

Chapter 29

Risk Management

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ORIGIN AND SCOPE

Risk management programs began in the 1970s as a response to increasing numbers of medical malpractice claims of hospitals, and they have since been adopted by other types of health care organizations. Risk management is the process of protecting an organization's financial assets against losses from legal liability. It is defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as "clinical and administrative activities that [health care organizations] undertake to identify, evaluate, and reduce the risk of injury and loss to patients, personnel, visitors, and [the organization] itself."¹

Comprehensive risk management is both reactive in its response to events that have already occurred and proactive in its prevention of further occurrences. The primary responsibilities of a comprehensive risk management program are identification of legal risk, prioritization of identified risk, determination of proper organizational response to risk, management of recognized risk cases with the goal of minimizing loss (risk control), establishment of effective risk prevention, and maintenance of adequate risk financing. Risk management in a health care organization requires knowledge of the law and of the legal process, an understanding of clinical medicine, and familiarity with the organization's administrative structure and operational realities.

The full scope of risk management encompasses all organizational activity—operational and clinical—because liability may originate in either area. This purview includes proper building maintenance and food preparation as well as adverse outcomes of medical care and accurate medical record keeping. This chapter, however, focuses on risk management as it relates to the medical care that is provided by a health care organization, called "*clinical*" risk management. Clinical risk management requires close cooperation between the legal department and the clinical administrators responsible for quality assessment and improvement and for clinical functional units (e.g., a hospital patient care unit, a medical office, or the physical therapy department).

Risk management is usually the prime responsibility of either a risk management department or the legal department, which in carrying out this function typically establishes a

close working relationship with the clinical administrative staff. Nevertheless, important risk management functions, such as risk identification, clinical case review, and clinical risk prevention, are the direct responsibility of the clinical staff. Many organizations employ specialized staff, commonly called *risk managers*, who often have training and experience in a clinical field, such as nursing, to work with the legal staff and take day-to-day responsibility for some specified risk management functions, such as the management of recognized risk cases (risk control) and the coordination of overall risk management activity. In this chapter the term *risk administrators* refers to those individuals in an organization with formal, organization-wide risk management responsibility, most notably the legal staff and risk managers. In the context of clinical duties, the term's meaning incorporates clinical administrators such as the director of quality assessment and improvement (quality management) and the chief medical staff officer.

Role

The escalating frequency of litigation and the decreasing affordability of liability insurance have generated the demand for increased sophistication in the identification, control, prevention, and financing of medical risk. For example, the trust fund of a self-insured hospital represents a sizable and important asset of that hospital. A highly synergistic commonality of purpose exists between financial management and risk management. A risk administrator seeks to manage what is substantially a financial risk—the loss of financial assets. This loss occurs through the payment of claims for damages and expenses arising from untoward events that become potentially compensable through judgments or settlements and that may erode the hospital's assets and increase the cost of providing health care.²

Although the basic purpose of a risk management program is to minimize the cost of loss, there is a tendency to evaluate a risk management program solely from a financial standpoint with regard to current cases and claims. Most administrators of successful risk management programs agree that such a "bottom line" view misses the overriding

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purpose of a clinical risk management program. Risk management in a health care institutional setting should be considered first and foremost a means of improving and maintaining quality patient care—the cornerstone of risk prevention.³

In pursuing this goal, risk administrators must have a close, trusting relationship with the clinical administrators who have direct responsibility for many risk management functions. Effective risk management depends on their active participation. Moreover, formal organizational quality assessment and improvement functions should be operationally linked to the risk management program. This linkage should include the exchange of all relevant information and the sharing of formal risk management responsibilities to maximize the understanding of all risk management issues, specific cases, and organizational data. Nonclinical risk administrators must have quick, thorough, and reliable access to medical consultation about clinical issues, specific cases, and organization performance data. The proper relationship avoids duplication of effort, the potential for misunderstanding between the clinical and legal staffs, and the potential to work at cross-purposes in carrying out specific risk management functions.

Risk administrators and quality managers in turn must be operationally linked to and influential in the overall management of the organization. For example, tragic consequences can befall the health maintenance organization (HMO) whose risk and quality administrators' efforts to reverse increasing risk exposure resulting from poor after-hours access to care are ignored and defeated by a financially driven, organization-wide effort to reduce emergency room use.

Despite the necessity of a close working relationship, risk management and quality management are not ideally combined in one department. Risk management is an extension of the legal responsibilities of an organization. Thus an attorney ultimately should direct risk management activity. Fulfillment of quality management responsibilities requires detailed medical knowledge and the trust, respect, and attention of the medical staff. Thus quality management activity is best led and directed by a physician.

An effective risk management program begins with its system for identifying the specific events likely to result in loss and the general clinical areas of risk exposure. This system should be predicated on a current, thorough understanding of the varied sources of legal risk faced by a health care organization. Risk management then proceeds to risk prioritization, risk control, risk prevention, and risk financing.

Sources of Legal Risk: New Developments and Recent Trends

Detailed discussion of the varied sources of legal risk that confront health care providers is covered elsewhere in this text and is beyond the scope of this chapter. However, it may be useful here to point out some recent data and trends that indicate the developing legal risks that are especially problematic for health care providers.⁴

The legal risk most commonly associated with the health care organization is medical malpractice. One of the

more recent reports to provide detailed data on the clinical and operational sources of malpractice risk is that provided by St. Paul Fire and Marine Insurance Company in its 1999 year-end report. In this report, St. Paul offered its policyholders an analysis of claims of physicians and surgeons for the period between July 1997 and June 1999. Appendixes 29-1 through 29-3 demonstrate, respectively, St. Paul's findings as to the top 10 malpractice allegations by average cost, the top 10 malpractice allegations by frequency, and all malpractice allegations by location.

The growing use of clinical practice guidelines may develop as a cause of increased medical malpractice risk.⁵ When followed, practice guidelines are widely viewed as means to improve the quality and appropriateness of care and as shields against liability. Unquestionably they provide great benefits to the extent that they improve the quality and efficiency of care. Unfortunately, they also have the potential to stultify and codify the practice of medicine by establishing innumerable sets of microstandards useful to plaintiffs in proving a departure from the standard of care. In the absence of legal protection accompanying their adoption, fear of deviating from guidelines and the difficulty of remembering their many details may bedevil physicians in years to come.

Another developing contributor to medical malpractice risk is the sometimes inordinate deference given to the principle of patient control over treatment choices. Obstetrical care may be the most problematic area. Today, many patients demand home deliveries, impose restrictions on care given to infants, and even refuse cesarean sections, all of which may pose a grave danger to an infant's health and increase the likelihood of an adverse outcome. Courts have generally been tolerant of patients' asserting their right to pick and choose how obstetrical care will be provided. At the same time, this attitude causes great unease among risk administrators, who note that the single most costly source of risk to a health care organization is birth-related infant trauma, which usually can be avoided by cesarean section. In the absence of reasonable limitations on patient choices, it is fully expected that childbirth-related trauma and other adverse outcomes stemming from increasing patient control over care will grow even more costly to both physicians and their health care organizations.

Failure to obtain informed consent is another important source of risk. It may give rise to an intentional tort or may be a secondary count in a medical malpractice action. States are divided in their approach to determining what information must be provided to patients to enable them to decide whether to accept the risks of proposed treatment. Some states require the disclosure of information that a reasonable physician would disclose to that patient, whereas others require the disclosure of information that a reasonable patient would feel was material to his or her decision of whether to accept the risks of treatment. As more clinical outcomes performance data become available, those data may play an increasingly important role in determining the content of disclosure. Risk administrators must be aware of and educate their physicians about the need to meet the legal standard of disclosure, particularly

if their organizations are located in states applying the "reasonable patient" standard. For example, a patient preparing to undergo heart bypass surgery at a hospital that is a high mortality outlier for this surgery might expect such information to be disclosed when the risks of surgery are discussed. In a cogent essay, physicians Topol and Califf argue for more extensive disclosure to patients of institution- and physician-specific outcomes data. Using coronary artery bypass surgery as an example, they suggest the following:

In the future, an ideal approach would be to shift "full disclosure" to inform patients. On the consent forms that patients sign before the procedure, the cardiologist and cardiac surgeon could include their actual risk and success rates, when appropriate, for the past several years, the cumulative number of procedures the physician has done, and the site's overall rate of complications for the procedure. This up-front disclosure to patients would be revolutionary because it is rarely practiced today. Without furnishing such data up front, we are not truly providing informed consent.⁶

Within the context of a patient's right to consent to or refuse treatment, an important question is whether care or treatment may be withheld or withdrawn from certain patients. The law in this area remains in a rather formative stage and varies from jurisdiction to jurisdiction. Generally speaking, care may be withheld if such care or treatment would be futile or would only delay the certainty of death. Withdrawal of care that has already been initiated is more problematic. In the absence of death, reliance may be given to living wills and durable powers of attorney for health care that under certain circumstances allow for care to be withdrawn. One or the other of these two types of advance directives is recognized by most states. In addition, some states have enacted health care surrogacy acts, which permit individuals other than the patient (usually the next of kin) in the absence of an advance directive to consent to or refuse medical care on behalf of a patient who lacks decisional capacity and may be terminally ill, in a persistent vegetative state, or suffering from an incurable or irreversible condition that will ultimately cause death. On the condition that they follow in detail the requirements set forth, these acts generally provide immunity from suit for health care providers who withdraw care from patients. In the absence of the death of a patient and in the absence of an executed advance directive, withdrawal of care may still be permissible on the order of a court of competent jurisdiction. Although resorting to courts may be costly and time-consuming and may generate media exposure, recourse to a court of law in an area that has not been previously clarified in a particular jurisdiction will provide the greatest amount of protection to the hospital, patient, family members, and other health care providers.

Another developing area of medical-care-associated risk is maintenance of confidentiality. Examination of state law reveals an array of privacy protections, frequently with gaps and areas of uncertainty. Often, paper records are presumed, so the status of electronic data is unclear. Consequently a developing area of risk is the release of electronic, patient-level data to government regulators,

business coalitions, insurers, and quality monitoring projects. A health care organization's marketing, information systems, and quality management staff may be insufficiently aware of confidentiality issues and therefore may release data with patient identifiers, such as name, address, and social security number, linked with personal information, such as diagnoses and procedures. All staff should be educated about the importance of maintaining patient confidentiality and should ensure that any electronic patient information released from their organization without specific patient consent is stripped of externally recognizable unique patient identifiers and is allowable under law.

Increasingly, health care institutions will be held accountable for the actions of providers on their staffs through the expansion of the corporate negligence theory, in which institutions have been held to have duties to properly maintain their facilities, to have available the necessary equipment, to hire, supervise, and retain competent and adequate provider staff, and to develop and implement policies and procedures that promote quality care. More recently, many courts have enhanced the corporate responsibility of health care institutions through the use of agency theory and a more expansive concept of corporate negligence, incorporating the duty to protect patients from medical staff negligence through the assumption of more control over the quality of care delivered within its facility and the duty to properly credential medical staff members.⁷ The federal Health Care Quality Improvement Act of 1986 extended the corporate responsibility of health care organizations by requiring them to make reports to and check with the National Practitioner Data Bank maintained by the Department of Health and Human Services. Failure to check the data bank may subject an organization to the burden of being constructively informed of (i.e., deemed to have knowledge of) the information it would have received had it done so, with this information being admissible in medical malpractice actions.

Finally, important developing sources of medical liability risk for both managed care insurers and managed care providers are found in the areas of utilization review, benefit determination, and capitation reimbursement. The line between insuring care and directing care is rapidly evaporating. Insurers have exerted leverage through a variety of maneuvers, such as requiring second opinions, denying claims, and canceling provider agreements. In the tradeoff of discounted fees for patient referrals, the best interests of patients may not always be given sufficient consideration. It is likely that this will be an area of increasing controversy between patients and health care organizations. Although verdicts against managed care organizations (MCOs) may serve as a wake-up call to insurers (e.g., *Fox v. Health Net of California*), hospitals and physicians have no immunity from being equally culpable if medical decisions are made on financial grounds.⁸ Risk administrators of MCOs should be vigilant in searching for inappropriate financial incentives to limit benefit coverage and utilization of services.

RISK IDENTIFICATION

Importance of Early Risk Identification

Risk of financial loss through legal liability presents itself to an organization in one of two ways. It can appear in the form of an individual patient event that, on inspection, carries with it a significant risk of liability. The actions that may result in liability in a specific case could be unique to that case or could be part of a general pattern of problem care or activity that can be referred to as *risk exposure*. Risk exposure can be identified even in the absence of a specific risk case related to it because a pattern of activity may be “risky” in terms of liability even though no specific patient injury related to that activity has yet occurred. The earliest recognition of both types of risk is crucial to a health care organization and as such is a fundamental risk management activity.⁹

The benefit of early risk detection is that it enables risk administrators to conduct the earliest possible investigation of any identified risk cases and to intervene against risk exposure with prevention strategies before any, or at least further, risk cases develop. Successful risk management departments do not wait to be sued before undertaking an investigation of a case and establishing a defense or settlement posture. Within a 2-year time (the period for most statutes of limitations pertaining to medical malpractice), valuable testimony and evidence about a risk case may be lost. All health care organizations should have a set of methods in place to obtain the earliest possible notice or warning of a specific risk case or risk exposure. Quick recognition of a risk case can enable attorneys and risk managers to record the facts of the case when the events are fresh in the minds of the participants and to counsel members of the organization on how to respond to the event. A particular opportunity exists to ensure that the organization delivers subsequent care and administrative services in an expedited and satisfactory way to minimize any patient and family anger over the incident. With proper methods in place, a risk management program should have knowledge of most risk cases long before service of process is made. More sophisticated risk management programs should have notice of 75% or more of the incidents that eventually result in lawsuits filed against the organization.

Methods

Most health care organizations use a variety of means to identify risk cases and risk exposure. In reactive case identification an organization assesses for risk in cases identified external to the organization as being problematic. In proactive case identification an organization initiates the identification of cases that are more likely than others to contain risk. Finally, in data-based performance monitoring an organization moves beyond the individual case as the basis of risk identification and focuses on performance monitoring as the means to uncover risk exposure. Risk administrators should use each of these three general approaches in their identification of risk cases and risk

exposure. These approaches are complementary, for risk detected by one may be entirely missed by the others. Risk management programs that rely on only one or two of the approaches run the great danger of failing to recognize all identifiable risk cases and areas of risk exposure. However, some methods within each approach are more likely than others to detect risk, so risk administrators with limited resources should select those methods that are most cost-effective in their organizations. Once a case has been identified as a risk case it is managed according to the principles discussed in later sections on risk prioritization and risk control.

External Case Identification

Legal Actions

The easiest and most instinctive approach to the identification of risk is the assessment of clinical events that come to an organization's attention in the ordinary conduct of its business. The clearest example of this is a lawsuit. Every organization is compelled to assess and respond to legal actions against it. Such an assessment usually entails a careful examination of the specific circumstances of the clinical case, including a peer review of the medical record. By definition, a lawsuit establishes a case as a risk case because even if an organization feels that the likelihood of loss from liability is small, the cost of preparing for litigation and the cost of the litigation itself amount to a significant financial loss even without the finding of liability.

Medical Record Requests

The review of medical records requested by attorneys is another method by which risk can be identified. The fact that an attorney is requesting the records indicates that the case is involved in some legal activity, and some organizations routinely review all such cases. However, reviewing all attorney-requested records, no matter how natural it may seem as a response, can be problematic. First, medical records may be requested for reasons other than suspicion of wrongdoing by providers or institution (e.g., disputes involving payment of claims or worker's compensation). In the absence of knowledge about the reason for the record request, detailed review of every requested record can be an unfocused activity that may produce a low yield of findings and hence may not be cost-effective. At the same time, a cursory review of requested records might produce reliable identification of those cases deserving more detailed review.

Patient Complaints

Review of patient complaints is a good way to detect cases with risk and poor quality. Many organizations have a formalized mechanism for handling patient complaints. Often, descriptive statistics of patient complaints are generated routinely, such as a monthly compilation of all complaints by type, clinical/administrative area, and involved providers. A focused review of complaints that on their face suggest risk or poor quality can be a reasonably productive undertaking when attempting to discover problematic cases.

Billing Disputes

Often, patients refuse to pay bills because they believe that the care received was substandard and therefore not deserving of payment. As a result, like patient complaints, review of billing disputes is an excellent method of identifying risk and quality deficiencies. However, the cost-effectiveness of reviewing billing disputes is compromised because some patients make accusations of poor quality simply to justify their refusal to pay for care. Even reviewing the records of only those billing disputes in which there is an accusation of poor quality would result in the review of many cases in which the accusation was knowingly unfounded. Detailed clinical review of all cases resulting in a billing dispute should probably be reserved for cases involving either large sums of money or significant accusations of substandard quality.

Internal Case Identification

Occurrence (Incident) Reporting

Rather than wait for a legal action, a record request, a patient complaint, or a billing dispute to initiate the process of risk identification, most organizations ask their staff to notify the risk management or legal department whenever an untoward or unusual incident occurs. This process is often referred to as *occurrence reporting*. Often a special form, commonly referred to as an *incident report form*, is provided for this purpose. This form indicates the minimum, specific information that must be provided about the incident (Appendix 29-4 is an example). Although the information contained in incident reports is commonly protected from legal discovery by state law, some institutions request that reports of patient harm resulting from medical misdiagnoses, therapies, and procedures be reported verbally rather than in writing.

Incident reporting can be useful in identifying areas of risk exposure. Its usefulness as a method of identifying specific risk cases is limited, however, by a number of factors. The reliability of incident reporting can be compromised by the clinical staff's failure to appreciate a risk case or an area of risk exposure, uncertainty about what events to report, fear of getting involved, ignorance of how to file a report, and apathy. Risk administrators must recognize these barriers to reliable incident reporting and take active steps to eliminate them. Risk administrators should work hard to establish a trusting relationship with all physicians, who often see incident reporting as a nursing function and are wary of admitting the occurrence of adverse clinical outcomes. Physicians should be continually reassured that their communications will be held in the strictest confidence and that their statements will be protected from legal discovery. Physicians should be allowed to report incidents verbally, which should make reporting easier and somewhat alleviate their fear of reporting.

Progressive organizations actively cultivate a network of risk-sensitive and risk-educated clinical and administrative staff to facilitate incident reporting—a matrix of what can be called *risk management champions*. This effort is especially directed at having risk management champions in important areas of patient care and patient interaction. The theory

underlying this matrix approach to information gathering is that within an organizational infrastructure (departments, units, sections, and ancillary services) there are certain essential intersections through which potential plaintiffs are likely to pass. Important intersections include a hospital's surgical recovery room, emergency room, intensive care unit, and patient relations department. In addition, the utilization management department, given its expanding role both in hospitals and in MCOs and the detailed data bases used, can be one of the best and most reliable sources of information about potential risk cases. Furthermore, the clinical departments of radiology and perhaps even more importantly pathology often are recipients of crucial information that medical malfeasance has occurred. Progressive risk administrators aggressively solicit and maintain a network of risk management champions located in important areas of patient contact.

A refinement of incident reporting is specified occurrence reporting. With this method, risk administrators specify a set of events that must be reported by staff. This approach takes incident reporting a step further to educate the staff about what specific events must be reported. Staffs are nonetheless still encouraged to report any unspecified event or possible area of risk exposure. Specified occurrences can be significant adverse outcomes of medical care (such as significant postoperative complications), accidents or mishaps in the provision of ancillary medical services (such as needle stick injuries), and non-medical-care-related accidents that occur in the institution (such as slip and fall injuries). Many of the specified occurrences are organization-specific based on the particular risk exposure history.

Random Medical Record Review

Random medical record review was one of the first proactive approaches taken to uncover problem cases. It consisted of unfocused peer review of randomly selected medical records and for a time was a widespread "quality assurance" activity. However, because of its low yield of positive findings, it has now fallen into disfavor as a method of case identification in quality management. It never found use in risk management because the less frequent occurrence of risk, compared with quality deficiency, made this method cost-ineffective for risk identification. Nevertheless a program of random medical record review by providers can be beneficial in educating them about the wide variety of practice styles and approaches present among the staff and over time may lead to a group consensus on the identity of relatively weak performers.

Occurrence Screening

In an effort to avoid the potential unreliability of occurrence reporting, many risk administrators identify groups of cases for screening review without depending on reporting from the staff. This method identifies groups of cases in which the yield of detailed review is likely to be higher than with routine review of cases identified through incident reporting (or its variant of specified occurrence reporting). The criteria used to identify cases for review are event based (e.g., all emergency room deaths) and can be

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specified as the result of a known institutional area of concern about clinical quality or risk (e.g., all coronary care unit deaths from cardiac dysrhythmias). The event that flags a case for review can on its face represent a quality problem (e.g., all medication errors), which may or may not create risk depending on the specific facts of the case, or can be nonspecific (generic). The latter events are generic in the sense that they are not particular to a certain type of case or a certain field of medical practice. Commonly used generic screening events, often called *generic indicators*, include unexpected inpatient death, unplanned postoperative return to the operating room during the same admission, and unplanned postdischarge readmission to the hospital within a specified time period (such as 14 days). The occurrence of a generic event does not imply a quality deficiency or the presence of risk in that case. That is, the fact that a patient recently discharged from the hospital needed to be readmitted within 14 days of discharge does not imply a quality or risk problem. Each case identified by a generic occurrence indicator must be carefully reviewed to determine whether any quality deficiency or risk is present.

Occurrence screening has found wider use in quality management than in risk management, where the approach to case evaluation is still based primarily on external case identification and occurrence reporting. Even in quality management, though, occurrence screening has met with mixed results as a method for uncovering quality deficiencies. Most cases that meet a criterion are not found by detailed peer review to have a quality deficiency, leading many to conclude that the expense involved in identifying the cases and then having them all reviewed by busy professionals is not justified by the relatively low yield of findings. The growing consensus is that most cases with quality problems and risk are not detected by the widely used generic screening criteria, and that of the cases that do meet screening criteria, after careful and time-consuming review most do not contain risk or a quality deficiency.

Case Evaluation

Once a case has been identified as a possible risk case through one of the methods just discussed, the medical record is reviewed clinically. A physician who is an experienced reviewer of cases and who has an understanding of the potential sources of liability should first review the case. This physician should recognize the need to be completely objective in assessing for quality of care deficiencies, a risk event, and risk exposure. This physician may have a formal administrative role in the organization, such as the medical director overseeing the quality management activity. If the care is squarely within the field of the experienced physician reviewer, that review may be the only one necessary, especially if the physician finds no arguable evidence of quality deficiency or risk. In any cases of doubt the physician reviewer should refer the case to another physician for a second review. Risk administrators should realize that complex cases often involve care in more than one clinical field. Therefore it is imperative that all aspects of the patient's care be carefully reviewed. This may require a

review by an internist or pediatrician (general or subspecialized) of surgical cases because all surgical cases involve at least some "medical" care.

Evaluation of clinical care by peer review usually includes determination of any culpability of the involved providers and institution. The results of case review can help assess the risk in that specific case, as well as identify organizational risk exposure or substandard providers. Unfortunately, peer case review as a method of identification of risk and quality deficiency is compromised by the understandable reluctance of clinicians conducting the review to criticize the care provided by colleagues with whom they may practice and socialize. This reluctance is magnified by the frequent defensive posture of clinicians regarding clinical care in general and the widespread fear that an adverse assessment will create interpersonal conflicts and be returned in kind when the roles of reviewer and reviewee are reversed in a future case. Moreover, clinicians often differ in the issues that they think are of paramount importance in a specific type of clinical case, which occasionally results in multiple reviewers of the same case focusing on different events and different aspects of care.¹⁰ These factors create a bias against the recognition of poor quality and risk. This bias may be less problematic in a provider's assessment of system deficiencies, as opposed to provider-related deficiencies, but still could be considerable. Risk administrators must recognize the potential for this bias in provider assessments of individual cases and take decided action to minimize it. Initial review by a trained reviewer and the subsequent use of multiple reviewers can reduce the effects of this bias.

Many experienced risk administrators and clinical managers have had the experience of seeing two physicians come to dramatically different conclusions after reviewing the same case record.¹¹ Sometimes this discordance stems from a genuine disagreement over the proper clinical care for a specific problem. Occasionally, however, in complex cases two physicians (or other clinical providers) may focus on entirely different sequences of care and come to different conclusions about the case in question. Informed only that a suit has been filed by the family of a hospital patient who died unexpectedly as a result of postoperative sepsis, one reviewer may concentrate on postoperative wound care, whereas another may direct most attention to the question of whether the proper prophylactic antibiotics were given.

A second problem with peer review is that, even when practitioners agree on the specific care to be examined, they may not agree on the appropriate standard of care against which to judge the actual care provided. Indeed, some reviewers have difficulty articulating a standard of care at all and may appear to regard all but the most egregious care as acceptable.

A third problem with peer review is that often it is not thorough. Many practitioners, especially physicians, feel overwhelmed by the time demands of clinical practice and are unwilling to devote much energy to ancillary responsibilities like peer review. Moreover, physicians in particular are often hostile toward the legal process and may have a

tendency to diminish the legitimacy of clinical issues identified through it. At times, physicians charged with conducting a case review only cursorily review the record, skimming physician notes and ignoring nonphysician notes all together. (Nonphysician notes are often of crucial importance in understanding the care in a case.) Laboratory data, radiology reports, and pathology data may receive only brief attention.

Risk administrators can use a number of approaches to increase the usefulness and reliability of peer review. One approach is to cultivate a network of willing, fair, and thorough case reviewers on which to rely. Risk administrators should continually reinforce the need for thoroughness and fairness in the evaluation of care by peers. Risk administrators should foster the development of this group with informal training and should demonstrate appreciation for the reviewers' efforts.

Another approach is to adopt a structured, explicit method of case review. Structured, explicit case review is designed to reduce the unreliability of case review through explicit identification of questionably problematic sequences of related care and the corresponding standards of care. Case review begins with a "foundation review" by an experienced case reviewer, preferably with a background in quality and risk management, who identifies the major processes of care and any issues associated with them. For each issue identified a written form is prepared that asks subsequent reviewers to explicitly state in writing the standard of care for all aspects of related care in which a problem was spotted and to assess the care against that standard. Reviewers can be asked to reference applicable published or organizational practice guidelines. Reviewers are given space to identify and comment on issues not identified during the foundation review.

A final technique is to ask more than one reviewer to perform a structured, explicit review. As stated earlier, it is often useful to have reviewers of different specialties assess a case, particularly if it is a surgical one.

Routine structured, explicit peer review of all cases identified as possible risk cases is too costly and is unnecessary. Although they are an important and indispensable source of information, most cases identified either internally or externally, with the exception of lawsuits, ultimately are not found to contain either risk or a quality deficiency. Therefore an experienced reviewer who can create a structured, explicit case review form if necessary should screen all identified cases first. Structured, explicit case review should be reserved for those cases that appear on initial screening review to have resulted in a serious adverse outcome and a measurable risk of liability.

Strengths and Limitations of Case Identification Methods

Although all case identification methods can reveal cases with a risk of loss, some are more useful than others in identifying cases with probable losses. For example, informal studies by hospitals indicate that incident reports are generally poor predictors of lawsuits, which perhaps is not surprising given the large number that are filed in organiza-

tions with aggressive risk management programs. However, incident reports remain useful sources of information that can reveal potential risk cases and areas of risk exposure. On the other hand, attorneys' requests for medical records, patient complaints, and billing disputes are factors associated with a higher probability that a lawsuit will follow.

However, case-by-case evaluation does not provide the entire picture of organization-wide clinical risk exposure and quality of care. It paints a picture only of those cases that were identified and is not a complete sample of all cases with risk, risk exposure, and quality problems. In particular, cases that result in a patient complaint are a biased sample of patients from which to make inferences about overall organizational clinical risk because not all patients are equally likely to register a complaint given the same care. Inferences about the general state of clinical risk exposure and quality of care should not be made solely from a review of cases flagged through external identification methods and by occurrence reporting.

Despite various strengths and limitations, all of the aforementioned methods for case identification should be used by a health care organization. Because no method is perfect, a case overlooked by one method may be detected by another. The use of a wide variety of case-specific risk identification methods can be enhanced but not replaced as a method of identifying risk exposure by data-based performance monitoring.

Data-Based Performance Monitoring

Data-based performance monitoring is a method for assessing organizational quality of care and risk exposure that has developed recently and is growing in importance. It is a method for identifying areas of quality deficiency and risk exposure as opposed to specific risk cases. Its premise is that an indispensable way to assess organization-wide clinical risk exposure and quality of care is to monitor everyday activity, which has the benefit of avoiding the reporting bias encountered with many of the already discussed methods of risk identification. Data derived from continuous monitoring are used to either identify quality deficiencies and risk exposure or monitor an organization's response to corrective action taken to remedy previously identified quality and risk problems.

The initial purpose of data-based performance monitoring was the assessment of quality of care. Interinstitutional public release of data-based assessments of clinical performance began in earnest with the Health Care Financing Administration's report on hospital mortality rates in the care of selected Medicare patients. Subsequently, various projects have begun ongoing compilation and reporting of comparative hospital performance. Some are sponsored by state agencies and some by voluntary coalitions. Private comparative data are also available. A primary goal of these programs is to stimulate internal quality improvement through comparative performance assessments. Many organizations also gather clinical outcomes data internally and compare their results with published benchmarks or information obtained from outside data bases.

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Risk administrators should be aware of all comparative performance data available on their organizations. Proper interpretation of comparative performance data requires a working familiarity with the strengths and limitations of clinical outcomes monitoring and provider performance profiling.^{12,13} Heretofore, analysis of clinical outcomes data has been the province of clinical quality management staff, in no small part because of its substantial clinical and statistical content. However, comparative clinical outcomes data should be of great interest to risk administrators because they may point out areas of substandard hospital performance and consequently risk exposure. Hospitals with high adverse outcome rates (e.g., mortality) in specific areas of care should aggressively analyze their processes of care in an effort to reduce the rate of adverse outcomes to the lowest achievable levels. High adverse outcomes in specific clinical areas may indicate unusually high-risk exposure in those areas. Although performance data aggregated over hundreds and thousands of cases do not give information about a specific case, a pattern of persistently high severity-adjusted adverse outcomes in a specific clinical area may signal a deficiency in the quality of care, which may have already and could in the future lead to liability in specific cases. For example, a hospital with a high surgical mortality rate, after adjustment for the severity of illness of its patients before surgery, may have clinical problems that result in greater risk exposure than hospitals with lower rates. Comparative performance data afford risk administrators an excellent means of risk identification.

Performance data have a second important use. They are indispensable as a tool used inside an organization to continually assess its success in eliminating areas of known risk exposure. This process entails the design and continual measurement of risk indicators and is discussed later in the section on risk prevention.

RISK PRIORITIZATION

Risk administrators must prioritize identified risks to expend organizational resources in the most cost-effective way. Organizations usually have limited resources of personnel time and attention. Most risk administrators concentrate risk prevention efforts on events that are infrequent but of great consequence, on the one hand, and events that are of lesser import but of frequent occurrence.

A rare event of relatively minor consequence often can be handled directly without assembling a quality improvement team. Sometimes the source of risk exposure is suggested by a pattern of events or by data, and the challenge is first to discover the source of the problem. At times the cause of risk exposure is obvious, such as a physician office's failure to have all routine screening mammogram reports reviewed by a physician or nurse, and so preventive efforts can be focused immediately on faulty clinical or operational processes. The intensity of administrative risk prevention efforts should be tailored to the complexity of each individual risk. Clinical problems will usually require a multidisciplinary team, including physicians, with familiarity in all involved clinical and operational areas.

Risk prioritization is important in both assessing the proper response to a recognized risk case (risk control) and in allocating resources for risk prevention. For example, medication errors frequently occur in hospitals. These errors generally include delays in providing patients with prescribed doses of medicine. Identification of such delays is most frequently accomplished through incident reports but also may be identified through occurrence screening, random medical record review, or patient complaints. The total number of medication delays may then be divided between those delays that actually injured patients and those that had the potential to injure patients. Obviously, risk management personnel must give immediate attention to an error that has resulted in an injury to a patient. In determining the proper response to a medication delay, risk administrators should seek to answer the following questions: Did the error result in an injury to the patient? How significant was the injury? Was the injury of a temporary nature or of a more permanent nature? Has it compromised the care of the patient? Will the adverse effect on the patient extend beyond the current hospitalization? What was the reason for the delay? Was the delay the result of an individual error or a larger institutional problem? Is this an error that has occurred before, on a particular unit, or during a specific shift? Did a specific health care provider cause the error?

The differences between iatrogenic and custodial injuries serve as an illustration of the kind of considerations important in risk prioritization. The distinction between iatrogenic and custodial injuries is relevant when assessing these two types of injuries in terms of frequency and severity—the two major considerations in prioritizing the organization's response to specific risks. Frequency refers to how often the type of injury occurs, and severity refers to how likely it is that the type of injury will result in financial loss. Custodial injuries are estimated to account for as much as 75% to 85% of all patient injuries in hospitals and ambulatory care areas. However, measured in terms of financial loss, custodial injuries account for less than 25% of aggregate losses. Iatrogenic injuries, on the other hand, although less frequent than custodial injuries, account for approximately 75% to 85% of hospital losses.¹⁴ The lesson to be learned from the distribution of risk between iatrogenic and custodial injuries is not that a concentrated effort should be directed only toward the prevention or management of iatrogenic claims; hospital risk management programs obviously must address both types of injuries. The lesson, rather, is that their relative risks must be carefully evaluated to achieve a balanced approach in preventing and managing both types of injuries.

Identification Of Major Risks

What risks should be considered major risks? For most organizations a list of major risks can be found in their reporting requirements under excess liability policies. For hospitals, such mandatory reporting is typically required in the event of the following injuries to a patient: unexpected

death; brain damage; neurological deficit, nerve damage, or paralysis; loss of limb; or failure to diagnose a condition that results in a continuous course of treatment. In addition to the aforementioned events, a catch-all provision is often included that requires reporting of any claim or medical incident the value of which is equivalent to a certain percentage (e.g., 50%) of the self-insured retention limits. This list is not exhaustive, but if a hospital risk management program is constrained because of financial or staffing limitations, it can serve as a priority list that fulfills most needs.

Key Specific Risks

Risk management programs of large health care organizations may find it necessary to use a more detailed list of key specific risks. Such a list may be compiled based on the individual experience of that organization. Using a hospital as an example, a typical list includes the following major headings: medication error, patient fall, equipment related, security related, blood related, surgery related, anesthesia related, food related, patient induced, policy related, radiology related, medical record related, laboratory related, intravenous line related, newborn related, maternal related, and physician related. Box 29-1 contains a representative sample of subcategories for each of the aforementioned key specific risks. The categorization of risks associated with a specific hospital will, of course, vary depending on the risk experience of that hospital.

RISK CONTROL

Risk control is the process of managing a recognized risk case to minimize the potential for loss. Most risk administrators find their time primarily directed toward risk control, rather than risk prevention, for an obvious reason: A lawsuit represents an actual loss. Even if successfully defended, a lawsuit will result in expenditures for its defense, primarily in terms of fees for legal counsel and expert witnesses. Tangentially there also may be an increase in insurance premiums or in the organization's deductible. Consequently, risk administrators find a greater part of their time allocated to risk control than to risk prevention.

Completing the Initial Investigation

On identification of a risk case an initial investigation is undertaken. This investigation has two purposes—the early assessment of probability and value of loss and the identification of relevant sources of information. The essential steps necessary to complete these objectives are (1) review of the medical record; (2) interview of the potential defendants for whom the organization provides insurance coverage; (3) identification, cataloging, and collection of physical evidence that may be relevant and could otherwise be lost or misplaced (e.g., monitor tracings, temporary logs, and policy and procedures); (4) identification of witnesses who may have information concerning the incident and who might have to be

interviewed at a later time because of time constraints; and (5) collection of medical bills. This five-step initial investigation is not intended to serve as an extensive investigation or to replace the more thorough investigation conducted upon service of process. It is only a preliminary action to determine the essential facts of the case and to identify which personnel have personal information about the incident.

With this information in hand, risk managers and attorneys select and prioritize those incidents that warrant further investigation. This process fulfills the essential risk control functions of gathering and assessing information about potential losses and prioritizing time and efforts toward investigation of probable losses.

Predicting the Potential Plaintiff

An important part of identifying those risk cases likely to result in loss is predicting which patients will bring a lawsuit. As varied as plaintiffs may be, many of them share certain common characteristics. The following factors often determine which patients are most likely to sue a health care organization.

Poor or Unexpected Results

The most reliable identifying characteristic of the potential plaintiff is that he or she has suffered an unsatisfactory outcome as a result of or despite medical care. The outcome may be direct harm (e.g., a postsurgical complication) or a result that, although not harmful per se, is less than that expected after the care (e.g., unsatisfactory outcome of cosmetic surgery). A poor or unexpected result from medical care does not mean, of course, that any medical malfeasance has occurred.

Seriousness of Injury

Another characteristic of the potential plaintiff is that the injury sustained is permanent and serious, involving death, disability, or disfigurement. Disability may be manifested in various ways; at a minimum, it usually must be sufficient to have resulted in lost wages. The economics of pursuing a legal claim and the impact of medical malpractice reforms have served to impose a modicum of self-regulation and limitation on medical malpractice claims, reducing claims for minor injury and claims that might be frivolous.

Weak Physician–Patient Relationship

A third trait of the potential plaintiff is the absence of a strong relationship with his or her physician. The single greatest deterrent to litigation remains a strong physician–patient relationship rich with positive interactions and communication. A recent study analyzing the demographics and risk of malpractice concludes that a physician's gender, specialty, and age affect the risk of a suit. Of note, male physicians were three times as likely to be in a high claims group as female physicians. The investigators surmised that female physicians may interact more effectively with patients than their male colleagues.¹⁵

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Box 29-1. Operational Subcategories of Key Hospital Risks

Medication error

Adverse reaction
Wrong route
Wrong patient
Pharmacy error
Medication not given
Wrong medication given
Medication duplicated
Medication not ordered
Medication not given at correct time
Transcription error
Medication given despite hold order
Wrong dosage

Patient falls

Caused by a liquid or substance on floor
Fall from bed (siderails up? siderails down? position of siderails unknown?)
Fall in bathroom
Fall in room
Fall outside of room
Fall off table or equipment
Fall in elevator
Fall from crutches or waiter
Fall outside of building
Fall from chair or wheelchair
Near fall with assistance

Equipment related

Failure of life support or monitor
Equipment missing or unavailable
Injury related to medical device

Security related

Personal property damage
Personal property disappeared
Injury resulting from conduct of another patient

Blood related

Wrong blood
Transfusion reaction

Delay in transfusion

Surgery related

Incorrect sponge count
Incorrect surgical instrument count
Surgical instrument broken
Loss of pathology specimen
Unplanned return to surgery
Removal of retained foreign body
Unplanned return after readmission

Anesthesia related

Respiratory distress reaction
Related to intubation or related to extubation

Food related

Poisoning
Foreign body
Improper diet
NPO order violated
Burns from foods or liquids

Patient induced

Attempted suicide
Self-mutilation
Refusal to consent to treatment
Returned late from approved pass
Discharge against medical advice
In possession of drugs, alcohol, or weapon

Policy related

Procedural error
Violation of physician order
Performance of wrong procedure
Autopsy signed with no autopsy performed

Laboratory related

Transport delay
Identification problem
Loss or damage of laboratory specimen
Incorrect reading

Intravenous line related

Infiltration
Wrong solution
Contaminated or expired solution
Line disconnected
Incorrect timing
Pump malfunction
Incorrect rate
Central line complication

Newborn related

Apgar scores of less than 3 at 1 minute
Apgar scores of less than 7 at 7 minutes
Skull fracture
Resuscitation
Transfer from in-house nursery to special-care nursery
Meconium aspiration

Maternal related

Maternal injury from obstetrical treatment
Blood loss

Physician related

Failure to diagnose
Unexpected death
Brain damage resulting from treatment
Injury relating to resident supervision
Adverse reaction
Delay in response

Radiology related

Reaction to contrast dye
Unmonitored cardiac or respiratory arrest
Disappearance of films

Medical records related

Orders not charted
Consent not signed
Disappearance of record

Uncertain Financial Future

Many plaintiffs are individuals who face an uncertain financial future. They are often unable to withstand the financial burden of medical expenses attendant with a poor or unexpected result. Therefore potential plaintiffs are frequently unemployed, underemployed, recently retired, single or recently divorced, or students.

Strong Support Group

The last trait frequently found among potential plaintiffs is the presence of a strong support group, especially if there are family members who are directly or indirectly associated with medicine or law. As socially acceptable as litigation may be in the United States, persevering through the process of selecting an attorney and initiating legal action

still requires a certain degree of motivation and strength, which can be buttressed by supportive family and friends.

In preparing themselves to initiate a lawsuit, potential plaintiffs commonly use similar phrases, with which most risk managers quickly become familiar. Many potential plaintiffs, instead of making a direct threat to sue, often use expressions such as "I want to make sure that this never happens to another patient," "I want to teach you a lesson," and "I am not interested in the money, it's the principle."

Conducting Investigations

In conducting investigations, risk administrators need to be aware of legally imposed limits and restrictions.

For example, some courts have ruled that risk administrators may not interview subsequent caregivers of an injured patient. Some courts have extended this theory to prohibit discussions even with members of a hospital's house staff and nursing staff. The rationale is that such ex parte discussions violate the sanctity of the physician-patient relationship and are prohibited under physician-patient privilege statutes.¹⁶ A second rationale offered is that a physician has a fiduciary duty to refrain from assisting his or her patient's adversary.

Although the aforementioned rationales may be persuasive regarding subsequent providers who care for the patient and are not used by the health care organization, application of a rule that bars an organization from interviewing employees creates a number of practical problems. Such a restriction would prevent the organization from being able to respond to a complaint, develop litigation strategy, provide accurate or complete responses to discovery requests, prepare employees adequately for depositions or trial, depose experts adequately, and prepare the best presentation at trial.

Of equal concern to an attorney is the protection of investigative reports and interviews from disclosure. There are two avenues by which such protection may be ensured. A recognized principle is that such information constitutes "work product." The work product principle protects an attorney's representation of his or her client's interest and requires that good cause be shown before a court will allow discovery of an attorney's preparation of the client's case. Generally, work product includes information prepared by an attorney or his or her representative (e.g., a risk manager) in anticipation of litigation. Such information includes personal knowledge and legal theories, as well as statements of witnesses. This principle, though, does not necessarily protect information about the location of such information and the names and addresses of witnesses. In applying this principle to the protection of reports and interviews made by attorneys and risk managers, care should be taken to follow the general rules of the work product principle. Disclosure of such information to a third party may result in loss of ability to assert the principle to defeat discovery requests by the other party. If information is gathered by nonattorney risk administrators, the information should be forwarded to the attorney, sometimes with the inclusion of a statement that it is being sent to assist the attorney in contemplated litigation.

A second means of protecting such information from discovery by the other party may be available under state statutes that prohibit disclosure of information used internally to improve patient care or to reduce morbidity and mortality. Precise adherence to the rules set forth in a statute usually is critical to protect the information from disclosure. Some statutes may address only hospitals and have not been updated to incorporate HMOs. Generally, information is protected when used and discussed within recognized health care organization committees for quality improvement purposes.

Notifying Insurance Carriers

Risk administrators have the responsibility to properly notify an insurance carrier of a claim or possible claim that exposes its coverage. Reference to the exact wording of the insurance policy, of course, is critical as to the necessary timing and scope of notification. Generally, the notice requirement is phrased in one of two ways: A policy may require that the insured give the carrier "immediate notice of a lawsuit" or may require notice "when it appears that an occurrence is likely to involve indemnity" under the policy. The second type of notice language can be particularly problematic for a health care organization because it is vulnerable to a subjective interpretation as to when an occurrence is "likely to involve indemnity." The phrase may be interpreted from both an objective and a subjective standard. The controlling rule in insurance law is that if the language of an insurance policy is ambiguous or otherwise susceptible to more than one reasonable interpretation, it is to be construed in favor of the insured. Notwithstanding this rule, insureds may wish to be cautious and provide notification at the earliest possible moment that it appears a carrier's insurance policy may be exposed.

Selecting Defense Counsel

The skills expected of a litigator are likely to be different from those of a corporate attorney. Of course, competency, truthfulness, honesty, and responsiveness are important traits in both, as well as the ability to communicate effectively with the client. On the other hand, a certain aggressiveness that might be expected of a litigator might be inappropriate in a corporate attorney. Undoubtedly, one of the greatest assets of a litigator is that he or she possesses the capabilities to take a case to trial, advocate the position of the defendant(s), and, of course, obtain a favorable verdict.

As with the selection of any other consultants, in selecting defense counsel a health care organization would do well to keep in mind the following:

1. Selection should not be made solely on the basis of price.
2. Expectations should be made clear to the defense counsel from the outset.
3. A new defense counsel, regardless of his or her reputation, should always be started on a small project or a single case to ensure that a positive working relationship will result.
4. The defense counsel should be allowed reasonable professional latitude to do his or her best job, although giving defense counsel freedom of action does not eliminate the organization's responsibility to monitor defense counsel's progress.
5. The results achieved by defense counsel should be fairly evaluated because both the organization and defense counsel deserve honest feedback from each other.

Assisting Defense Counsel

A medical malpractice action may be costly to an organization, but it can be extraordinarily disturbing to a health

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care provider named as a defendant. Generally speaking, physicians and nurses are unaccustomed to the confrontation and adversity that characterize the litigation process. They may be frightened and intimidated by the procedures that may appear to them to be geared more toward proving them culpable than determining what actually happened.

In the discovery or fact-finding stage of the litigation proceeding, risk administrators have a dual role. Both roles reduce the cost of use of outside litigation counsel and the possibility of loss to an adverse verdict or disadvantageous settlement. Risk administrators should assist outside defense counsel in discovery. This task may be easy or difficult, depending on the thoroughness with which the initial investigation was conducted. Equally important, risk administrators should help guide the defendant through the litigation process.

Clarification of Expectations

The first step in assisting legal counsel is to express the expectations of the organization's risk administrators about how defense counsel will handle the claim. Expectations are best clarified in advance and with a single attorney charged with managing the case. It is important that direction be given to defense counsel in the following five areas: assignment of file, initial review, conduct of discovery, conduct of trial, and arrangement for billing.

If the relationship involves multiple claims, the defense firm and risk administrator should mutually designate an attorney who will have overall responsibility for supervising the various cases referred to that firm. If because of a conflict or another reason the defense firm to which a case has been sent is unable to represent the organization, this fact should be communicated immediately to the organization by telephone and the file should be returned promptly. As to the assignment of a case to a particular attorney, some organizations defer to the supervising attorney at the defense firm. Conversely, some risk administrators prefer matching particular cases to the skills, styles, or personalities of particular attorneys and will retain the right to make the selection. An assignment letter should include the name of the risk administrator working on the file. If a defense attorney other than the one selected to handle the case works on the case, this fact should be communicated to the organization.

As soon as possible after a claim is assigned to a defense firm, the primary defense attorney should send an acknowledgment, as well as his or her assessment of the case, to the risk administrator. This review should include a summary of the pertinent facts revealed to date, a review of medical records, a recitation of the issues presented in the complaint, a mention of areas that will require additional research and investigation, and, if there is sufficient information available, a statement of opinion as to liability, verdict potential, and settlement value.

Any motions filed on behalf of the organization should be limited to meaningful issues and receive prior approval from the risk administrator. Any requests by the defense attorney to interview employees of the organization or to retain outside experts should also receive prior approval from the risk administrator. The risk administrator should

obtain a status report from the defense attorney at least twice a year.

Defense attorney requests for approval of travel expenditures should be made in writing and should include the purpose of the trip; the travel destination; the time period required to complete the work; the exact means and the cost of travel; the specific identification, location, and cost of lodgings; and the cost of car rental, if required. In any event reimbursement should always be supported by receipts. The billing cycle also should be clearly understood, and the hourly fees of all defense attorneys working on the case should be provided in writing. Changes in those fees should not be made without the approval of the risk administrator. To enable evaluation of the charge, the bill should provide details of the legal services rendered, including (1) the date of service, (2) a clear description of the service rendered, (3) the actual time expended, and (4) the identity of the attorney who rendered the service. Charges for review of files should be kept at a minimum, and interoffice conferences between attorneys of the defense firm should be discouraged or prohibited. Finally, the defense firm should be informed of which legal expenses will not be reimbursed. Such items might include interoffice conferences, time spent filing papers with the court, secretarial time, copying charges, and unsupported charges for travel.

Distribution of Responsibilities

The manner in which the risk administrator and the primary defense attorney share responsibilities during discovery should be clear to both. The risk administrator should help compile answers to interrogatories, if he or she is not entirely responsible for their completion. It is cost-effective for risk administrators to undertake as much of this task as possible. Similarly, risk administrators should be responsible for the production of documents, such as medical records, billing statements, policy and procedure manuals, incident reports, photographs, laboratory reports, logs, scheduling reports, and other physical evidence.

In most risk management programs, risk administrators automatically assume primary responsibility for drafting answers and producing documents. However, they are probably not as involved as they should be in preparing witnesses for depositions. This task is too often left to defense counsel. As with drafting answers to interrogatories and producing documents, witness preparation should be a shared responsibility between defense counsel and the risk administrator.

A common complaint of deponents is that they have not been adequately prepared. Unfortunately, at times defense counsel may not have or may not take the time to prepare each witness adequately. To avoid this situation, risk administrators should be trained and ready to prepare witnesses. The two important aspects of this preparation are to provide the general rules of demeanor and conduct of a witness in a deposition and to review in detail the care and treatment rendered by the deponent, relying in particular on office or hospital records.

Some organizations have shown prospective deponents videotapes of staged depositions. Such tapes are commercially available. In addition, various articles and monographs have been written on the subject. In their excellent book, *Preventing Malpractice: The Co-Active Solution*, Dr. Thomas Leaman and attorney James Saxton provide 10 rules for deposition preparation (Box 29-2).¹⁷ Although the rules are directed to physicians, they are equally applicable to other health care providers or for that matter to any person who is required to give a deposition.

RECENT DEVELOPMENT: USE OF ALTERNATIVE DISPUTE RESOLUTION

Alternative dispute resolution has been used successfully in a variety of settings to bring people to agreement. Now, physicians and hospitals are adapting these same methods

of reconciling differences to medical malpractice cases to avoid the hassle and expense associated with trial preparation. The two forms of alternative dispute resolution with which most people are familiar are mediation and arbitration. Mediation is the process whereby a neutral third party assists parties in a dispute to reach a voluntary settlement of their differences. In arbitration a neutral third party hears the evidence and arguments of each party and then renders a final and generally binding decision.

Rush-Presbyterian-St. Luke's Medical Center in Chicago has developed an interesting model for the use of mediation in medical malpractice litigation. In 1995 it began the first hospital-based mediation program in Illinois and one of the first in the country in response to the excessive costs, adversarial nature, and unpredictable outcomes associated with jury trials in Cook County. The program was created in an effort to resolve disputes in a rational and reasoned manner and as an alternative to trials by juries, which are susceptible to emotional appeals.

Box 29-2. Ten Rules for The Physician's Deposition

1. The physician must know the records intimately—office records, hospital charts, any statements by other health care professionals, medical literature, and alternative treatments.
2. The physician must listen to the question carefully and respond only when he or she understands it completely. If the physician does not understand it, then the attorney must be asked to rephrase it. Never help to rephrase it or suggest a more appropriate question.
3. The physician should respond thoroughly, but directly and to the point, and not tell stories, ramble, digress, or volunteer information. On certain topics one may need to be more comprehensive if appropriate to the theme of the defense.
4. The physician should use the medical record. If the record is in order, it can be the best defense tool. For example, the plaintiff's attorney may describe the client's level of pain and suffering. If the physician's records do not confirm this, the chart can be used to demonstrate it.
5. The theatrics of the plaintiff's attorney should be disregarded. Sometimes the attorney will act surprised and shocked by a response, use body language, or repeat certain phrases in an attempt to irritate the defendant. Such theatrics are intended to make the physician uncomfortable and unsure of the response.
At times the plaintiff and defense attorneys may resort to arguing with each other. It is important for the physician not to misinterpret the defense attorney's anger to mean that something has gone wrong or that there is a problem with the responses. Such battles may be a technique for the defense attorney to maintain control of the deposition. If such tactics are to be used, they should be discussed with the physician before the deposition. Their use should also be minimal; professional courtesy is an important part of legal ethics.
6. The physician should be consistent. If the physician does not give the desired response to a question from the plaintiff's attorney, the attorney may ask the question over and over, each time phrasing it a bit differently, looking for an inconsistent response. The physician should remember that the plaintiff's attorney has been working on these questions for weeks before the deposition. The physician's failure to give the anticipated response can be devastating; the attorney will work hard to get the needed response or at least neutralize the damage from an unfavorable, unanticipated response.
7. The physician should wait for the next question after finishing a response. Often the plaintiff's attorney will pause, using body language to urge the physician to say more. The physician should not try to fill the void, but should simply wait patiently for the next question.
8. The physician should be extremely cautious in responding to leading questions, such as "Is it a fair statement...," "Let me summarize your testimony as follows...," and "Doctor, just so I understand what you are saying..." Statements like these mean the plaintiff's attorney is about to reinterpret the physician's testimony. Usually there is a slight twist to that interpretation, which the attorney is hoping to have affirmed. The physician should remember that fairness has nothing to do with this process; the interpretation may not correctly reflect what was said. The physician should agree only with those statements with which he or she is comfortable. If the physician disagrees, then he or she must simply say so, and repeat the previous response.
9. The physician should be careful of conversation during breaks. Although inappropriate, the plaintiff's attorney may try to engage the physician in conversation. This could have an impact on the case. A deposition is not the time for social niceties. Breaks should be used to relax and regain composure. One must be on guard from arrival at the deposition until departure.
10. The physician should be courteous, professional, firm, and credible. Demeanor should be professional and serious, for a physician's professional ability has been challenged. As such, a deposition is neither the time nor the place for chitchat and humor. However, under no circumstances should a physician be offensive, insulting, or argumentative.

From T. Leaman & J. Saxton, *Preventing Malpractice: The Co-Active Solution* 68–70 (Plenum, New York 1993).

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One of the unique features of the Rush model is the use of co-mediators. These individuals are drawn from the ranks of the most prominent and active trial attorneys from both the plaintiff and defense bar. They undergo mediation training offered by the medical center in association with local law schools. As an indication of the fairness and neutrality of that training, the Rush program allows the plaintiff to pick both of the mediators. Plaintiffs agree to mediation when it is offered largely because they can see the benefits of a fast, less expensive resolution.

The mediation process begins with both parties voluntarily agreeing to participate in the program. Premediation submissions, including a statement of the facts, description of the injury, claim of special damages, and past and future expenses, are exchanged. A neutral location is selected in which the mediation will take place. To once again enhance the neutrality of the process, the mediation proceedings generally are held in a location away from the hospital.

The experiment in the use of alternative dispute resolution by Rush-Presbyterian-St. Luke's Medical Center in the first 4 years has been positive. An average of 12 cases have been submitted to the Rush program each year, with close to 90% of the cases being resolved, many on the same day of the mediation. The operational costs of the mediations have been nominal and, in the event a lawsuit has been resolved, there have been substantial savings through the elimination of additional defense costs.¹⁸

RISK PREVENTION

Effective risk prevention depends on the reliable recognition of risk exposure, determination of its causes, implementation of corrective action, and continual monitoring of risk indicators to determine if risk exposure resolves. This process requires close and active cooperation of risk administrators and clinical managers.

Assessing Risk Exposure

Risk exposure is identified either by examination of the facts of an individual case, which could reveal a continuing source of liability risk, or from examination of data, which can be trend data of a particular risk indicator or clinical performance data. Once risk exposure is identified, quantitative measures, or indicators, reflective of that exposure should be developed to enable risk administrators to determine the presence of similar risk in other areas of the organization and to be used as a measuring stick to gauge the success of interventional efforts. Literally hundreds of indicators can be measured, so risk administrators must identify a manageable number that will yield the required information.

Indicators are usually rates of selected events, such as hospital falls, medication errors, and adverse clinical outcomes. They may be measured in targeted areas or throughout the entire organization. Data for indicators can be obtained from a wide variety of sources in an organization. Unique data bases are often found in claims and billing (whose data

bases typically contain patient encounter data consisting of at least ICD-9-CM codes, visit status, care delivered, and patient disposition), utilization management (often a rich source of data), the pharmacy, medical staff offices (including the credentialing data base), the patient relations department (which might have a detailed data base of patient complaints and corrective actions), and quality management (which should have all available clinical performance data). The risk administrator should have in his or her own department data on lawsuits, risk cases, incident reports, and specified occurrence reports and screening.

As an example, if a hospital risk administrator identifies falls by patients, staff, and visitors as a source of risk exposure, he or she might determine that much of the problem relates to travel on floors that are wet from cleaning. Further analysis may lead to the identification of a number of interventions that would serve to minimize or eliminate travel on wet floors. Interventions might include using large yellow plastic warning signs placed six feet apart around the wet area, confining routine floor cleaning to evenings (after visiting hours), and cleaning no more than 50% of the width of a walkway at one time. Appropriate indicators for monitoring risk exposure could include the monthly rates of a series of measurements based on routine, random walk-around inspections, such as the percentage of just-mopped floors without proper warning signs, the percentage of floors actually cleaned during visiting hours, and the percentage of floor cleanings in which more than half the hallway was mopped. These three represent "process" indicators that reflect the success in executing the interventions. Of course, if the hypothesis that these three interventions will be effective in reducing the rate of falls is wrong, then successful implementation of the interventions will have no effect on the rate of falls. Therefore it is crucial to include measurement of an "outcome" indicator that will provide information about whether the problem was ameliorated by the interventions. A useful outcome indicator would be the monthly number of falls by patients, staff, and visitors. Outcome indicators, as opposed to process indicators, should be reflective of the level of risk exposure and thus should be the measure of success of any risk prevention effort.

Clinical quality indicators are often but not always risk indicators. Clinical risk indicators are limited to those aspects of medical care that present risk. Quality management, however, encompasses the improvement of medical care that is not considered to present any legal risk. For example, a hospital with the lowest rate of surgical complications in town may seek to lower it even further through an aggressive quality improvement project. If no risk exposure in that area had been identified, the indicators developed to monitor surgical complications would be clinical quality indicators but not clinical risk indicators. Similarly, not all risk indicators are clinical quality indicators. An institution may identify risk exposure because of the failure of its medical staff to consistently obtain proper written informed consent before certain procedures, as required by the staff bylaws. The indicator of percentage of procedures with written informed consent

forms completed beforehand would be useful to assess risk in this situation. However, failure of the physician to obtain written informed consent to a procedure is a legal rather than a medical issue, so an indicator of this failure would be an indicator of legal risk but not of clinical quality.

Risk indicators should be valid reflections of the clinical or operational activity they are intended to measure. They should be free from measurement bias, and each measured event should be reliably observed. Poorly crafted risk indicators prevent the accurate recognition of risk exposure and the understanding of its causes and doom to failure many risk avoidance efforts.

Defining Performance Expectations

The next step in risk reduction is to establish for each indicator a target level that will be used as the measure of success in risk reduction. For example, a project to reduce medication errors could establish a target of a 50% reduction in errors over 3 months, and a rate in subsequent months of no higher than 10 incidents per month throughout the organization. These targets are the standards against which the success of the project should be measured, and if the indicator target rate is not met, further corrective action is warranted. Many risk reduction and quality improvement projects ultimately fail despite initial promise because of inadequate long-term monitoring of the risk exposure and the lack of a predetermined commitment to further action if expected results are not achieved.

Monitoring the results of action is so important that the necessary indicators and their expected values over time should be established before any action is taken. The measuring sticks (the indicators) and the criteria for success (the expected values) should be established before taking action so that the determination of whether an intervention is successful will not be biased by the personal stakes acquired by staff in the development and implementation of the corrective action plan.

In particularly troublesome areas, performance expectations can be formalized and reinforced through operational protocols and clinical practice guidelines. These guides are written formal expressions of courses of action expected in defined circumstances. Classic examples are nursing protocols for initiating blood transfusions and physician practice guidelines for pacemaker insertion. Care must be taken, however, to avoid the interpreting of clinical practice guidelines as strictly defined standards of care. Nevertheless, protocols and guidelines, when properly and carefully designed, can be an effective way of standardizing selected features of operations and clinical care and reducing risk exposure. Adherence to them can be measured through indicators.

Taking Specific Action to Reduce Risk

Risk prevention depends on the accurate identification of those clinical and operational processes in need of corrective efforts. In their efforts to diagnose the causes of risk exposure, risk administrators should adopt a structured problem-solving technique predicated on an organized approach to identifying all of the clinical and operational

processes that affect the clinical area with risk exposure. This approach may include the construction of process flow diagrams and cause-and-effect diagrams. Input should be obtained from staff with daily working knowledge of each relevant clinical and operational process.

Once an operational or clinical process has been identified as a problem, corrective interventions should be crafted, and each step necessary for their successful implementation should be detailed in a written “corrective action” plan. The plan’s formulation should be made with multidisciplinary input, and specific responsibilities and times for completion of each task should be specified. Successful implementation of a corrective action plan will often depend on widespread, continual staff education and committed involvement of managers in all relevant clinical and operational departments.

Adopting General Risk Avoidance Strategies

Risk administrators should develop a general risk avoidance plan that includes organization-specific strategies. Two universally important components deserve specific mention. The first is to provide regular general risk management education to all staff. This program need not go into detail about legal principles but should keep all staff—clinical and nonclinical—aware of the constant need to avoid risk and report it whenever discovered. This education is particularly important for physicians, given the greater risk exposure encountered in their work. Periodic (e.g., annual) seminars should review the essentials of risk prevention in clinical practice, stressing the crucial elements of good communication and proper medical record keeping. The presentation of recent organizational and comparative trend data on risk indicators can be an effective tool to stimulate physician interest and maintain attention.

A second important component of a risk avoidance plan is to strengthen the medical staff credentialing criteria and procedures. Criteria for good standing should be far beyond mere possession of current licensure and malpractice insurance. Data on quality of care, risk cases, patient complaints, and particularly the clinical outcomes of the physician’s care (e.g., surgical mortality and complication rates) should play a role. It is becoming increasingly perilous for health care organizations to ignore such data in their credentialing process. In their review of the impact of performance data on medical practice, physicians Topol and Califf comment that:

The problem of too many physicians [doing procedures, many of whom perform too few each year to achieve competency,] is compounded by the lack of adequate training for many, who too frequently derive their “training” by attendance at a demonstration course. Careful consideration should be given to the criteria for privileges of individual physicians. Low-volume physicians whose patients have poor outcomes should be prohibited from doing procedures. The minimum number of cases per year should be strictly enforced. [For example,] the Joint American College of Cardiology and American Heart Association Task Force recommends that cardiac surgeons do at least 100 bypass operations per year, but in a review of the data now available

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in New York and Pennsylvania, more than one third of cardiac surgeons did not meet this criterion. Volume is not the only issue; guidelines are necessary for the actions that should be triggered when indicators of poor-quality medicine are evident. Indeed, availability of outcome data would likely alter the behavior of low-volume or poor-outcome practitioners. However, if these measures are unsuccessful, strategies ranging from admonitory communication to frank termination of procedural privileges could be used.¹⁹

Continually Reassessing Risk Exposure: The Cycle of Continuous Risk Reduction

Risk reduction is a continuous cyclical process (Fig. 29-1). The first step of the cycle is the assessment of risk, which includes the identification of risk exposure and its measurement through risk indicators. In doing this step, an organization is determining its degree of exposure to a certain risk, which is referred to as point A in the diagram. The second step is the creation of expectations of where the level of risk exposure should fall to over time; in this step the organization determines its risk reduction goal (referred to as point B). The third and final step is taking action to reduce the risk exposure, that is, to reduce risk exposure from point A to point B. This step requires the development of a corrective action plan and its successful implementation. Once action is taken, the steps of the cycle are repeated as necessary. Risk exposure is reassessed to gauge the success of the intervention and the need for further action. If risk reduction expectations are not met, they are revised as appropriate and further action is taken. Failure to monitor known risk exposure, especially once improvement begins, can allow attention and resources to be diverted to other projects and lead to the ultimate failure of an initially successful intervention.

RISK FINANCING

A health care organization finances the risk of loss from liability in one of two ways. It may retain the risk, or it may seek to shift or transfer the risk.²⁰

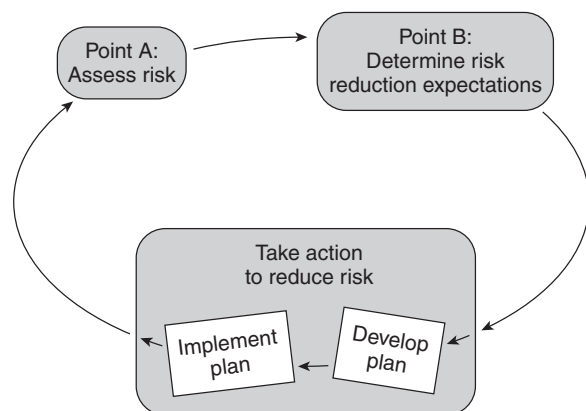


Figure 29-1 Cycle of continuous risk reduction

Retaining Risk

The use of internal funds to pay losses is referred to as *loss retention* or *retaining risk*. Under this arrangement, a health care organization may either fund or not fund the cumulative value of the risks retained. Of course, the more fiscally responsible approach is to fund the losses in a self-insurance program by which a trust fund is established and the organization makes annual contributions according to actuarial studies as to the estimated value of losses retained. A self-insurance program is most appropriate when a hospital (1) wishes to achieve an advantageous cash flow, (2) has the capacity to satisfy actuarial funding requirements, (3) possesses the sophistication to set appropriate reserves, (4) is able to maintain a reasonably low level of self-retention or deductible, and (5) finds it otherwise impossible or impractical to transfer the risk.

On occasion an organization that has a fully funded self-insurance program, nevertheless, may elect to assume a risk for a type of loss not covered under the self-insurance program if insurance for such a risk is either unavailable or the price is prohibitive. The organization, despite accepting responsibility for it, may neglect to fund it. In the event a loss does materialize, the organization would have to fund it from general operating funds. An alternative is to fund a loss reserve or consider alternative approaches to self-insurance.

Self-insurance programs pose some inherent problems for the institution. Pressures to achieve short-term financial objectives can jeopardize long-term financial viability of the self-insurance program. For example, some institutions limit the funding of a self-insurance fund to actual lawsuits as opposed to probable claims. This approach eventually could result in an inadequate surplus in the trust fund. A similar tendency is for organizations to accept coverage of losses in cases in which the losses are less clear or more unpredictable. Such losses would more prudently be either transferred or covered under a commercial insurance policy. Yet another disadvantage of a self-insurance program is the inability to counteract pressures by excess carriers to increase the self-insured retention limits.²¹

Other insurance arrangements might serve as alternatives to developing a self-insured retention program. These arrangements include insurance purchasing groups, risk retention groups, and offshore captive insurance companies.²² However, these alternative structures may be more expensive and time-consuming to implement and operate than a self-insured trust and may be more applicable to a multihospital system or a physician hospital organization as opposed to a single hospital entity.

Transferring Risk

For most organizations the transfer of risk in whole or in part takes place in one of three ways. Most commonly, risk is transferred to a commercial insurance company under a primary or excess policy. A second approach is to share risk by requiring physicians who are members of the medical staff or network to maintain minimum levels of insurance.

These two approaches are commonplace and do not require further elaboration.

The third approach is also fairly common but has been the subject of misunderstanding and misuse. It attempts to shift liability by use of an indemnification or "hold harmless" agreement in a contract. Such a provision allows one party to transfer the legal liability to another contracting party and is frequently insisted on by vendors, insurers, and managed care programs. Health care organizations should not unwittingly accept such provisions. First of all, many malpractice insurance policies expressly exclude such transfers of liability so that the acceptance of the liability of another may be an uninsured loss. In addition, such provisions are typically worded in an overly broad fashion. An even worse alternative is a mutual indemnification clause. Neither should be accepted by an organization. A one-way agreement unfairly shifts liability to the hospital, whereas mutual indemnification ensures that both parties will become entangled in the question of liability.

When faced with an indemnification provision, an organization's legal counsel should endeavor to have it deleted, should not accept a mutual indemnification, and may suggest the following alternative wording:

It is understood and agreed that neither of the parties to this agreement shall be liable for any negligent or wrongful act chargeable to the other and that this agreement shall not be construed as seeking to either enlarge or diminish any obligation or duty owed by one party against the other or against third parties. In the event of a claim for any wrongful or negligent act, each party shall bear the cost of its own defense.

EXTERNAL REQUIREMENTS

The environment within which a health care organization's risk management program operates is a fabric of loosely connected laws, regulations, and accreditation requirements. Voluntary accreditation is available from a number of organizations, including the JCAHO and the National Committee for Quality Assurance (NCQA). This environment continues to be one of constant change, with, for example, revisions to some accreditation requirements released annually. Risk administrators must vigilantly monitor the ever-changing external regulatory environment and ensure organizational compliance with all risk-management-related requirements.

CONCLUSION

Health care organizations are dynamic entities in which programs, personnel, priorities, and external requirements are in a constant state of flux. As a result, legal risks often can assume a fluid state. A successful approach to the prevention of injuries caused by a certain set of circumstances may ultimately fail when those circumstances change. The benefits of a fall prevention program successfully instituted in a geriatric unit might be undermined by a reduction in nursing staff, expansion of the unit, change in patient mix,

or physical reconfiguration of the unit. When that happens, new solutions and alternative approaches will be required. Risk management programs must be modifiable, adapting to changing patterns and trends. Risk administrators must realize that problems once solved may reappear and require new solutions, sometimes repeatedly. Constant vigilance through monitoring is essential. Effective risk management requires continual attention to the ever-changing organizational realities and legal milieu.

Endnotes

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APPENDIX 29-1: TOP 10 ALLEGATIONS BY AVERAGE COST

1998 Rank	1999 Rank	Allegation	Claims (no.)	Average cost
1	1	Improper treatment—Birth-related	309	\$260,300
6	2	Failure to diagnose—Hemorrhage	91	\$221,900
9	3	Failure to diagnose—Abdominal problems/other	91	\$167,600
2	4	Failure to diagnose—Myocardial infarction	150	\$166,100
3	5	Surgery—Postoperative death	109	\$160,800
5	6	Failure to diagnose—Cancer	379	\$149,500
8	7	Failure to diagnose—Pregnancy problems	75	\$147,100
+	8	Surgery—Unnecessary	64	\$141,400
4	9	Failure to diagnose—Circulatory problem	170	\$128,600
7	10	Failure to diagnose—Infection	232	\$125,900

From St. Paul Fire and Marine Insurance Co. (1999).

APPENDIX 29-2: TOP 10 ALLEGATIONS BY FREQUENCY

1998 Rank	1999 Rank	Allegation	Claims (no.)	Average cost
1	1	Surgery—Postoperative complications	901	\$85,800
2	2	Failure to diagnose—Cancer	379	\$149,500
5	3	Improper treatment—Insufficient therapy	364	\$64,000
3	4	Improper treatment—Birth-related	309	\$260,300
4	5	Surgery—Inadvertent act	265	\$107,000
6	6	Improper treatment—During examination	240	\$51,000
8	7	Failure to diagnose—Infection	232	\$125,900
9	8	Improper treatment—Drug side effect	221	\$89,200
7	9	Failure to diagnose—Fracture/dislocation	189	\$54,100
10	10	Improper treatment—Infection	178	\$101,200

From St. Paul Fire and Marine Insurance Co. (1999).

APPENDIX 29-3: ALL ALLEGATIONS BY LOCATION

Location	Claims (no.)
Hospital	
Emergency department	846
Labor/delivery/nursery	363
Other	298
Outpatient surgery	200
Patient care area	643
Surgery	<u>1517</u>
SUBTOTAL	3867
Office	
Physician office/clinic	2446
Other	217
Surgicenter	20
SUBTOTAL	<u>2683</u>
TOTAL	6550

From St. Paul Fire and Marine Insurance Co. (1999).

APPENDIX 29-4: UNUSUAL INCIDENT REPORT

THIS IS AN INTERNAL QUALITY CONTROL DOCUMENT
DO NOT PLACE IN PATIENT RECORD

I. NAMEPLATE I. _____ PATIENT _____ VISITOR _____ OTHER (check one)
 Date of incident: _____ Time of incident: _____ A.M. _____
P.M. _____
 Location of incident: _____
(Unit/Area)

If NO addressograph, print name, DOB, unit, patient number; if visitor, give address. Attending physician: _____
Witness: _____ Phone no.: _____
Witness: _____ Phone no.: _____

- II. TYPE OF INCIDENT: (check at least one)
- | | |
|---|---|
| <p>_____ Reaction to contrast dye
 Type: _____
 _____ Wrong blood gives
 _____ Unexpected return to the operating room
 Brain damage that could be the result of treatment or medical intervention
 _____ Neurological deficit, nerve injury or paralysis that could be the result of treatment or medical intervention
 _____ Unexpected patient death
 _____ Inaccurate needle or sponge corneum
 _____ Unplanned hospital admission subsequent to outpatient surgery procedure</p> | <p>_____ Informed consent form not signed or inaccurate
 _____ Total or partial loss of limb or the use of limb
 _____ Needle stick to patient or visitor
 _____ Burns from food, liquid, or mechanical equipment
 _____ Central line complication/problem resulting in patient injury
 _____ Intubation / extubation injury
 _____ Damage to or disappearance of personal property
 _____ I.V. infiltration (provide detail in Section III)
 _____ Fall (provide detail in Section III)
 _____ Medication error (provide detail in Section III)
 _____ OTHER (provide detail in Section III)
 _____ Serious illness or injury (including death) to patient that might have been caused to medical device* (see Section IV)</p> |
|---|---|

III. INCIDENT FACTS/DATA: (should be consistent with what is written in the medical record)

IV. PRODUCT IDENTIFICATION; (this information is required by the FDA through The Safe Medical Device Act of 1990 if the Medical Device has caused serious illness or injury [including death] to patient)

List all products/devices connected to the patient at the time of the incident:

Product/Device name	Lot #/Expiration date	Serial #	Manufacturer
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Disposable items *should not be discarded* until cleared by Risk Management.
 Location of medical device/product: _____

V. Preparer's signature: _____ Date: _____ Time: _____ A.M. _____
P.M. _____

Title: _____
 Unit Leader's Signature: _____ Date: _____ Unit: _____

- Routing instructions:
1. Submit original to Office of Risk Management (ORM).
 2. Original must be received by the ORM within 24 hours of incident.
 3. For Patient Care Units, carbon to be maintained by Quality Improvement Coordinating Committee Chairperson.
 4. For Ancillary Units, carbon to be maintained by Ancillary Care Evaluation Committee Chairperson.

SERIOUS INCIDENTS—CALL OFFICE OF RISK MANAGEMENT DIRECTLY
 THIS FORM MAY NOT BE DUPLICATED

