COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety Focused Review

# A Look into Pediatrics

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The American Academy of Pediatrics reports that approximately one out of three pediatricians will be sued for medical negligence in their career. These national rates have remained constant over the last 30 years.

While pediatric medical negligence lawsuits have remained infrequent, indemnity payments tend to be larger than most other specialties, with the exception of neurosurgery, neurology, and obstetrics/gynecology surgery.[1]

### According to The Medical Professional Liability Association (MPLA)

**$428,999**
national average pediatric indemnity payment (2006-2015)*

**$330,000**
national average indemnity payment for all other healthcare specialties

**$341,000**
average CAP pediatric indemnity payment (2009-2018)

The data also indicate that CAP member pediatricians experience a lower rate of claims in comparison to those covered by other companies. CAP credits this decrease in risk exposure to aggressive risk and claims management, as well as sound underwriting procedures.

## General Allegation Category

Many patients suffer preventable harm due to a missed, wrong, or delayed diagnosis. In fact, a 25-year study of claims submitted to the National Practitioners Data Bank, completed in 2014 by Saber-Tehrani, Lee, and Mathews, concluded that "diagnostic errors appear to be the most common, most costly, and most dangerous of medical mistakes." CAP data indicate that when physicians make diagnostic errors, problems with medical treatment naturally follow. The following chart is a breakdown of the allegations in the 23 cases.

### In This Focused Review...

Risk management staff at the Cooperative of American Physicians, Inc. (CAP) identified 281 medical negligence claims against CAP member pediatricians over a 10-year period dating from January 1, 2008 to December 31, 2017. CAP paid indemnity on 69 claims, of which 32 had an indemnity payment over $100,000. The highest payout was $3.95 million. As noted below, the total indemnity for this period was notably high, over $20,000,000.

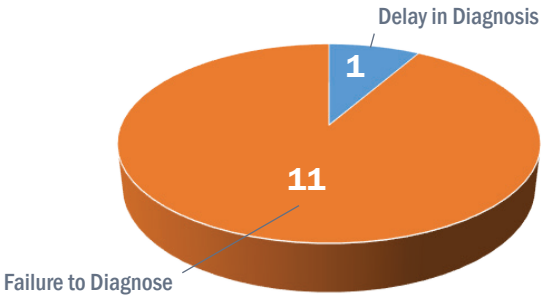
**CAP Pediatric Claims Financial Data: 2008-2017**

| | |
|---|---|
| TOTAL LITIGATED CLAIMS | 281 |
| TOTAL INDEMNITY *(Paid on 69 cases)* | $20,661,144 |
| AVERAGE INDEMNITY | $299,436 |
| TOTAL EXPENSE | $8,121,166 |
| AVERAGE EXPENSE | $28,900 |
| TOTAL AMOUNT INCURRED | $28,782,311 |

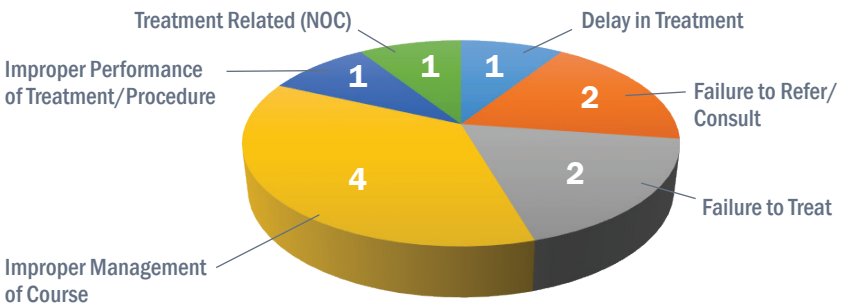
For this study, we reviewed 23 (n=23) of the 281 claims identified against CAP pediatricians involving diagnosis and treatment-related allegations where CAP paid indemnity over $100,000. In each case, the child suffered tragic life-altering injuries or death.

## Summary of Findings (based on 23 claims)

### Diagnosis Related - 12




### Treatment Related - 11




*The higher payments are attributed to the cost of life-long medical expenses and dependent care costs, as well as a loss of potential earnings.



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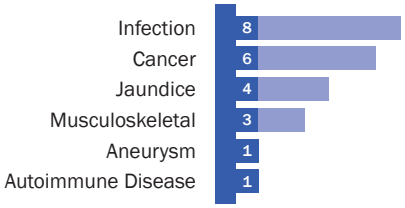
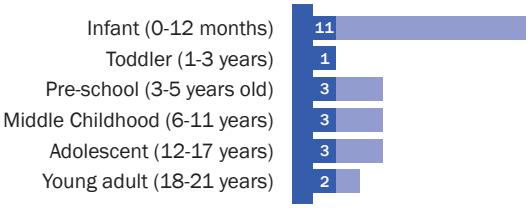
### Conditions Associated With Injury




### Location of Incident


### Age When Injury Occurred




## Causative or Contributing Factors

It is important to recognize that the following causative factors seldom stand alone. A typical case involves a chain of events—not just the error—that lead to catastrophic patient injury. Furthermore, there are a number of variables that might influence the origin of the claim that cannot be accounted for, including individualized elements like workload, staffing, provider-specific conditions (i.e. exhaustion/stress/divorce), institutional metrics and directives driving costs, and funding of new and current technologies and software.

Nonetheless, CAP has identified the following five key areas of risk and developed specific risk reduction strategies for each to help improve patient safety and minimize liability risk.

## Documentation

**43%**

Nearly half (43%) of the 23 cases reviewed contained deficiencies in documentation contributing to a physician's inability to assign a proper diagnosis and implement appropriate treatment. In fact, one 15-year-old female patient lost her life due to a delayed diagnosis and treatment of synovial carcinoma—a very rare, aggressive soft tissue disease. Reviewers found that the physician failed to obtain a comprehensive medical history and did not perform a complete physical exam, never once palpating the left thigh where the tumor was located. Furthermore, the lack of documentation in the medical record of the partial exam, as well as any follow-up care or referral to specialists, caused difficulty in the physician's legal defense.

### Risk Issues Identified

- **No medical record available.**
- **Incomplete documentation of the patient's medical history.**
- **No documentation of examination, referrals, tests, and follow-up care.**

The medical record is key to documenting important clinical findings and treatment rationales that support safe and informed medical decision-making. Whether kept in paper or electronic format, documentation *should* reflect the patient's medical story and provide a conduit of communication between healthcare providers. Complete and accurate documentation in the medical record is therefore essential and serves as the primary tool in medical negligence defense. Stick to the old adage: "If you didn't document it, you didn't do it."

### Risk Reduction Strategies

- Make time to document.
- Document *ASAP* before memory fails and important details are lost.
- Document *every* encounter for health-related services for the patient.
- Document patient and family involvement in care.

# Communication

*"The single biggest problem in communication is the illusion that it has taken place."* - George Bernard Shaw (1856-1950)

**70%**

Effective communication is critical to patient safety. Yet, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports that ineffective communication is among the top three root causes in sentinel events.[i] Similarly, 70% of the 23 cases researched for this focused review revealed multiple communication failures that significantly contributed to the patient's injury. Miscommunication occurred between healthcare providers, as well as between physician, patients, and their families.

## Risk Issue Identified

- **Inadequate information relayed.** Patients and families failed to provide accurate or complete medical history and/or pertinent information related to current complaint.

## Risk Reduction Strategies

- Employ language interpreters for patients with limited proficiency of the preferred language used in the practice and sign language interpreters for patients who are deaf or hard of hearing.
- Don't expect patients to always volunteer relevant information. The patient may not know what information is critical to allow for an accurate diagnosis. Therefore, it is important to ask all pertinent questions. Ask open-ended questions and listen without interruption.

## Risk Issue Identified

- **Ineffective communication among healthcare teams.** Failures between physicians, specialists, and nurses in communicating abnormal lab and imaging results and needed referrals and consultations, as well as not knowing who is in charge of patient care, can result in negative patient outcomes.

In two separate cases, a newborn suffered permanent, non-operable brain damage when the physician ordered bilirubin testing and did not follow up on outstanding results before the baby was discharged from the hospital. Hospital nurses also failed to notify the physician of the newborn's abnormal bilirubin levels. Parents, in each case, lacked the knowledge to appreciate the significance of worsening signs of hyperbilirubinemia that should warrant a return office visit or a trip to the ER.

## Risk Reduction Strategies

- Adopt the core standards of effective communication. A culture of communication must be the standard across the healthcare spectrum. Communication should be:

| | |
|---|---|
| **Complete** | *Communicate all relevant information.* |
| **Clear** | *Convey information that is plainly understood.* |
| **Brief** | *Communicate the information in a concise manner.* |
| **Timely** | *Offer and request information in an appropriate timeframe. Verify authenticity. Validate or acknowledge information.* |

- Utilize "SBAR" and TeamSTEPPS "PASS the BATON" techniques to facilitate prompt and appropriate communications, especially during transitions of care.[ii]

## Risk Issue Identified

- **Failures to provide verbal and written aftercare instructions.** Patients and their parents did not receive important instructions after their visit to the office or hospital.

## Risk Reduction Strategies

- Provide verbal and written instructions--diagrams and pictures are helpful too—that includes a diagnosis, a list of medications to take/discontinue and why, any recommended follow-up care, detailed appointment information, and who/when to call for worsening symptoms.
- Utilize "teach-back" methods and have patients and parents restate instructions or concepts in their own words. They should leave with five takeaways:

1. I understand my current diagnosis and healthcare needs.
2. I understand the purpose for taking each of my medications and possible side effects.
3. I understand what I am responsible for in managing my health.
4. I know the warning signs of a worsening condition.
5. I know all of my questions were answered.

[i] JC Sentinel Event Data; Root Causes by Event Type; 2004-2012
[ii] TeamSTEPPS, https://www.ahrq.gov/teamstepps/index.html

## Clinical Judgment

**70%**

Clinical judgment is the root of the practice of medicine. A practitioner's judgment determines diagnoses, treatment plans and, to a great extent, patient outcomes. It is not surprising that clinical judgment was a significant contributing factor in 70% of the 23 claims reviewed. Therefore, it is important to further drill down to the cause(s) of the clinical judgment error in order to take a closer look at the practice.

### Risk Issue Identified

- **Failure to investigate signs and symptoms**. Nearly 75% of the physicians in our study failed to perform a comprehensive physical exam, often limiting their focus on one or two patient complaints. It was noted that the errors in diagnosis and delays in treatment were directly related to the patient's poor outcome when the doctor failed to investigate all patient complaints and abnormal clinical findings or lab results.

### Risk Reduction Strategy

- Be curious. Avoid "anchoring" on just one symptom. Investigate each patient complaint and observable abnormality via a comprehensive history, carry on a robust dialogue with the patient and family, and perform a full physical examination until all potential diagnoses have been ruled out and the correct diagnosis achieved.

### Risk Issue Identified

- **Diagnosis bias, also known as tunnel vision.** This can occur when a physician adheres to the initial diagnosis, failing to appreciate the progression of symptoms. For example, a one-month-old full term male infant born via an uncomplicated spontaneous vaginal delivery was being treated for the flu during the recent H1N1 outbreak when he died. No blood cultures were done, nor did he receive prophylactic antibiotics at the time of treatment. An autopsy revealed that the baby died of sepsis, pneumonia, and meningitis.

### Risk Reduction Strategy

- Consider alternative differential diagnoses and consult with other physicians when unsure. Ask "What else could it be?" or "What am I missing?" or "What is the worst case scenario?" or "Why?"

### Risk Issues Identified

- **Deviations from the standard of care.** These ranged from failures to order timely/regular tests to a failure to advocate that the patient be taken to the ER for a lumbar puncture.
- **Knowledge and experience deficit.** Examples include rare diseases that were not recognized (e.g. retinoblastoma) to lack of awareness of a recent disease outbreak (pertussis). In another case, experts opined that "classic signs and systems" of Kawasaki's Disease was missed by a young physician who had very limited experience with the disease.

### Risk Reduction Strategy

- Take charge of professional development. Familiarize yourself with the American Academy of Pediatrics best practice guidelines and adhere to peer-reviewed practice recommendations. Attend educational conferences and seminars. When in doubt, ask for help. Consult with a more experienced colleague or a specialist.

## Systems Failures

**26%**

Having sustainable and efficient systems in place is essential to ensuring that the care being delivered is safe, timely, and effective. Identifying and implementing best practice systems not only supports patient safety and prevents errors or oversights from occurring, but also ensures consistent practices among staff. When a process or system failure occurs, the resulting consequence can often lead to significant patient harm.

In 26% of the 23 claims reviewed, systems failures were identified as a direct contributing factor, which allowed for a devastating result. Each of the following failures were found to impact the patient outcome.

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### Risk Issue Identified

- **Equipment availability.** In one case, necessary IV fluids were not available for a dehydrated newborn patient with jaundice.

### Risk Reduction Strategy

- In the hospital, immediately contact the nursing supervisor and/or biomedical department for needed supplies. In the medical office, develop a process for ensuring appropriate inventory levels of important supplies and medication, with defined indicators that alert staff when to re-order.

### Risk Issue Identified

- **Recall/tracking of requests and diagnostic tests.** Failure to identify delays in requests and orders unfortunately affected the patient's outcome in several cases, causing life-altering injuries, when diagnostic test results and referrals to specialists were not addressed in a timely manner. In one case, a STAT bilirubin test was inadvertently ordered as routine by a medical assistant, causing a 3-day delay. In another case, labs sent out for state Newborn Screening (NBS) resulted in a 7-day turnaround time. Unfortunately, in both cases, the physicians failed to follow up on the lab results, which indicated critically high bilirubin levels, causing delays in diagnosis in treatment, resulting in both patients suffering irreversible and inoperable brain damage.

### Risk Reduction Strategy

- Create a recall and tracking system for all ordered diagnostics that includes both a process that prompts staff to look for high risk and STAT test results at the time they are expected, as well as to ensure appropriate follow-up on all pending diagnostic studies, referrals, and patient feedback. Train staff to alert the office if there are delays or failures to obtain results, or if they are the first recipients of abnormal lab or test results.

## Supervision of Staff


Physicians hire medical assistants, nurses, and physician assistants in the physician's practice to provide access to medical care. Their skill and licensure vary, yet each play an important role and add value to the physician's practice. With this team approach, the physician is expected to be in charge of the patient's care as "the captain of the ship." However, in 22% of the 23 cases reviewed, physicians failed to supervise both unlicensed and licensed staff under their direction resulting in injury to the patient.

### Risk Issue Identified

- **Failure to consult with supervising physician.** Two physician assistants failed to consult with their supervising physician or refer to an orthopedic specialist about worsening symptoms of compartment syndrome in a six-year-old male patient, causing a permanent loss of arm function.

### Risk Reduction Strategy

- When it becomes difficult to make a diagnosis or when there is a concern or question about medical care, it is the responsibility of the extender to contact the physician for advice and direction of care. Be available to your Advanced Practice Professionals (APP) to ensure open lines of communications, especially when you are away from the office. Staff should have a clear understanding of when consultation with their supervising MD or DO is required.

### Risk Issue Identified

- **Practicing outside of their scope and training.** A physician allowed his medical assistant to provide "advice" to a parent.

### Risk Reduction Strategy

- Medical assistants perform in an administrative and clerical capacity; some have additional training to conduct limited, non-invasive technical procedures. As an unlicensed individual, interpreting clinical data, triage, and giving medical advice to a patient or parent is not within an assistant's scope of practice. Familiarize yourself with the medical assistant's scope of practice by visiting the Medical Board of California's website at www.mbc.ca.gov.



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## Risk Issue Identified

- **Failure to supervise staff.** An 18-year-old male patient experienced a delay in treatment of his right radial arm fracture due to office staff's lack of efforts to complete an orthopedic referral for surgery. Without the records, the insurance company denied the referral and the window for an ORIF surgery passed. There was no documentation of calls or faxes to the IPA by staff and the ordering physician was completely unaware of the problems and failed to advocate on the patient's behalf. The patient suffered a malunion of his fracture, causing limited range of motion.

## Risk Reduction Strategy

- Clearly define staff roles and responsibilities and develop office policy and procedures directing staff actions. Staff should notify you immediately if there are problems or delays that affect medical care.

## CAP's Commitment to Patient Safety and Physician Well-Being

This study was created to share the real experiences and stories of CAP pediatricians, with the goal of bringing awareness to the variety of, and sometimes overlooked, risks associated with the complexities of modern healthcare systems and practices.

Although CAP's pediatric lawsuit history is better than the national average, both in average indemnity and rate of claims, cases involving babies and children result in an additional toll on the physician. Injuries to children tend to be more severe, and over half of all lawsuits result in a child's permanent disability or death. The unseen and unappreciated effect on the physician is as the second victim. According to Scott, et. al., healthcare providers may become "second victims" when an adverse event causes injury to a child. The physician often endures feelings of guilt, incompetence, and may consider leaving the profession.[2]

Each claim in this study represents a human toll, the story of a child, a family, and a doctor. A key goal of this study is to share our pediatricians' experiences with *all* CAP physicians—regardless of their specialty or location of practice—who care for children and their families with the hope of improving healthcare and patient safety, as well as reducing medical liability risk.

The well-being of CAP members and their patients remains a priority for our team of risk management experts, who are committed to providing easily accessible resources, tools, and education designed to improve healthcare, patient safety, and reduce medical liability risk.

**Risk Management Onsite Practice Survey** This all-inclusive practice evaluation, conducted by one of CAP's senior risk managers, includes a review of the practice's medical records and effectiveness of the practice's office systems, including defensive documentation, complaint management, appropriate delegation of duties, recall and tracking, and patient confidentiality. To request an onsite risk assessment, email **RiskManagement@CAPphysicians.com**

**CAP Cares** This early intervention program is designed to assist members in managing adverse outcomes or events arising from patient care. When you call the 24/7 CAP Cares Hotline at **800-252-0555** about an adverse event, you can speak directly with a risk management specialist to get expert guidance.

**Litigation Education Retreat** Conducted in a non-threatening and interactive environment, CAP's day-long retreat provides a thorough overview of the medical litigation process and its potential impact on your physical and emotional well-being. For more information, email **LERinfo@CAPphysicians.com**.

[1]Physicians Insurance Association of America (2006-2015)

[2]According to Scott, "Second Victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in a sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base." (Scott SD, et. al)



## Tools and Resources:

**Cooperative of American Physicians**
www.CAPphysicians.com

**Agency for Healthcare Research & Quality**
www.ahrq.gov

**American Academy of Pediatrics**
www.aap.org

Fleck, Andrew Ryan, Assessing Risk Factors for Pediatric Medical Injuries using Nationwide Malpractice Data, Thesis. University of California at Irvine, 2015. https://escholarship.org/uc/item/48n862sh.

**Institute of Healthcare Improvement**
www.ihi.org

**Medical Board of CA**
www.mbc.ca.gov

**Society to Improve Diagnosis in Medicine**
www.improvediagnosis.org

We would like to recognize Risk Management and Patient Safety Specialists: Cynthia Mayhan, Deborah Kichler; Lee McMullin, Joseph Wager, Michael Valentine; Ann Whitehead, Vice President Risk Management and Patient Safety; Jeff Stoner, Senior Vice President, Claims and Risk Management

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