

RISK MANAGEMENT ADVISOR

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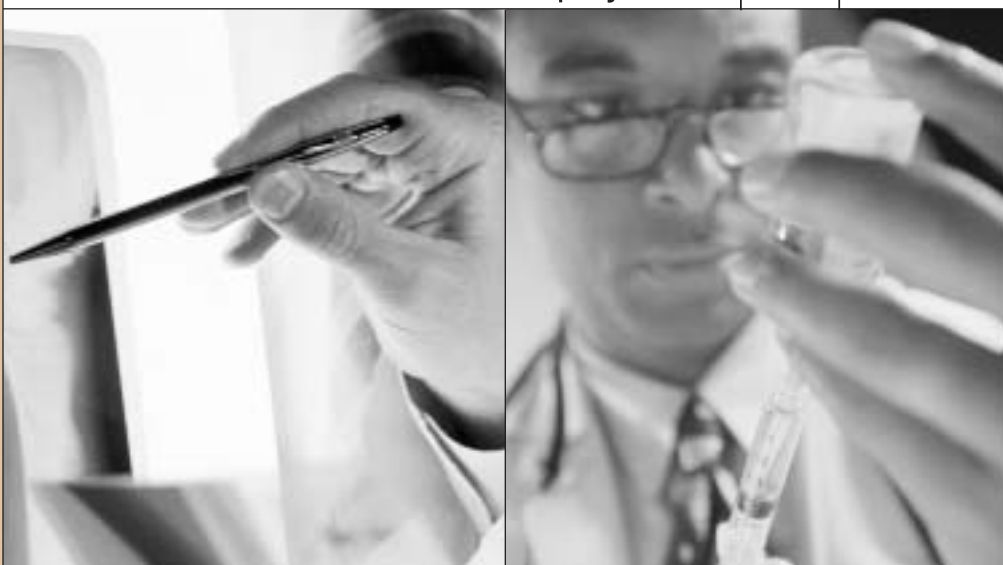
Welcome to the first edition of the *Risk Management Advisor*, a quarterly newsletter specifically written and designed for physicians insured by Missouri Physicians Mutual.

As you will see, we will make every effort to address a wide variety of topics to help you and your staff manage risk within your practice.

We hope you find our first issue informative and helpful. Please feel free to provide questions or comments to Scott Anderson, Physician Risk Services, at 314.854.1394 or sanderson@physician-risk.com.

Content for *Risk Management Advisor* contributed by Kathryn K. Wire.

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A NEW LOOK AT DIABETES AND INFECTION

IN THIS ISSUE:

- We look at the connection between diabetes and infection.
- We ask the important question: Is your office ready for more obese patients?
- We examine those patients who fall "in-between" the traditional assignments of physician responsibility, and how you need to avoid risky dangers associated with them.
- We look at autopsies and the important role they can play in lowering your risk of malpractice claims.

Researchers studying this increasingly prevalent disease are also uncovering information that should impact your loss prevention strategy — and simultaneously improve patient care.

First, the obvious: even moderately high blood sugars can cause blindness, peripheral neuropathy and other life-altering and life-threatening conditions. All diabetic patients need comprehensive education about the disease and stringent efforts to control it. Non-diabetic patients with risk factors such as obesity and family history need monitoring and education.

But recent studies support what plaintiff attorneys have argued lately: uncontrolled diabetes, even at moderate levels, significantly increases your patient's odds of developing a serious infection and carefully controlling glucose levels dramatically improves outcomes. Hospital studies at The

Stamford Hospital in Connecticut (affiliated with Columbia University) and SSM St. Joseph's Hospital in Kirkwood, MO have demonstrated significantly lower mortality and morbidity when staff monitors ICU patients more frequently and controls glucose levels more aggressively. The authors recommend that routine monitoring protocols include patients who were not previously diabetic. As reported in *The New York Times*, Dr. Filippo Ferrigni at St. Joseph began monitoring blood glucose on all ICU patients, using intravenous insulin to control blood sugar. Mortality in the unit dropped 40%. While infection rates dropped, so did transfusions and the rate of renal failure. The savings that resulted from reduced complication rates justified the increased staff time to monitor those patients. Based on those results, the hospital will intensively monitor all patients.



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Risk Management Implications

Infections in the community or in a hospital are a fact of life. Though patients sometimes sue after they develop an infection, we have defended those cases easily if the practitioner followed standard treatment and infection control protocols. Both the occurrence of the infection and its seriousness were beyond our control, we argued, so long as there was no evidence of failed infection control techniques. But the stress of surgery or illness can increase blood glucose levels in non-diabetic patients, and can take well-controlled diabetics out of their normal therapeutic zone. Some patients just don't comply. Uncontrolled or poorly controlled diabetes increases a patient's risk for infection and makes infections more difficult to treat. These studies demonstrate that we can and should control glucose levels, especially in hospitalized patients exposed to "hospital flora." Now we know that these "unavoidable"

complications may result in part from failure to do that. Plaintiff attorneys are quickly learning to look for appropriate testing, and to pounce on elevated levels that remain untreated.

While these studies took place in hospital intensive care units, their authors are moving the protocol to regular hospital floors. The logic also applies for non-hospitalized patients with elevated glucose. If your patient develops an infection or other illness, don't let diabetes care fall off your radar screen. Aggressively controlling the diabetes will probably improve your patient's outcome, and may prevent a claim. And if the patient fails to cooperate with the program, document both your education and treatment efforts, and the specific elements of non-compliance.

IS YOUR OFFICE READY FOR MORE OBESE PATIENTS?

As our nations' waistlines grow, are you prepared to handle patients who weigh 250 or 300 pounds or more? Physicians should address weight issues with patients as a health issue, but they must also make sure that their equipment and physical facilities can handle patients of that size.

Make sure that you and your office staff are comfortable caring for these patients, that you treat them respectfully, and that you are prepared to provide complete care. If you don't respect patients' needs, then they won't feel well cared for.

For common-sense suggestions on caring for large patients, as well as references to more good internet and printed resources, visit: <http://www.niddk.nih.gov/health/nutrit/pubs/medcare/medcare2.htm>, at the website for the National Institute of Diabetes & Digestive & Kidney Diseases of the National Institutes of Health.

OFFICE ACCOMMODATION CHECKLIST:

- Do you have a room large enough for a patient of such size to dress and undress?
- Are there sturdy and comfortable armless chairs available?
- Are your syringes and gloves long enough to accommodate the extra distances involved?
- Can the toilets in your office or the building's restrooms accommodate more than 300 pounds? Is it configured to allow a very large patient to obtain a specimen? (Elongated, with open-ended seat?)
- What about your examination tables? The steps up to the table? Is the table bolted to the floor?
- Do you have a larger blood pressure cuff to get accurate readings? Larger tourniquets?
- Can your weight scale accommodate their size?

WATCH OUT FOR "IN-BETWEENS"

In an old episode of the WB show "Charmed," the three witch-sisters learn of mean and ugly trolls who inhabit the "in-betweens": midnight (between days), doorways (between rooms), shadows (between light and dark), and windows (between inside and out).

Risk Management Implications: Think about "in-betweens" and when they occur in your practice. Then take extra care to avoid your own trolls, who undoubtedly resemble angry patients and plaintiff attorneys! When you spot an "in-between," pay extra attention to clear communication, and ensure your patient knows the plan.

Documentation often suffers at these times, just when we need it most for both continuity of care and defense purposes. Make sure you have good notes of treatment and communication with other providers, and, of course, the patient. If tests have been ordered, know which physician should follow up on the results—NEVER ASSUME.

Awareness of an "in-between" and thoughtfulness about the conditions on either side will help avoid the dangers.

"IN-BETWEENS" IN MEDICAL CARE PRESENT EVEN SCARIER PROSPECTS FOR YOU AND YOUR PATIENTS.

■ Coverage Arrangements:

Does your covering physician have baseline knowledge?

■ Referrals:

Who will follow up on tests?

■ Shift Changes, Hospital Discharge:

All situations involving a transfer of care increase the risk of an untoward event.

AUTOPSIES: A TOOL THAT IMPROVES CARE

Your patient just died, and you don't understand why. The family has expressed questions about the patient's condition and the quality of care. Do you rush to sign the death certificate, listing your best guess as to cause of death, feigning omniscience and hoping for the best?

That would lay the groundwork for a painful deposition, exposing your own uncertainty and concerns in a very difficult arena. Instead, express your uncertainty to patients and families before the death, outlining why you cannot be certain of the diagnosis or why you are surprised by the patient's response to treatment or

whatever else has puzzled you. Tell them WHY you cannot resolve your questions. Recent articles stressing the inherent uncertainty in diagnosis and the need for information that only autopsies provide will support you in that explanation. And when the patient has died, suggest an autopsy in a face-to-face conversation and document that request in the medical record. Then talk to the pathologist to make sure that he/she knows your questions and will take the necessary steps to obtain answers, even if that means consulting with another specialist in anatomic pathology or laboratory medicine.

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The public fears that healthcare providers conspire to cover up mistakes, and many juries will presume the worst about the decedent's condition and medical care, as well as doubting your intentions. Admitting to incomplete knowledge of the unknowable and asking for an autopsy (with good documentation of the conversation) shifts that presumption of "less-than-honesty" TO THE PLAINTIFFS, and makes the jury suspect that the results might have favored the defense. More often than not, the lack of an autopsy or the failure to suggest one proves more damaging to the defense than the results could ever be. And the discussion with the family presents a

great opportunity to dispel their fears, questions and concerns, which may well eliminate the need to defend. Remember, most plaintiffs sue because they don't feel they received complete and accurate information. Make sure that your patients and their families know how much you value getting to the answers, as well.

Sources: Combes, A., Arch Intern Med 2004; 164: 389-92; O'Connor, A., New York Times, March 2, 2004, accessed at www.nytimes.com; "Examining Death To Learn About Life, New York Times, March 4, 2004, accessed at www.nytimes.com.



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