



## PRF NEWS

Covering Practice and Risk Management Issues for Physicians

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## The 'High-Complaint' Physician *(continued from page 3)*

and physician-physician), "did not listen", physician "jousting", charting problems, etc.;

"Access," with 153 complaints involving the "high-complaint" cohort, as opposed to 59 involving all other physicians within the group. These issues included "made me wait", "calls not returned," "access refused," "felt rushed," etc., followed by: "**Humaneness**" and "**Environment**."

These results corroborated similar studies that focused on malpractice prevention, including a notable 1989 Florida study<sup>2</sup> that concluded that being sued for malpractice was not necessarily a random event. That study revealed that, within each specialty reviewed, 3-8% of physicians were responsible for 75-85% of the total payments of awards and settlements. In other words, past behavior apparently *does* have a tendency to predict future behavior. The study noted that while physicians within some specialties perform higher numbers of more complex cases, a disproportionate share of lawsuits were filed against a small proportion of physicians within these specialties. Did a physician's technical competence play any role in these findings? To find out, a retrospective chart review of all obstetrical patients was carried out. The results of the review indicated that there were no clear objective or subjective differences of technical proficiency (including use of ancillary tests, documentation, etc.) among "high-malpractice-risk" physicians and their colleagues.

The Vanderbilt study concluded that two tools created as part of the study were worthy of attention. The first was ongoing,

systematic data collection and analysis through the use of the hospital's Office of Patient Affairs' "Patient Complaint Analysis System (PCAS)" (referred to above). Unlike more conventional "patient satisfaction" surveys, the

in a supportive peer review venue, the "report card" concept has been found to help physicians improve interpersonal skills, with the result being a decrease in the number of complaints and lawsuits filed against them.

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PCAS database captured the impressions of patients in their own words. The second was the development of a "report card" for physicians that included an index of complaints, along with representative statements by the patients, filed over a specific period of time, with the physician's "score" highlighted so that they can compare themselves with their colleagues. When used with-

Understandably, change is difficult for some to accept. But the effort made to convert "high-complaint" behavior into "low-complaint" will invariably result in an overall improvement in patient satisfaction coupled with a related decline in claims and lawsuits. When viewed in this perspective, the importance of malpractice prevention takes on a whole new meaning. ■

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*This article was written originally for Physician's Risk Advisory, a publication of Sutter Health Affiliates, and is reprinted with permission.*

<sup>1</sup> Gerald Hickson, James Pichert, Charles Federspiel, Ellen Wright Clayton; *Development of an Early Identification and Response Model of Malpractice Prevention* 60 Law and Contemp. Probs. 7 (Winter 1997)

<sup>2</sup> Frank Sloan et al., *Medical Malpractice Experience of Physicians; Predictable or Haphazard?*, 262 JAMA 3291 (1989).



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## Medical Abortion

BY BERNARD Z. GORE, MD.

**The approval of mifepristone (RU 486) by the FDA has provided a safe and effective option for women requesting an early pregnancy termination. Mifepristone is not only less invasive and emotionally traumatic than a surgical procedure, it is far superior to methotrexate.**

The safe use of mifepristone requires that the candidate for a medical abortion meet the following rigid criteria:

- 1) A pre-abortion sonogram showing an intrauterine pregnancy of less than 63 days duration must be obtained. An intrauterine pregnancy must be identified to preclude the possibility of ectopic pregnancy. A quantitative B-HCG measurement is not sufficient.
- 2) The Rh factor must be determined.
- 3) The patient must be in overall good health. (See package insert for contraindications relative to existing medical conditions).
- 4) A post-procedure sonogram must be scheduled. This will document that the abortion has been successfully completed.
- 5) The patient must understand and sign an informed consent form after appropriate discussion of alternatives, risks, and benefits.

The FDA approved protocol requires 600 mg. of mifepristone followed by 400 mg. of oral misoprostol, 24 to 48 hours later, requires two office visits, and has a 95 percent success rate. However, the standard of care now suggests that 200 mg. of oral mifepristone be followed by 800 mg. misoprostol placed vaginally by the patient at home 24-72 hours later. The

vaginal misoprostol is more effective and has fewer side effects than oral administration of the drug and results in a success rate of 98 percent. Note that this modification of the FDA protocol is an "off label" utilization of the medications that results in greater medical benefit to the patient as well as being more convenient and less expensive.

The most common side effect of the procedure is the pelvic cramping brought about by uterine contractions. Vicodin or Tylenol #4 are commonly prescribed for pain relief. Nausea can be mitigated with either large doses of Vitamin B6 or

antiemetic suppositories. Excessive bleeding or retained tissue is a rare occurrence and may require surgical intervention.

Mifepristone can only be obtained from Danco Laboratories ([www.earlyoptionpill.com](http://www.earlyoptionpill.com)). The dose-pack of three tablets costs \$270. The physician dispenses the mifepristone as well as the misoprostol (Cytotec). Danco Labs has

informed consent sheets provided for the patient with a duplicate copy for the patient's medical chart; however, using the alternative "off-label" methodology, a separate informed consent sheet must also be provided to the patient. Additionally, the patient receives a booklet of facts pertaining to the procedure, which is provided by Danco. All fact sheets and consent forms are provided when the drug is purchased. ■

*Dr. Gore, a member of PRF, is experienced in medical abortion.*

### Inside PRF News

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The criteria for prescribing RU486, how to administer the drug, how to obtain it, and how to handle side effects.

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# Health Care at the End of Life

BY MARSHA NUNLEY, MD

**Why is it that the majority of Americans die in institutions when most say they would prefer to be at home surrounded by friends and family? Why do so many die in emotional, spiritual, or physical pain?**

**To address these issues, palliative care programs are being introduced in hospitals across the country.**

**Pain management has become part of a hospital's accreditation evaluation and physicians may be**

**required to take a course in pain management and end of life care as part of their CME requirements.**



## HAVE IDEAS FOR RISK MANAGEMENT EDUCATION?

The Risk Management & Education Committee is seeking member input. They are looking for newsletter topics of interest and authors for articles. Please call June Riley, PRF Executive Director, at (415) 921-0498 or send an e-mail message to [june@prfrg.com](mailto:june@prfrg.com). ■

Unfortunately, pain management and end of life care have not been routinely included in medical school or residency curricula. Most doctors either get this training “on the job” or not at all. Today, because it is common for patients to change medical plans or move to another city, it is rare for a primary care physician to develop a life-long familiarity with his or her patients’ needs and personalities. In addition, medicine has become so specialized and health care has become so fragmented that patients are increasingly being passed from doctor to doctor so that each specialist can address his or her particular area of expertise. As a result, when patients reach a stage where medical expertise and technology have been exhausted, dealing with end of life issues may be very difficult for both patients and physicians.

This is a situation where hospice services may be invaluable, yet, unfortunately, referrals come so late – despite the fact that the response to hospice services is overwhelmingly positive. In fact, the average stay in hospice is less than two weeks. Consider that if a person facing death has unresolved emotional or spiritual issues it may be almost impossible to relieve their physical pain – but when patients finally get physical relief of pain and resolution of emotional and spiritual issues, not infrequently death comes swiftly and peacefully. Therefore, to use hos-

pice services most successfully, keep the following points in mind:

1. One barrier to an earlier referral to hospice is that the physician may feel powerless and frustrated in the face of the “failure” of medical interventions to save the patient. In his or her effort to cope with these feelings, the physician may withdraw emotionally or physically from the patient and return to those with more hopeful prospects for cure.

2. Patients referred to hospice may feel that they have been abandoned by their doctor. The doctor-patient relationship is very powerful and loss of that relationship can be frightening and confusing for the patient. The patient may view the hospice recommendation as a loss of all hope.

3. It is important to provide a “transition” for the patient. Reassure the patient that you will be available and will be in consultation with the hospice or palliative care doctor as needed. Keep in mind that the goal at this time is peace, serenity, and resolution for the patient. If you do not have the time, experience, or personal resources to deal with end of life issues, it may be best to allow the hospice or palliative care physician to manage the patient’s care. A phone call from the referring doctor to the patient can serve as an important connection. Knowing that you have entrusted their care

to a “specialist” in this area helps to assure the patient that you are doing what you consider is best for him or her.

4. Most patients want to know what will happen when they die. Will they be in pain? Will they struggle? Many are concerned about the impact on their loved ones who are watching the dying process. The main reassurance that patients want is that their symptoms can be managed and that death is not a terrifying experience.

Ideally, patients should be introduced to a palliative care team when they are diagnosed with any incurable disease – not just cancer. These conditions could include congestive heart failure, chronic obstructive pulmonary disease, dementia, or ALS. In the ideal situation, the team would follow the patient through whatever treatments were indicated. The patient’s spiritual, emotional, mental, and physical health would be included in the process of palliative care. When further intervention could offer no more for the patient, a smooth transition to hospice oriented care would be expedited. The circle of life includes death and it is unavoidable. Do not forget that it is our responsibility to include consideration of end of life care for our patients. ■

*Dr. Nunley is Medical Director for Visiting Nurses and Hospice of San Francisco.*

# The 'High-Complaint' Physician: A Study in Malpractice Prevention

It is not at all uncommon among physicians to feel victimized by the legal system's approach to dispute resolution. Legal decisions that appear inconsistent with "the facts of the case," frivolous lawsuits, "unscrupulous" attorneys, etc. are just a few of the targets of the medical community's wrath.

However justified these feelings are, these objections tend to emphasize the results of the malpractice dispute resolution process, not its cause.

From a risk management standpoint, the more important focus remains on preventing lawsuits from developing in the first place, not just spending large amounts of money to resolve them. In other words, what influences patients to file malpractice claims against their physicians in the first place? This issue has been addressed in numerous studies over the years. Prominent among them is a 1997 study from Vanderbilt University entitled "Development of an Early Identification and Response Model of Malpractice Prevention."<sup>1</sup> The findings of this study reinforced the widely-held observation that a patient's dissatisfaction with the inter-personal relationship with their physician plays a statistically significant role in their decision whether or not to sue.

The subjects of this study were members of a 717-member medical group comprised of primary and specialty physicians on the faculty of the Vanderbilt University School of Medicine. The study was carried out under the auspices of the hospital's Human Subjects Protection Committee. Data was collected by the hospital's Office of Patient Affairs ("OPA"), whose function was to serve as a resource to patients with questions, concerns or complaints about medical ser-

vices. The OPA developed a database, the Patient Complaint Analysis System (PCAS), to track the patients, the substance of their complaints, to whom the complaints were directed, efforts at resolution, and final outcomes (if any). Thirty-five specific categories were defined under one of six general headings; physician

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communication, humaneness, care and treatment, access and availability, environment, and billing problems. Over 8,000 patient complaints were coded, including the name of the individual who was the subject of the complaint. Two coders reviewed every complaint and its coding to ensure consistency. Any differences in opinion between the two were referred to a third for resolution.

The results of the study revealed that complaints about physicians were not random at all. A total of 641 (90% of the group's members) were named in fewer than 10% of the complaints (including the 40% of the members who had no complaints lodged about them at all). These physicians were defined as "low-complaint". In dramatic contrast, the remaining 76 physicians (10% of the group's members) accounted for close to 66% of all complaints and were characterized as "high-complaint." The distinctions among the two groups were dramatic.

The most common patient complaints concerned "Billing/Payment" followed by:

"Care and Treatment," with the "high-complaint" physicians accounting for 434 of all complaints, against a total of 240 lodged about their "low-complaint" colleagues. Issues within this category included treatment and diagnosis-related problems, adverse outcomes, perceptions of competency, etc.;

"Communication," with 278 complaints registered against the "high-complaint" group, versus 125 against their "low-complaint" counterparts. This section included overall communication problems (including patient-physician

*(continued on page 4)*



## MALPRACTICE AWARD LIMITS?

A Republican majority in the Senate may revive legislation proposed last summer by President Bush that would limit medical malpractice awards along the lines of caps mandated by California's MICRA law. Up to now, that measure has stalled in the Senate. The defeated legislation was proposed in late July by Senator Mitch McConnell (R-Ky). Senator McConnell proposed an amendment to a generic drug bill that was intended to limit punitive damages to twice the amount of compensatory damages, require that 50 percent of punitive damage awards go to state activities and restrict attorneys' fees. ■