECORD AS EVIDENCE

The purpose of the record is threefold: to communicate the care given, to communicate the patient's condition, and to provide legal documentation of the patient's hospitalization. The patient's medical record almost always becomes the primary piece of evidence in a malpractice action. As the memories of the plaintiff and individual defendants can be faulty, selective—or both—juries usually rely upon the medical record as the primary and authoritative account of what actually transpired.

Most plaintiff's attorneys will obtain a photocopy of the medical record and have it reviewed by a consulting physician before accepting a patient's case. The review usually focuses on the following questions:

1) Does the record agree with the general circumstances of the patient's complaint? This helps an attorney evaluate whether the patient is "making up stories" or actually has a legitimate grievance.
2) Does the record clearly show that a reasonable decision-making process took place before settling on the course of treatment under review?
3) Was the appropriate diagnostic data collected, correctly interpreted and reviewed by the primary physician?

4) In cases that involve invasive, experimental or high risk procedures, is there a chart entry detailing the "consent" discussion with the patient? These entries must include the nature of the procedure, the inherent "material" risks to the patient, and the other treatment options (if any) that may have been available. Remember, the more the informed consent progress note reflects the specific content of the consent discussion, the better.

5) Are there any significant differences between the various professional staff records (consultants, nursing, respiratory therapy, etc.) regarding the condition of the patient? If an alternative course of treatment is recommended—especially one that is at variance with other opinions—are the reasons clearly defined and documented?

6) Is the record legible, comprehensive and neat, or would it make a poor impression on a jury? Such an impression can often be given by the presence of illegible handwriting, unaimed or undated notes, the use of "whiteout", adversarial or critical commentary, and so forth. Remember, not only is the medical record a legal document, it is an essential component of the complete diagnostic and therapeutic process—treat it as such.

A plaintiff's attorney may be convinced to take on even the most marginal of cases if the medical records are incomplete and poorly written. By persuading the jury the attorney could damage the credibility of the staff involved. The jury will look to the medical record to resolve conflicts in testimony between the patient and the health care staff. If the record is silent, juries have been known to favor the patient's version of an event, simply because they may find it difficult to believe that a nurse or doctor can selectively reconstruct what occurred in the past by relying on memory alone.

The medical record is not the appropriate place for criticizing your colleague or making unnecessary comments regarding the patient or the patient's medical management. The use of "slant" words such as "inadvertently" "unfortunately", and so forth, must be avoided. A well documented record can be the deciding factor in a plaintiff's attorney's decision whether to accept or reject a patient's case.

From the Hospital's position, the decision to either settle or defend a claim may be heavily influenced by the content of the record and its potential effect on a jury.

E. SUED-NOW WHAT?

In the event that you should have a legal claim or lawsuit filed against you, it is important that you take a couple of minutes to review the following guidelines carefully:

1) Notify the Risk Management Office immediately if the suit involves the Hospital. If you receive a letter from your patient (the plaintiff) or his or her

attorney that says (or even implies) that it is their intent to file a lawsuit against you or the Hospital, let the Risk Management Office know immediately. Forward a copy of the letter with the date you received it. If you decide to keep a copy of the letter, do not file it in the patient's medical record of your own office file. Make a separate "litigation" file and keep that copy, and any future correspondence regarding the lawsuit in it.

2) If the legal claim or lawsuit does not involve the hospital, please notify the Risk Management office of the suit. If you receive a Summons and Complaint (formal notice of a lawsuit) notify your insurer immediately. Because they may have only thirty days from your original receipt to file a response with the courts, time is of the essence. If you do not let them know when you are served, a default judgment could be filed against you. In other words, you could forfeit the case for the entire amount of damages demanded.

3) Do not alter the patient's medical record in any way. By the time you receive your notice of claim or lawsuit, the plaintiff's attorney has probably already obtained a copy of the record. If a comparison between their copy and our original shows obvious deletions or other alterations, a claim of fraudulent concealment or "spoliation of evidence" could be added to the original lawsuit. If this should occur, the possibility of successfully defending the lawsuit could be seriously jeopardized, regardless of whether or not there is any liability on your part.

4) Do not discuss the case with anyone without checking with your attorney first. The opposition attorney is permitted to ask you if you have discussed the case in litigation with anyone. If you have, you could be required to identify those people and they, in turn, could be subpoenaed to testify as to what you talked about. Although immunity from discovery does exist for discussion with your attorney, representatives of Risk Management, and in connection with formal department peer review and quality assurance activities, it does not cover casual conversations with your colleagues and friends.

5) Do not discuss the case with the patient. After litigation has begun, do not contact the patient and attempt to "work things out" or offer explanations. You will have plenty of opportunity to offer your side of the story later on.

6) Do not discuss the case with the patient's attorney. Under no circumstances should you discuss any aspect of the case with the plaintiff's attorney, either in person or by phone, unless accompanied by your own attorney. Do not vent your anger by phoning opposition counsel and calling names or threaten to countersue. These attorneys already know what you think of them and really could not care less.

7) Do not get legal advice from your cousin or at a dinner party. Invariably, the quality of legal advice you would get in these situations may be about as

worthwhile as the quality of medical advice you could expect to get under the same circumstances. Unless the person is an experienced medical malpractice defense attorney with an intimate knowledge of all aspects of the case, his or her opinion could be of little practical value. At worst, you could be given bum advice which, if followed, could result in additional problems later on. Beside, these conversations could, under certain circumstances, be discoverable by the plaintiff's attorney (see #3 above).

8) Avoid comparing your case with someone else's. First of all, no two cases are alike—period. Just because your colleague was involved in a similar case, do not assume that your case should—or will—resolve the same way. Although the cases may appear to be similar at first glance, differences invariably exist beneath the surface and it is these many variations that will dictate how a case is finally resolved.

9) Avoid discussing the case with anyone from the news media. Do not take it upon yourself to vent your anger on the front page of the local paper or on the six o' clock news.

10) Do not spend your time thinking about countersuing the plaintiff for malicious prosecution. Although you have the right to countersue—under certain, well-defined circumstances—you will have to do so entirely on your own time and at your own expense. In addition, the burden of proof is entirely upon you to prove that the lawsuit in question was started maliciously. It may be true, but it is very difficult to prove.

F. TIPS ON TESTIFYING

In preparing for your testimony, whether at a deposition or during trial, there are a few important points to keep in mind.

1) Review all pertinent medical records. This allows you to respond intelligently and accurately and to avoid confusion. Do not hesitate to ask to review the record if you are being asked to comment upon any part of it. The records should be available to you. DO NOT bring copies of any record with you to the deposition or to court unless ordered to do so under separate subpoena. If you should receive a subpoena for medical records, take it to the Medical Records Department as soon as possible.

2) Do not volunteer information. This point is very important. If a question can be answered with a simple "yes" or "no", or "I don't know", then do so. Do not volunteer additional information even if you believe it is relevant. Often a witness will give a perfectly acceptable answer and then proceed to ramble. Keep your responses concise.

3) Tell the truth. Do not withhold pertinent facts or information unless you have been instructed not to respond to a question by the attorney acting on your behalf. Do not speculate or pass on information unless specifically asked to do so by your attorney. NEVER GUESS. Do not allow an attorney to intimidate you into thinking that you should know the answer to every question or that you might appear foolish for not knowing.

4) Do not answer a question unless you fully understand it. If the question is unclear or ambiguous, do not hesitate to ask the examining counsel to repeat it or rephrase it. Consider each question carefully and take as much time as you need to phrase your answer and respond.

5) Be polite to the questioners. Do not let their questions or attitudes upset you. If they adopt an abrupt or abrasive manner, they are probably only doing it to test you. Your ability to calmly and thoughtfully answer questions will increase your value as a witness. DO NOT LOSE YOUR TEMPER. A witness rarely comes out ahead in a shouting match with an attorney.

6) Correct your answer. As each of us is subject to lapses in memory, concentration, or both, you may discover during the testimony that you have given an inaccurate answer. You have the right to correct your prior answers at any time. Do not hesitate to speak up and say that you wish to do so.

7) Listen to your attorney. Often, attorneys will object to questions. Therefore, you should pause slightly before answering to allow time for an objection to be raised. If your attorney should object to a question, do not answer it unless directed to do so. Do not attempt to second guess your attorney's judgment.

G. YOUR DEPOSITION

What is a deposition? A deposition is one of several means for taking testimony under oath. Depositions serve several purposes:

1) They allow attorneys to discover what you know about matters relevant to the case;

2) They commit you to testimony given under oath;

3) They allow attorneys for both sides an opportunity to evaluate the impression you would make as a witness upon a jury at the time of trial; and

4) They preserve your testimony should you be unable to be present for trial.

The deposition process is fairly simple. A Notary Public (usually the court reporter) will ask you to take the standard witness oath (or affirmation, if your religious beliefs do not permit you to take an oath). The attorneys in the room will then take turns asking you questions. The court reporter will record everything said by you and the attorneys. These

notes will later be typed and bound in a book called a transcript. Under court rules, a witness has the right to read a transcript of his or her deposition and to correct any mistakes on a separate sheet of paper. Sometimes attorneys may waive this process and may ask you to do so as well. Discuss this situation with your attorney if it should arise.

Although the atmosphere at a deposition may appear to be relatively informal, do not be misled. Depositions are vitally important to a lawsuit and attorneys take them very seriously.

If you receive a subpoena for a deposition regarding care provided an Eaton Rapids Medical Center patient, or are asked to arrange one, notify Risk Management as soon as possible. We will assist you scheduling the deposition at a time convenient to you and at a suitable location, preferably here at the hospital. If indicated, we will also arrange to have an attorney accompany you, if one has not already been appointed to you by your insurer.

Because of the importance of a deposition and the latitude given to the questioner, it is important that you be prepared to respond to the questions asked as accurately and completely as possible.

If you are called to be an expert witness in which you are neither named defendant nor an involved witness or participant, you must do it on your own time out not as a representative of Eaton Rapids Medical Center. Furthermore, because this is considered outside the scope of Eaton Rapids Medical Center practical/duty, no liability coverage is extended outside the scope of employment.

H. SUBPOENAS

Subpoenas are usually issued by the Eaton County District Attorney's office, but may also come from the Public Defender's office, Juvenile Court or private attorneys. Generally, they relate to treatment issues associated with criminal matters such as assaults, drunk driving, etc. Sanctions may be imposed if you fail to appear when subpoenaed.

Upon receipt of your subpoena, contact the issuing attorney at the phone number noted on it. Ask for an explanation of the circumstances of the case, the name, date of birth and medical record number (if available) of the patient in question, and what specifically you will be asked to testify about. Ask to be placed "on call". If agreed to, this would still require your attendance in court, but only if you have been contacted by the requesting attorney on the day of your scheduled appearance. This means that, although you will not have to appear at court until called upon, you will have to keep your calendar clear in the event that you are called upon to testify.

NOTE: Subpoenas for medical records must be referred to the Medical Records Department.

I. MEDICAL PROCEDURES REQUESTED BY POLICE OFFICER (See Policy 10.14.7)

From time to time, police officers may bring an arrestee to the hospital to: (1) evaluate the arrestee to determine whether it is medically safe to incarcerate the person, or (2) perform blood alcohol or other evidentiary examinations. As a general rule, hospital staff may perform evaluations or procedures requested by law enforcement officers only under the following circumstances:

1) The patient consents.
2) There is a medical emergency and the patient does not object.
3) The request is for a blood test.
4) The request is for a non-invasive medical evaluation to determine if it is medically safe to incarcerate the arrestee.
5) The request involves the collection and release of evidence of a rape or sexual assault.

If the arrestee's actions make the performance of the requested procedures unsafe, or if the tests or treatment are medically contraindicated, the procedures should not be performed.

A BASIC RISK MANAGEMENT GLOSSARY

ACCIDENT: An event or occurrence that is unforeseen or unintended.

ACTIONABLE: An event or circumstance which may be remedied by a lawsuit.

AD LITEM (Latin): "For purpose of litigation"; an individual who has been given the authority to act on behalf of another. For example, a parent acting ad litem on behalf of his or her minor child in litigation.

ASSAULT: A demonstration of an intent by one person to inflict injury on another; a threat.

BATTERY: The actual unpermitted, unlawful and intentional touching of one person by another.

CAUSATION: The legal concept of cause and effect.

COMPLAINT: The first or initial pleading on the part of a plaintiff in a civil lawsuit wherein the actual allegations of misconduct are presented.

CLAIM: A demand made against the board of Directors, Hospital or members of its staff; usually precipitated by an accident or injury.

DEFENDANT: An individual or entity against whom a civil or criminal action is brought.

DISCOVERY: The entire pre-trial process entered into by both parties to a lawsuit in order to obtain facts and information about the case in preparation for trial.

EXCESS INSURANCE: An insurance policy covering the insured against loss or damage above the stated amount of primary insurance.

EXPERT WITNESS: An individual, not party of the lawsuit, who is qualified by experience or education to form an expert opinion regarding one or more elements of a case.

HAZARD: A condition that creates or increases the probability of loss.

INCIDENT: An event that either did or potentially could have resulted in injury or loss.

INDEMNITY: The general principle of insurance that provides for the financial restoration of a victim or loss to the approximate level enjoyed prior to the loss.

INSURANCE: A contractual relationship which exists when one party (the insurer), for a fee (the premium), agrees to reimburse another party (the insured) for loss to a specified subject (the risk) caused by designated contingencies (perils or hazards).

CLAIMS MADE: A form of insurance that will only cover claims "made" (reported or filed) during the year the policy is in force for any events which occurred that year or any previous period covered by the contract.

OCCURRENCE: A form of insurance which covers events occurring within the contract period regardless of when in the future a claim is filed.

JUDGMENT: The decision of a court or the reason for such a decision.

LIABILITY: Generally, any legally enforceable obligation or responsibility.

LIMITS OF LIABILITY (policy limits): The maximum amount which an insurance agrees to pay in the event of a loss. No such limits apply for actions involving the staff of the hospital arising out of activities engaged in within the course and scope of their hospital employment or appointment.

LITIGATION: A contest in a court of law for the purpose of enforcing a right.

LOSS: The basis for a claim of damages.

MALFEASANCE: The wrongful performance of a act that the individual has no right to perform or has been expressly forbidden by contract to perform.

MALPRACTICE: Any professional misconduct, unreasonable lack of skill or illegal or immoral conduct that causes injury or loss to another.

MOBILE HAZARD: A careless attitude on the part of an insured which increases the chance of loss or causes losses to be greater than would ordinarily be the case.

NEGLIGENCE: The failure of an individual to exercise the ordinary degree of care that would be expected from a reasonable and prudent person acting in the same situation under the same or similar circumstances.

OCCURRENCE REPORT: The form used to document the details of an incident. The occurrence report is the primary communication mechanism used by the Risk Management Office to identify events or situations that may represent liability exposure.

PERJURY: Willful and false testimony given while under an oath or affirmation to tell the truth.

PLAINTIFF: The individual in a civil suit who brings the action into a court of law and makes charges against another (the defendant).

PREMIUM: The payment a policy holder agrees to make for an insurance policy.

PROXIMATE CAUSE: The immediate or actual cause of an injury or loss.

PUNITIVE DAMAGES: Damages awarded to a plaintiff, separately and in addition to any other compensatory damages, for the sake of example and as a form of punishment imposed upon the defendant for "despicable" conduct.

RES IPSA LOQUITUR (Latin): "The thing speaks for itself." The presumption that the cause of the injury itself is of a type that would not normally occur in the absence of negligence.

RESERVES: Money set aside in anticipation of paying any awards or settlements as well as the general costs associated with litigation (attorney fees, expert witness fees, etc.)

RESPONDENT SUPERIOR (Latin): "Let the master answer." A legal doctrine under which employers may be held liable for the actions of their employees.

RISK: The possibility of an adverse deviation from a desired outcome. The uncertainty of loss.

RISK MANAGEMENT: The practice of identifying and analyzing risk or losses and taking those measurers necessary to minimize the real or potential losses to levels acceptable to the organization. The risk management function can be broken down into four steps:

1) Identification and analysis of loss exposures;
2) Selection of the appropriate mechanism(s) to reduce or, if possible, eliminate the possibility of loss;
3) Implementation of the chosen technique(s); and
4) Monitoring and review of the results.

STATUTE OF LIMITATIONS: A statute prescribing the period of time within which a legal action may be brought. With certain exceptions, the time period in which a malpractice action must be filed is within two years of the date of the injury or two years after the Plaintiff discovers, or through the use of reasonable diligence, should have discovered, the injury, whichever occurs first. For obstetric cases, patients have 21 years or 2 years after the plaintiff discovers the injury, whichever occurs first. For actions alleging fraud, intentional concealment or a retained foreign object which has no diagnostic or therapeutic effect, the year statute of limitations may be waived.

SUBPOENA: The process by which the attendance of a witness is compelled by authority of the court; Latin: "under penalty", usually abbreviated from subpoena duces tecum, "bring the documents with you under penalty (if you do not)".

SUMMONS AND COMPLAINT: The first notice and initial pleading on the part of a plaintiff in a civil court action. The complaint details the various allegations of misconduct by the defendant as well as a request for monetary compensation.

TERM: The length of time covered by an insurance policy or a premium.

TORT: An injury or wrong committed against an individual.

UNDERWRITING: The process by which an insurance company determines whether or not and on what basis it will accept an application for insurance.

REVIEWED and REVISED:: November 1999