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Communication key to reducing liability claims in patient handoffs

In the Courts. By ALICIA GALLEGOS, amednews staff | June 20, 2011.

Some medical liability insurers are noting an alarming rise in lawsuits stemming from the transfer of care of patients.

A trend of incomplete patient information, missing tests and poor communication among physicians is causing more medical errors, said Alan Lembitz, MD, vice president of COPIC, a professional liability insurance company based in Denver. These mishaps are leading to more liability claims, he said.

Health professionals can reduce these legal risks by being more aware of potential communication failures and creating safety checklists, said Dr. Lembitz, who discussed the topic May 13 at the Physician Insurers Assn. of America annual conference in Scottsdale, Ariz.

"These claims are increasing because the number of providers in the health care team have grown," he said. "Rarely, there is only one physician that follows a patient through their entire course of treatment. These are well-trained, well-intentioned [professionals] in systems that become unsafe because of their complexity."

COPIC has seen rising claims from various types of patient handoffs, particularly during the last five years. Patient handoffs include transfers from partner to partner, primary care physician to specialist, or vice versa, institution to institution or during shift changes.

In one case highlighted by Dr. Lembitz, a healthy child was born and treated by a neonatologist within the first 12 hours. Although a bilirubin was ordered, another neonatologist discharged the child within 24 hours, unaware of the lab results.

At 60 hours, the baby visited a pediatrician and a bilirubin was again ordered before the pediatrician left for vacation. The covering pediatrician was unclear about the baby's history, and the bilirubin was never completed. At 125 hours, the baby was admitted to the hospital and died of kernicterus, a preventable disease.

In another case, a 38-year-old woman detected a lump in her breast and was referred by her primary care physician to a surgeon. The surgeon found no mass, but recommended she be re-examined in one month. Each physician assumed the other would do the follow-up, Dr. Lembitz said. Nine months later, the patient returned to her doctor with a larger mass and was diagnosed with breast cancer.

Both cases ended in lawsuits against the physicians involved.

"We're seeing the [same] patterns of claims over and over again," he said. "The inconsistent or incomplete handoff are what leads to the problem."

Differences in perception
Communication breakdowns during patient handoffs are frequently the cause of errors, experts say.

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A study in the Jan. 10 Archives of Internal Medicine found wide disparities among primary care physicians' and specialists' perceptions of how often they send and receive patient information. The study showed that 69.3% of primary care physicians said they send specialists notification of patients' history all or most of the time, while only 34.8% of specialists said they routinely receive such information.

Meanwhile, 80.6% of specialists said they send consultation results to the referring physician all or most of the time, but 62.2% of primary care physicians reported ever receiving that information.

Direct communication between hospitalists and primary care physicians also is rare, happening between 3% to 20% of the time, according to a study published in the Feb. 28, 2007, issue of The Journal of the American Medical Association.

"It's very well-documented that communication between providers is far from optimal," said Ann O'Malley, MD, MPH, a senior health researcher with the Center for Studying Health System Change in Washington, D.C. "From a clinical perspective, I'm not surprised at all" at the rise in lawsuits based on the transfer of care.

Avoiding communication failures starts with two forms of successful information delivery: synchronous and asynchronous, Dr. Lembitz said. For ideal synchronous communication, physicians should speak face-to-face whenever possible and limit interruptions, he said. The receiver of information should be focused on listening, not speaking.

In asynchronous communication, physicians should first agree on the best mode of delivery and be consistent about the type of information being transferred. Most important, the receiver should confirm that the information was received. Many errors result from one doctor assuming that certain information has sufficiently been passed along, he said.

Strengthening communication with patients is another step toward preventing transfer errors, especially before and after discharge, Dr. O'Malley said.

Implementing a consistent follow-up system at discharge is key, she said. Follow-up phone calls by medical staff to patients reduce emergency department visits after discharge, Dr. Lembitz said. He recommends that medical staff use automated discharge summaries to ensure that the most complete records are transferred from one doctor to the next.

Practicing medicine has evolved into a "team relationship," said Lytton Smith, MD, a California family physician who works in geriatric medicine at a nursing home. Physicians must embrace this team concept to achieve the best medical outcomes, he said.

"The closer the practitioners work together, the better."

Checking checklists
Reviewing a safety checklist is an essential final step in transferring care from one physician to another, Dr. Lembitz said. Doctors should confirm and document that medication has been discharged, that patients have a clear understanding of dosage and are aware of any side effects.

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The list should include whether discharge summaries have been completed and if follow-up appointments or tests have been noted or scheduled. Other checklist items include: Did the patient receive clear instructions on follow-up care? Were those instructions fully understood? Was adequate contact made to the patient's primary care physician or referring doctor?

Inviting a patient's family members into the discussion of after-care management also is helpful, Dr. Lembitz said.

Checklists are not just for health professionals; they are for patients, too. Physicians are encouraged to talk to patients about making their own safety checklists before leaving the doctor's office. Patients should confirm that they understand their diagnosis, are aware of future tests or appointments and know whom to contact if they have problems or questions.

As technology continues to advance, the transfer of care should run more smoothly, especially with the spread of electronic medical records, Dr. O'Malley said. But EMRs are only one part of ensuring successful transfers and prevention of errors.

"We have to do better as a system to guarantee the information transfers in a reliable and timely fashion, in a way that's clinically appropriate for the patient," she said.

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