Improve the physician-patient relationship to reduce liability potential

You’ve probably heard it before. More than half of all lawsuits against physicians arise from a poor physician-patient relationship.

An improved physician-patient relationship isn’t just a feel-good issue—it gets to the core of better business. It leads to greater physician and patient satisfaction, and better clinical outcomes, according to Douglas Drossman, MD, professor of medicine and psychiatry at the University of North Carolina (UNC) and co-director of the UNC Center Functional GI and Motility Disorders. (See story on p. 4 for tips on improving communication between the physician and patient.)

But assessing and improving the physician-patient relationship isn’t clear-cut, because at the core of any relationship is communication—an often subjective topic, says Peggy Martin, MS, ARM, MEd, senior risk management coordinator at Lifespan Risk Services in Providence, RI. “Risk managers have always known—even without scientific proof—that...”

Should hospitals ‘write off’ bills to patients who might sue?

A patient is dissatisfied with the care she receives at your organization and files a formal complaint with the institution or consults an attorney. The patient is very upset, and you’re concerned that she might take legal action against the institution. To mitigate your legal risk in this situation, should you “write off,” or waive, the patient’s bill for medical services rendered?

The practice of waiving bills to avoid litigation from angry patients is controversial. Would the patient see the move as an act of goodwill and drop any considerations of a lawsuit, or will she see it as an admission of guilt and sue anyway?

Although no published studies or reports indicate whether this practice consistently prevents patients from taking legal action, industry insiders say there are times when holding off on billing makes good sense.

Organizations should temporarily suspend billing or collection agency actions with dissatisfied...
nearly all claims and suits involve some elements of poor communication between the players. Quantifying and demonstrating that belief objectively is the trick,” she says.

However, the subjective nature of the problem doesn’t mean you can back away from it if you are in the business of preventing claims and helping providers deliver better, safer care. Outlined below is one method for looking at communication difficulties.

Assess the problem
Figure out where to start. Determine which physicians and other providers will be willing to work with you or, depending on the situation at your facility, which specialty seems to need the most assistance with communication.

You may want to combine several different methods of collecting information besides just a retrospective, focused look at previous claims, associated patient complaints, and incident reports. Some concurrent methods of information gathering can be useful to determine what’s happening right now, such as chart reviews, interviews with physicians and staff, and direct observation of physician-patient interaction or physician-patient interaction.

Collect some evidence
Don’t become hung up on doing a statistically significant, scientifically sound study that will undoubtedly consume more resources than you have. Narrow your scope, look at what evidence there is, and make some judgments about what else to look at.

Be clear that this will be a snapshot of what has happened and what may be happening now. Because you have not promised a publishable research study, you will not have to use sophisticated analytical tools to store, sort, and present the data. A colleague in Information Services can help you use a simple Excel spreadsheet or similar low-tech tool.

Consider the following example:

Material from patient/claimant depositions might indicate that the patient felt abandoned, couldn’t figure out who was in charge of his or her care, or never saw “his or her doctor.” If these complaints came from an inpatient service, you could start by interviewing staff on their perceptions of how the physicians worked, how available they are, and what the patients’ perceptions were.

Further, ask physicians to describe how they communicate coverage changes to hospital staff. What is the mechanism they use to communicate concerns with staff on weekends?

Ask physicians what they tell their patients about which member of the team is caring for them and at what stage, and ask them whether nurse practitioners, physician assistants, residents, and medical students routinely introduce themselves to patients.

On the other hand, your chart review could look at approximately one day a week (including weekends) to see how often physicians wrote notes that indicate they had actually visited the patient. Documentation of patients’ questions and physicians’ answers about care would show that the physician was being kept informed about his or her patient, especially when the documentation references notes by other providers caring for the same patient.

Tip: You might want to look specifically at records of patients who have language or cultural differences, since communicating with them will be a special challenge. If the physician and the patient do not speak the same language, but the physician’s note says he or she talked with the patient and his or her questions were answered, you may need to look further.

Communicate recommendations
Once you have identified your problem areas and collected what evidence you can, meet with the physicians and orally present what you have gathered and explain how it was gathered. Discuss with them how to use the information in practical ways to improve care and the patients’ satisfaction. You will want to discuss issues that bring up larger systems
problems and talk about how—or whether—they can bring about positive change. You may want to talk with them about any marketing value (now or in the future) of some of the information you have collected, and some of the positive changes they can make.

For example, if patients are confused about who they should expect to see and talk to about their care, you may be able to equalize expectations between the patient and care providers by giving patients a map describing the way the practice and hospital provide care, explaining the benefits of the process to the patients.

“A short, easy-to-read brochure can help get patients and providers get on the same page and may head off complaints that the [attending physician] is never around,” says Martin.

As part of the presentation of findings, secure a commitment from them about re-monitoring the “fixes” they agree to put in place. Decide on a realistic time frame and double it for the wider systems issues that need input from other personnel.

Follow up with re-monitoring

Physician lose credibility if they make an effort to look at their communication skills, try to improve them, and then don’t follow through. How often you choose to measure the changes will depend on the extent of your recommendations.

However, Martin suggests that you measure communication efforts at least every three months, but if it turns out there’s a systems problem, you’ll need to allow more time to fix it.

On the other hand, more frequent monitoring in the beginning of the change process may help the process stay on track and the good fixes to stay in place. “Old habits die hard and many of us revert to them when we are rushed and stressed. Monitoring at least monthly may catch some of the slips before they take over again, and you are back to square one,” says Martin.

Frequent monitoring may also catch the fixes that looked good at first but may create problems elsewhere in the system.

And what exactly do you re-monitor? “Before you decide how often you will need look at what you used to begin with, ask the physicians whether they are comfortable that the original criteria gave an accurate picture of their practice,” suggests Martin.

You may want to re-interview staff about any changes they have seen in the communication skills of the target group. In their opinion, are changes beneficial to patients, useful to staff, and more efficient? Or are they creating problems that were not anticipated? Have the number of complaints (written or oral) increased or decreased? Has the substance, frequency, or legibility of notes changed?

Changes in rates of claims and suits will not be useful criteria, at least in the short run. Look at the effects that some behavioral changes may have made on the satisfaction levels of physicians, staff, and patients.

Follow-up checklist

✔ Assess the problem
  • Define the information you need to look at and how to get it.
  • Collect evidence, including chart review, interviews with physicians and staff, and direct observation.

✔ Communicate recommendations
  • Meet with physicians to present what information you have gathered and how you gathered it.
  • Discuss with them how to use the information to improve patient care.

✔ Follow up with re-monitoring
  • Determine how often you need to measure the changes you have implemented. How often will depend upon the extent of your recommendations.
  • Confirm with your physicians that the original criteria you established is still acceptable for monitoring.
  • Re-interview staff about any changes in communication skills among physicians.
Improved communication for better clinical outcomes

Communication is about establishing a common ground, says Douglas A. Drossman, MD, professor of medicine and psychiatry at the University of North Carolina (UNC) and co-director of the UNC Center for Functional GI and Motility Disorders. And for the physician and patient, reaching that common ground can translate into improved clinical outcomes.

Specifically, if the patient is satisfied with his or her care, the patient will adhere more closely to the recommended treatment.

However, to reach that common ground, physicians need to adopt a “patient-centered” approach—understanding and incorporating the patient’s perspective to work toward a common set of goals for treatment, says Drossman. With the more traditional Western style of physicians asserting their medical point of view as the last word on treatment, the patient often resists the physician. The physician then feels frustrated, the patient alienated, and treatment often goes nowhere.

“If the physician understands what the patient wants, then, through negotiating, the physician can address that person’s needs and will get more than what he or she wants,” Drossman comments.

Therefore, excellent communication is critical. Drossman offers the following tips for you to pass on to your physicians to improve their communication skills with patients:

- **Active listening.** If the physician is really listening to the patient, he or she can pick up on subtle cues that might lead to the collection of important clinical data. For clarification, the physician should re-state what the patient says.
- **Validate the patient’s feelings.** Physicians should stay away from making personal judgments on someone’s lifestyle or habits.
- **Proper body language.** Physicians shouldn’t interrupt patients, look distracted, look down or away, or have a blank stare.
- **Ask questions appropriately.** A physician’s questioning style should be nonjudgmental and supportive.
- **Empathize with patients.** If physicians empathize, they will have a more satisfied patient.
- **Include the patient through negotiation.** Negotiation allows for both the patient and physician to agree on a treatment, which in turn, will promote adherence to treatment.
- **Offer reassurance.** Physicians can reassure their patients by identifying the patient’s concerns, acknowledging, and responding to those concerns.
- **Curb your anger.** When physicians become angry with patients, they may act impulsively. Physicians need to address what it is about the patient that makes him or her feel frustrated.

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patients until risk management and legal counsel review the situation. Any subsequent debt cancellation must be part of a comprehensive strategy that directly addresses legitimate reasons for which the patient is angry.

**Promote communication, encourage reporting**

The keys to heading off potentially litigious situations with patients are good self-assessment, quality improvement, communication, and an environment that encourages incident reporting, according to industry insiders.

“The provider [i.e., nurse, physician, etc.] should be the first person to try to mitigate a patient’s complaint,” says Deb Ankowicz, RN, BSN, CPHQ, risk management consultant with Physician’s Insurance Company, Madison, WI. “After all, they’re closest to the patient.”

Providers should clearly explain to patients up-front the risks and alternatives associated with any treatment or procedure. Ankowicz recommends that providers make note of this discussion in the patient’s medical record, in addition to collecting a signed informed-consent form (if the particular procedure and organization policy warrant one).

“If a patient expresses [his or her] dissatisfaction with the outcome or some aspect of [his or her] care,” she continues, “the provider should address those concerns immediately and try to resolve the issue right there.” But if the issue persists, the provider should immediately report it to the risk management department.

Ankowicz adds that organizations should promote a culture in which providers and other staff feel empowered to report such incidents. This message should come from upper management, she says. If providers see the system as punitive, they most likely won’t report.

**Waive on a case-by-case basis**

Not all situations warrant waiving a patient’s bill. Risk management should consider each incident on a case-by-case basis, advises Jerry Rakes, risk specialist, State Volunteer Mutual Insurance Company, Brentwood, TN. When a provider reports a case involving an untoward event (i.e., injury to the patient), risk management should notify the billing department to retain the patient’s bill until it thoroughly reviews the incident and consults with legal counsel.

It’s also extremely important that a collection agency doesn’t become involved. “Most patients are already upset when something goes wrong with their care, and to get a call from some collection agency that is oblivious to the situation could make matters much worse,” Rakes continues.

**Notify the billing department**

But how does an organization prevent its billing department from sending a bill to an unhappy patient? Once again, strong lines of communication are key, says Ankowicz.

“Some organizations have electronic systems for reporting incidents, and the billing department can access them as well as risk management,” she explains. “You can flag an electronic file to instruct the billing department to hold on to the bill of a particular patient until further notice.”

But Ankowicz cautions organizations not to rely solely on electronic or paper systems.

“Sometimes these processes are too slow and flags fall through the cracks,” she says. “Risk management should verbally tell the billing office to hold off on billing a patient until an investigation takes place.”

In situations in which an injury occurs, the patient’s chart should be sequestered, adds Rakes. “This would ensure that the patient isn’t billed as well as secure the record for future litigation,” he says.

**Don’t include incident reports in medical records**

Always exercise caution when flagging a patient’s file to keep the billing department from sending a bill. Specifically, never file an incident report or peer review report in a patient’s medical record, and never include notes or flags that label the patient as a “liability risk” or “disgruntled.”
James S. Kennedy, MD, CCS, consultant with Cambio Health Solutions in Brentwood, TN, explains why.

“I advise against having anything in writing or systems in place that cannot positively bear public scrutiny in a court of law,” he says. “Documentation that labels a patient as a ‘problem,’ ‘on the edge,’ or anything that could be reasonably deemed derogatory detracts from the organization’s image of being caring or compassionate.” The record certainly must document a patient’s diagnosis or treatment, especially adverse events, but the institution should not use this data as a “flag” for billing.

An organization should have its legal counsel/malpractice carrier review and approve its systems for handling patient complaints, Kennedy adds.

Look at federal and state law
If, after a thorough investigation, your organization decides that waiving a patient’s bill makes sense, it must consider the following legal caveats:

- **Centers for Medicare & Medicaid Services (CMS)** CMS requires physicians to bill Medicare or Medicaid for all services and not write off the patient’s copayment or deductible unless there is a documented financial hardship, explains Kennedy. “Should the bill be written off for any other reason, the Medicare or Medicaid carrier should be consulted for guidance regarding a possible refund to them as well,” he says.

- **Private insurance companies** Private insurance companies have contractual requirements similar to those of CMS. “In many states, an insurable event does not occur, under a patient’s insurance policy, until the patient satisfies his or her financial obligation—paying the copay or deductible,” explains Robert A. Wade, Esq., partner with Wade, Goldstein, Landau, Abruzzo, MacKarey & Davidson, PC, in King of Prussia, PA. As a result, insurance companies can assert that they are not responsible for their portion of the services unless the patient first pays the applicable copayment or deductible. “So organizations first must consult with the patient’s insurance company before writing off a patient’s copayment or deductible to resolve a quality of care issue,” Wade continues. However, if the organization intends to write off the patient’s copayment or deductible as well as the amount paid by the insurance company, prior approval is not necessary.

Measure your success
If your organization chooses to waive the bills of potentially litigious patients, it’s important to measure the effectiveness of this practice, says Ankowicz.

“Look at patient complaints handled by risk management on a yearly basis and see how many actually resulted in legal action,” she suggests. If a number of cases still end with a lawsuit, it might be a clue that the practice isn’t terribly effective. The risk management department should keep this type of data on file.
Infection control is not the concern of just one committee or department—it is an institutional-wide issue that could drastically affect your organization’s exposure to risk and liability.

According to the Centers for Disease Control and Prevention’s (CDC) Guideline for Infection Control in Health Care Professionals, “for infection control objectives to be achieved, the activities of personnel health service must be coordinated with infection control and other appropriate departmental personnel.”

In addition, according to a July Chicago Tribune analysis, there were 103,000 deaths linked to hospital infections in 2000. Therefore, infection control poses considerable risk to your organization, and now is the time to take steps to involve all departments—including the risk management (RM) department—for successful surveillance of infections, thorough investigation of infection control issues, and implementation of preventive strategies.

**Expand your scope**
A risk manager’s job is to reduce risk and liability, and infections pose risk and potential liability to an organization, according to Geri Amori, PhD, ARM, CPHRM, associate of Health Care Negotiation Associates (HCNA), in Lexington, MA, and former president of American Society For Healthcare Risk Management.

“Managing risk involves managing infections,” she contends. “The movement in RM is toward looking at risk in all aspects of a facility, not just clinical risk management.”

Institutions should make infection control an integral part of RM because the risk of infection is a factor in almost all situations, according to Amori.

“Infection control experts understand the potential for infection when it comes to packaging, where supplies are delivered, and how things are stored—issues that risk managers do not have the expertise to identify,” she says.

**Involve PI**
The RM department at Salem (MA) Hospital recognizes the connection between risk and infection control and has turned to performance improvement to reduce the organization's liability, according to Jennifer Costain, director of risk management at Salem Hospital.

“Our [RM] program is tightly intertwined with the PI process,” Costain says. “You can identify your risk, but you aren’t going to change your risk unless you use your PI program.”

Salem’s RM team tracks infection rates and key infection organisms—particularly problematic infections that have a high rate of replication among patients. The team also tracks infections associated with certain patient types and procedures, such as cesarean section and abdominal surgeries.

Further, the RM department monitors whether the physician follows the protocol of giving antibiotics to the patient after surgery to combat the high risk of infection, says Costain.

**Tip:** Your infection control department or committee monitors rates for a variety of infections. Your RM department should access those rates to identify and track key high-risk infections. Monitoring this information will allow the RM team to react quickly to any rate increases.

Salem Hospital’s RM department monitors these key issues using benchmark data and control limits. According to Costain, the RM team monitors rates and puts them on graphs for an ongoing examination to identify trends. If performance in these areas becomes problematic, the team reacts to the problem with both quality of care and RM in mind.

**Put the plan into action**
Costain asserts that vigilance in RM, along with a streamlined performance improvement process, will help your hospital quickly reduce risk.

For example, when Salem Hospital detected
a slight increase in ventilator pneumonia rates, the intensive care unit manager quickly put a team together to identify the factors that contributed to the increase. The team included residents, nurses from all shifts, physicians, respiratory therapists, the risk manager, and infection control specialists.

Costain explains that the team assembled to discuss the protocol for sterilizing and changing suction tubing, protocols for bed positioning, etc.

“The team came up with some factors that they thought may be contributing to the slight increase and implemented some strategies,” Costain says.

The team conducted staff education, changed protocols, and monitored compliance with those changes—and watched the pneumonia infection rate drop.

**Note:** According to the CDC, health care personnel are more likely to comply with infection control protocols if they understand the rationale behind their implementation. -

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**Follow-up checklist**

- **Take a team approach.** Your rapid response team should include infection control, performance improvement, risk management, and members of the clinical team relative to the infection issue. For example, you should include a representative from the surgery team if facing a surgical site infection issue.

- **Be aware of your key infection risks** relative to your patient population. For example, your infection rates are going to be different if you have a large pediatrics or geriatrics population.

- **Understand and continually monitor** your key infection rates.

- **Make infection rates accessible** to all stakeholders so that they can mobilize quickly when a problem is detected.

- **Continually review** which infections you should monitor based on your changing population and programs.
Reducing professional liability:
How to use BLRR’s White Papers

The issue
From risk management to liability reduction

Background
As health care facilities face a medical malpractice crisis that threatens both the practice and business of health care, reducing risk has never been more important. However, the rising cost of insurance affects more than just providers and health care organizations; it also affects the community. Consider the following developments:

- Physician groups in many states are having trouble recruiting physicians
- Senior physicians are either retiring or reducing their practices
- When specialists (e.g., radiologists and anesthesiologists) who provide services needed by all other specialties can’t find insurance coverage, hospitals may be forced to close
- St. Paul Companies, one of the country’s largest medical malpractice insurers, has withdrawn from the industry

Coupled with the medical malpractice crisis is the acceleration of the patient safety movement. Medical errors are under more scrutiny than ever before. Health care organizations, therefore, must strengthen their risk management efforts and become more clinically focused. Today, “risk management” means working proactively and assessing risk from the institutional level because often traditional risk management techniques, such as incident reporting, do not prevent risky events.

To address this problem, every issue of Briefings on Liability Risk Reduction (BLRR) will include a White Paper that focuses on a specific risk reduction strategy to help manage institutional liability. These papers will provide readers with an in-depth understanding of a particular problem—specifically focusing on assessment of the problem, solutions to that problem, and finally, measurement of those solutions’ success.

The risk-reduction strategies explored in future BLRR White Papers are based on a three-pronged approach to help organizations optimize their liability reduction programs: 1) preventing patient injury—prevent injury and you prevent the frequency of lawsuits, 2) minimizing the likelihood an injured patient will sue, and 3) maximizing an organization’s legal defense if a patient does sue. Future BLRR White Papers will analyze in-depth the individual components outlined in this three-pronged approach.

The involved parties
- Risk managers
- Physicians and other practitioners
First, it’s important to understand what a plaintiff attorney looks for when considering a case against a physician/organization. That way, you can identify and then assess potential problem areas for your physicians and your institution. Plaintiff attorneys will seek out the following:

1. **Patient injury.** First and foremost, an injured patient almost always lies at the heart of a lawsuit. Most patients don’t become irate enough to sue without an injury, and an attorney isn’t likely to pursue a case that’s not supported by a tangible injury. Without a compensable injury, there cannot be liability under the theory of torts, according to James Saxton, Esq., Stevens & Lee, Lancaster, PA.

2. **A poor physician-patient relationship.** Once an attorney is sure that a patient has been injured, he or she then will look for weak areas that led to that injury, such as poor communication, procedures, and credentialing processes, with a poor physician-patient relationship at the top of the list. In terms of the physician-patient relationship, some of the questions for which an attorney will seek answers are as follows:
   - Did the physician listen to the patient’s concerns?
   - Did the physician spend enough time with the patient?
   - Was the physician condescending or dismissive in any way?
   - Was the informed consent process up to par?
   - Was there a significant service lapse?

3. **Insufficient medical record documentation.** The medical record, in essence, is the story of a patient’s illness or condition. If an attorney finds any holes in that documentation, he or she can suggest that those holes led to a breakdown in patient care, especially if either the physician or nurse altered the record, says Ernest Naful, Esq., of The Naful Law Firm, Columbia, SC. Further, if a physician appropriately handled the patient’s care, but it’s not documented in the medical record, then the physician is in less of a position to successfully defend him- or herself, adds Saxton.

4. **Poorly documented hospital procedures.** The medical record isn’t the only area that requires excellent documentation. Take credentialing files, for example. This is often the first place an attorney will look to discover whether a hospital has done its job to ensure that a physician is qualified. If your organization hasn’t met the minimum credentialing requirements of the state or the Joint Commission on Accreditation of Healthcare Organizations, most attorneys do not look much further.

5. **Can a patient file a claim against more than just the physician?** Good plaintiff attorneys will not stop with the physician. They will look for who else may have contributed to the injury. A logical place for them to look first is the organization, which is why your facility needs to foster excellent relationships with its patients.

Defense attorneys will look for the flip side of these issues: No injury, excellent physi-
The three-pronged approach to liability reduction is straightforward. It logically starts with preventing error and injury. The approach is as follows:

1. Reduce patient injury
   As previously noted, reduce patient injuries and you will reduce lawsuits, although reducing injury alone will not significantly affect liability reduction since most injured patients do not sue. Potential injuries include a missed diagnosis, surgical injury, medication errors, and other medical errors, according to *Making Healthcare Safer: A Critical Analysis of Patient Safety Practices*, published by the Agency for Healthcare Research and Quality. It does not include an adverse outcome that is a natural evolution of the condition or illness. Reducing patient injury is a long-term goal and requires implementing programs in high-risk areas such as the following:
   - Surgical site-marking programs as recommended by the American Academy of Orthopedic Surgeons and others
   - Medication error reduction
   - Use of clinical guidelines for breast and other cancers
   - Better management of intensive care
   - Clinical protocols in the emergency department
   - Informed consent programs
   - Enhanced safety programs in general surgery

   All health care organizations already have programs designed to reduce patient injury. Examples include the medical staff’s quality improvement programs, sentinel event analysis, credentialing processes, polices and procedures, and more. However, how sophisticated are these programs? Are they targeted at areas of known risk, and how much further do organizations have to go to ensure reduced liability risk?

2. Minimize the likelihood that an injured patient will sue
   More than 50% of patients sue because of miscommunication, anger, and lack of information between physician and patient, according to research from both hospital and liability insurance carriers. If a hospital or other health care facility wants to reduce lawsuits against physicians and the facility, it must first reduce claims against the physician. To decrease the likelihood of a lawsuit, facilities must, at the very least,
   - foster excellent physician-patient relationships
   - inform patients of care that did not go as planned
   - reengineer excellent informed-consent practices
   - provide educational resources for patients
   - link claims and incident reporting with the finance system

   As you assess your organization’s areas for risk, you will add many other initiatives to this list. However, the most important point is to show patients that through these efforts, the institution has listened to them, considered their opinions, and has not withheld critical information.
3. Maximize your defense if a patient does sue

As noted before, most lawsuits arise from an unsatisfactory physician-patient relationship. However, usually physicians are independent contractors, and consequently, not employed by the hospital. They are simply appointed members of the medical staff. Nevertheless, often the hospital is named as a defendant in the claims arising from these independent contractors’ actions. Most patients do not understand that physicians are not traditional employees and therefore assume the hospital has some accountability in the alleged injury.

How, then, does a hospital go about reducing its defense costs and increase its defensibility should a patient sue? Hospitals must conduct careful exposure analyses of high-risk areas such as back surgery, neurosurgery, obstetrics, and physicians with unusual backgrounds, e.g., those with high rates of malpractice cases. From there, make sure you have at least the following programs in place:

- Well-documented patient records
- Excellent policies and procedures that help to deflect a claim
- Excellent, timely expert review
- A sound credentialing system, including the granting of clinical privileges
- Accreditation status
- Excellent quality assurance programs
- Access to highly qualified physicians for quick review of potential claims

As noted above, you can’t manage/reduce professional liability risk alone. You need the support of management and in-house legal counsel, as well as direct assistance from physician leaders. Nearly all suits filed against the hospital originate in a physician-patient interaction, so it’s imperative that you have physician support. Other requirements for managing/reducing professional liability include focusing on the following areas:

- Problematic procedures, such as complex new interventions/technology
- Informed consent procedures
- Credentialing processes
- Physician-patient relationships
- Organization-patient relationships
- Independent contractor status
- Proactive failure mode analysis
- Institutional priorities, such as performance improvement, etc.
- Better integration between liability reduction and existing programs, including quality assurance, credentialing, infection control, continuing medical education, hospital safety programs, etc.

Perhaps most important to note is that professional liability reduction is not a one-time effort. It requires ongoing identification, assessment, and measurement. Future issues of BLRR’s White Papers will help you achieve these goals regarding specific risk-reduction strategies.