Medical Errors

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OPTOMETRIC MANAGEMENT EDUCATION

Course Objectives:

To be aware of the history of medical errors training

Definition and categories of medical errors that can occur

Causes of medical errors within the optometric setting

Discuss how to prevent medical errors as well as root cause analysis

Why medical errors lead to malpractice

Discussion of methods to prevent malpractice claims in eye care

Review Root Cause Analysis and its role in prevention of ME

Why Are We Here?

- Required by Statute: FL. Stat. 456.013(7)
  - Statute Department of Health All Medical Specialties
  - Willie King Case - Later
- It continues to be a real problem
  - Prevention
  - Public Sentiment

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How Many Times/Years Have You Been To This Meeting?

Nobody has responded yet.

Hang tight! Responses are coming in.

What Do You Want to Talk About?

Nobody has responded yet.

Hang tight! Responses are coming in.

What Is a Medical Error?

Errors of omission occur because of actions not taken.

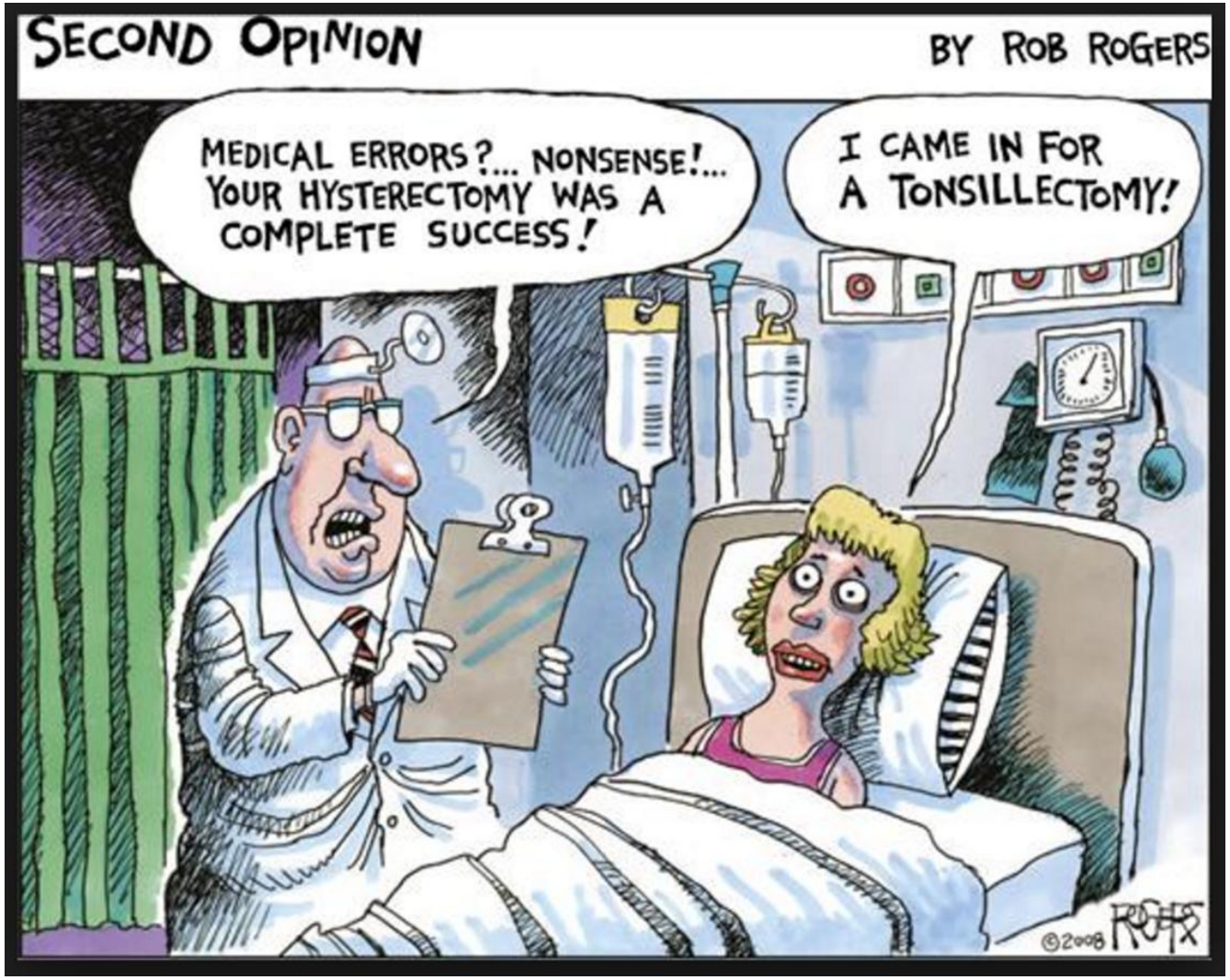
Examples: not following up on patient with ocular HTN, not dilating a patient with a retinal disease

Errors of commission occur because of the wrong action taken.

Examples: include administering a medication to which a patient has a known allergy or not labeling a laboratory specimen that is subsequently linked to the wrong patient.

Public Opinion

- 1997 survey from the National Patient Safety Foundation at the American Medical Association titled "Public Opinion of Patient Safety Issues Research Findings,"
- General public labeled the healthcare environment as only "moderately safe" with a rating of 4.9 on a scale of 1 to 7 (where 1 was Not Safe at All, and 7 was Very Safe).
- The survey reported that the general public found the healthcare industry less safe than airline travel or the workplace environment.
- 52% of respondents felt that the healthcare system did not have adequate measures to prevent medical errors
- Perceived cause of "medical mistakes," were "carelessness or negligence" and "overworked, hurried, or stressed" healthcare professionals


SECOND OPINION
BY ROB ROGERS
MEDICAL ERRORS?... NONSENSE!... YOUR HYSTERECTOMY WAS A COMPLETE SUCCESS!
I CAME IN FOR A TONSILLECTOMY!
©2008 ROGERS

The Scope of the Problem

- 1999 Institute of Medicine published report “To Err is Human: Building a Safer Health System”
- This report resulted in Federal Funding (50million in 2000 to the Agency for Healthcare Research and Quality) for patient safety initiatives
- Accreditation and reporting standards tightened
- Research on effectiveness of patient safety measures increased

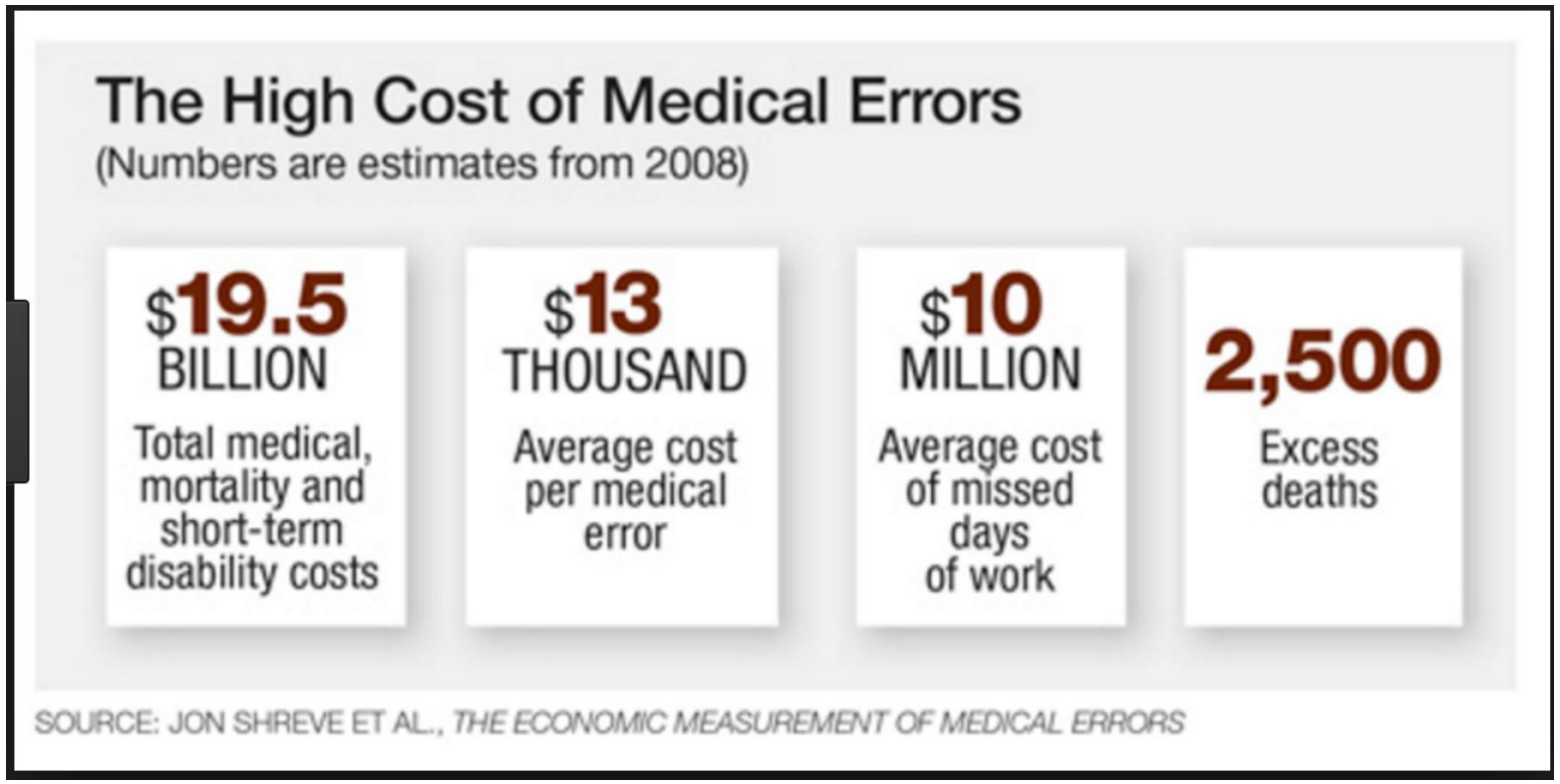
1999 Institute of Medicine Report

- "To Err Is Human"
  - Building a Safer Health System
  - At least 44,000 people and as many as 98,000 people, die in hospitals each year as a result of preventable medical errors
  - That is more than die from motor vehicle accidents, breast cancer and AIDS

1999 Institute of Medicine Report

Medical Errors (as defined in this report):

- Medical errors, “adverse events” which, in retrospect, are considered preventable are labeled Sentinel Events, those which signal a need for immediate investigation



1999 Institute of Medicine Report

The Cost of Medical Errors

Estimated between $17 and $29 Billion per year including hospital care and…….

1. Expense of additional care
2. Lost Income
3. Lost Productivity
4. Disability

1999 Institute of Medicine Report

Cause of Errors:

- Decentralized and fragmentation of the health care delivery system
- Multiple Providers in different settings, none of whom has access to complete information
- Medical Liability system that impedes efforts to uncover and learn from errors

1999 Institute of Medicine Report

Cause of Errors:

- Third party purchasers of health care provide little financial incentive for health care organizations and providers to improve safety and quality

1999 Institute of Medicine Report

Causes of Errors:

- **NOT** Bad Dr's
- Faulty Systems
- Faulty Processes and Conditions that lead people to make mistakes or fail to prevent them

“Dr. Death” is the nickname given to **Dr. Christopher Duntsch**, a former neurosurgeon in Texas whose shocking malpractice led to **permanent injury or death for 33 out of 38 patients** he operated on between 2011 and 2013.

Duntsch performed spinal surgeries that resulted in:

- **Paralysis**
- **Chronic pain**
- **Loss of mobility**
- **Two patient deaths**

- His errors included:
  - Severing arteries
  - Operating on the wrong part of the spine
  - Leaving surgical hardware in dangerous locations
- Despite repeated warnings and poor outcomes, he continued practicing due to **systemic failures in hospital oversight and reporting**.

⚖️ Legal Outcome

- **License Revoked:** 2013 by the Texas Medical Board
- **Conviction:** 2017 for injury to an elderly patient
- **Sentence:** Life in prison with parole eligibility in 2045

- His story inspired:
- The **Wondery podcast** *Dr. Death*
- A **Peacock TV series** starring Joshua Jackson, Alec Baldwin, and Christian Slater

1999 Institute of Medicine Report

What must be done:

1. Establish a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety

2. Identify and learn from errors by establishing a nationwide public mandatory reporting system

1999 Institute of Medicine Report

What must be done:

3. Raise performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of healthcare

4. Implementing safety systems in health care organizations to ensure safe practices at the delivery level

Then What Happened?

1. Federal funding for patient safety initiatives increased

2. Accreditation and reporting standards tightened

3. Research on effectiveness of patient safety measures increased

4. The Joint Commission in 2002 created National Patient Safety Goals and began enforcing these new standards by shifting from preannounced site inspections to unannounced visits

5. The National Quality Forum (NQF) released its initial list of Serious Reportable Events (SREs) updated in 2011

These errors are also called “never events”

More than 400,000 Medicare “never events” occurred in the U.S. in 2008, est. cost of $3.7 billion

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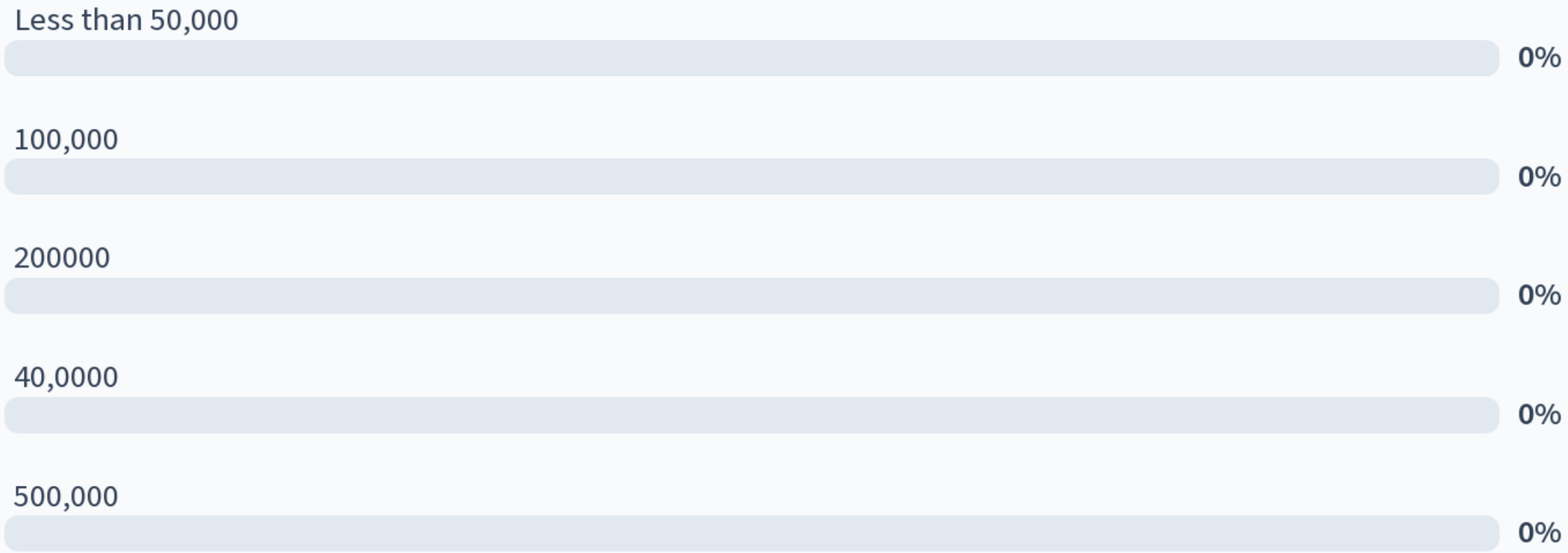
How Many Deaths Are Caused Each Year By Medical Errors?



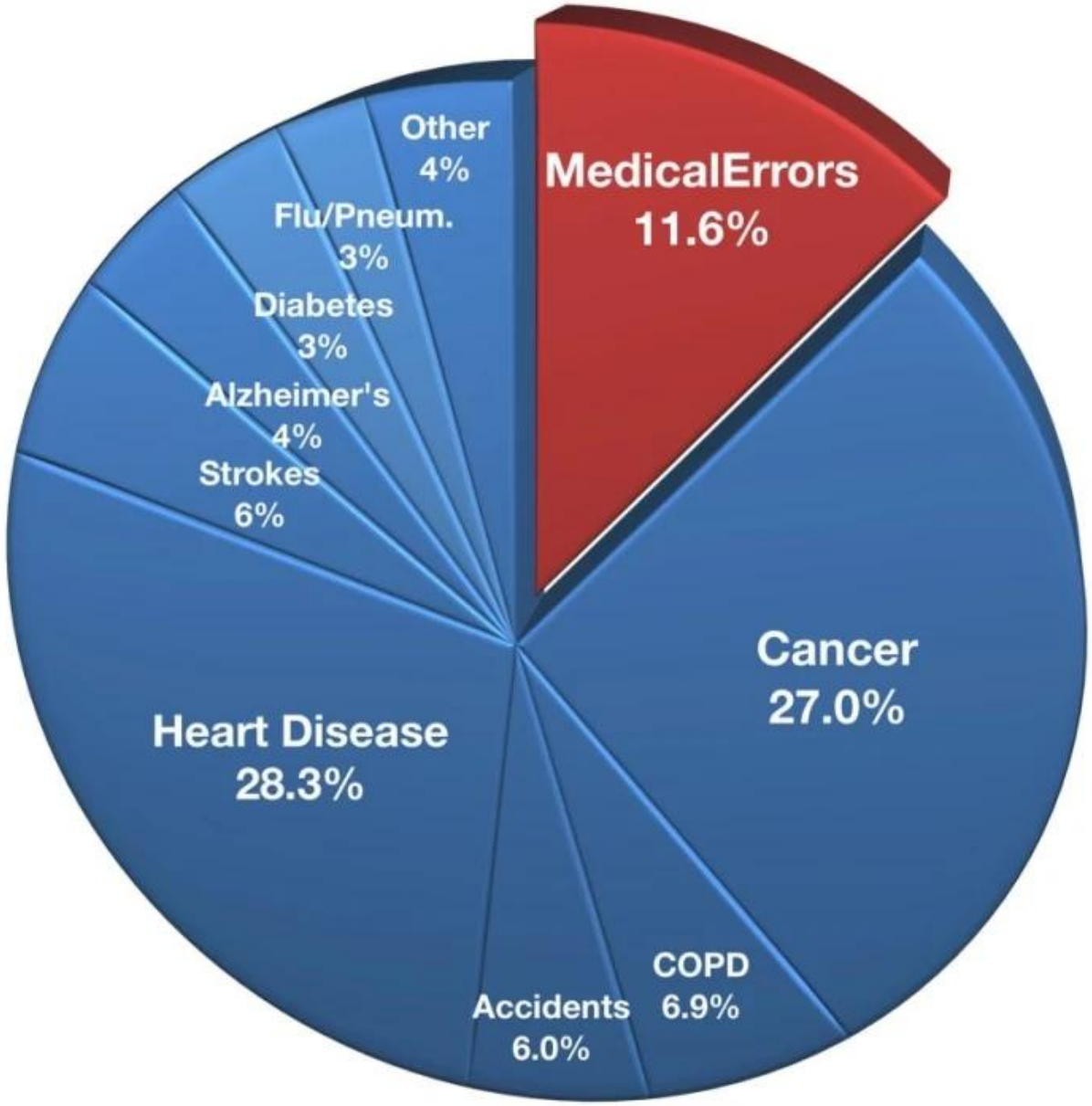
Estimates of the number of deaths due to medical errors vary widely, ranging from 22,000 to 440,000 per year

- A 2020 Yale University meta-analysis found evidence of about 22,000 preventable deaths annually, mostly in people with less than three months to live.
- A 2024 Johns Hopkins study led by Dr. Martin Makary found that medical errors cause over 250,000 deaths annually, making them the third leading cause of death in the United States, behind heart disease and cancer.
- The Journal of Patient Safety estimates that up to 440,000 deaths each year can be attributed to medical errors, injuries, accidents, and infections.

Hospital Errors are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow

Washington, D.C., October 23, 2013 – New research estimates up to 440,000 Americans are dying annually from preventable hospital errors. This puts medical errors as the third leading cause of death in the United States, underscoring the need for patients to protect themselves and their families from harm, and for hospitals to make patient safety a priority.

Top 10 Causes of U.S. Deaths (2013)



Sources: CDC and BMJ Publishing Group, Ltd (Johns Hopkins study)

Association of Health Care Journalists
Center for Excellence in Health Care Journalism

‘Medical errors are the third leading cause of death’ and other statistics you should question

Missing in the coverage was scrutiny of the researchers’ flawed methods, which involved extrapolating death rates from unrepresentative patient populations and making unsubstantiated causal connections between errors and deaths.

Meanwhile, lower estimates get ignored. As far as I can tell, no mainstream news outlet covered a 2020 meta-analysis by researchers at Yale University that found evidence of about 22,000 preventable deaths annually, mostly in people with less than three months to live.

Things To Consider

- **Include the range of uncertainty**. Harms from medical error are difficult to measure, and researchers shouldn't claim false precision. Report a study's confidence interval, which indicates if an estimate may be too high or too low.
- **Examine who was studied.** Small studies in which a handful of patients died can't reliably predict the entire U.S. death rate. Nor can studies of populations that aren't representative of all patients nationally, or studies that are decades old.
- **Determine how medical errors were defined.** Datasets don't always distinguish between errors that cause death and errors that coincide with death. Also, experts may disagree about whether a death or injury was the result of error.

Medical Error Reduction and Prevention

Thomas L. Rodziewicz; Benjamin Houseman; Sarosh Vaqar; John E. Hipskind.
Author Information and Affiliations

Last Update: February 12, 2024.

- 400,000 hospitalized patients experience some preventable harm each year, while another estimated that
- >200,000 patient deaths annually were due to preventable medical errors.
- $20 $45 billion annually for adverse events

Have You or a Family Member Suffered an Adverse Event/Medical Error?

Yes

0%

No

0%


katie

CMS Rules regarding Medical Errors

- 2007 Medicaid funds will be denied for treatment of preventable errors, injuries and infections
- 2011 expansion of rule prohibits use of Federal Medicaid funds to pay doctors and hospitals for treatment of services related to **“never events”**
- The 2011 changes also say the bills cannot be transferred to the beneficiary
- States were given until July of 2012 to implement this new CMS policy

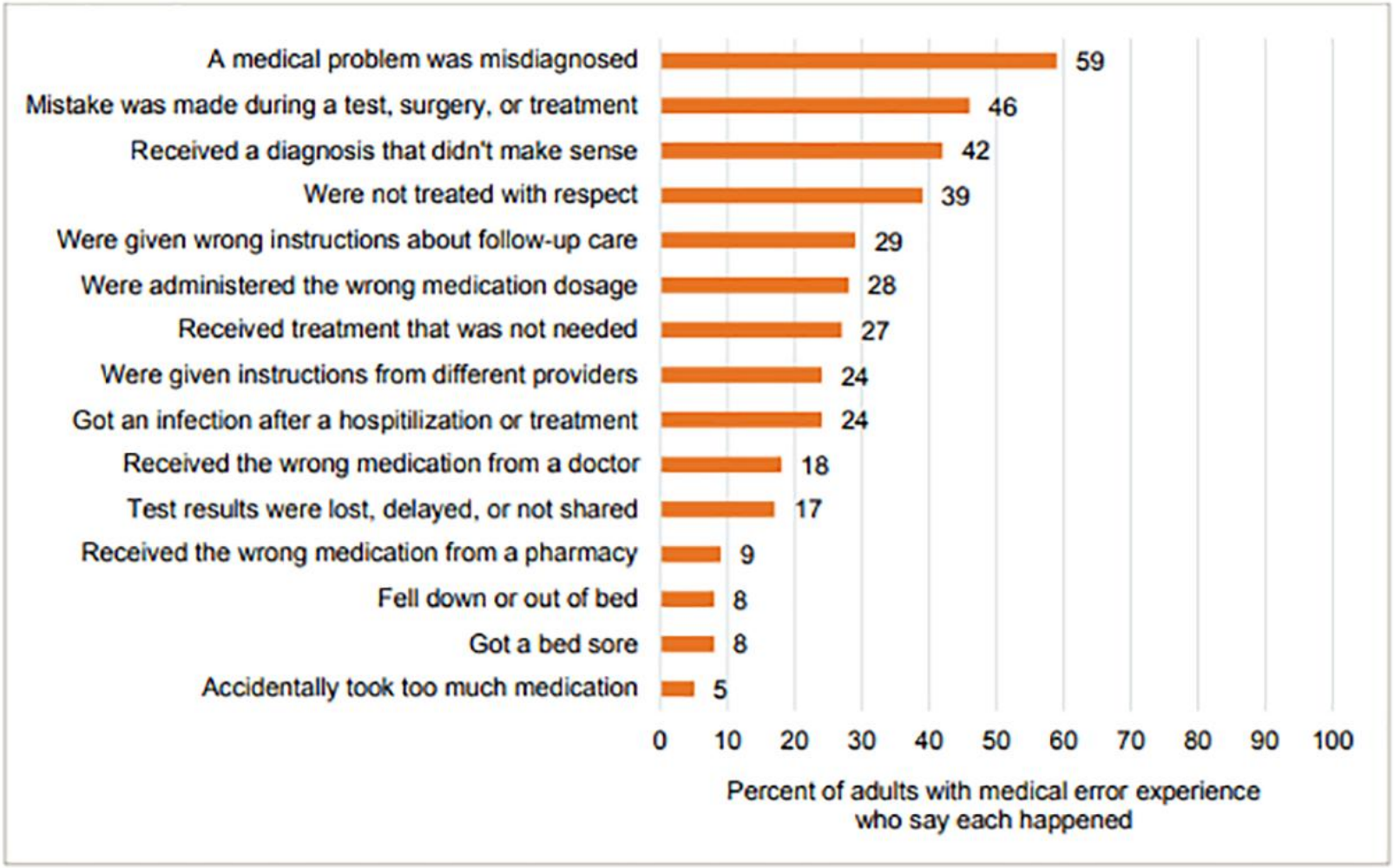
3 Basic Types of Causes of Errors

A. **Physical causes** – Tangible, material items failed in some way (for example, a car's brakes stopped working).
B. **Human causes** – People did something wrong or did not do something that was needed. Human causes typically lead to physical causes (for example, no one filled the brake fluid, which led to the brakes failing).
C. **Organizational causes** – A system, process, or policy that people use to make decisions or do their work is faulty (for example, no one person was responsible for vehicle maintenance, and everyone assumed someone else had filled the brake fluid).

Medical Errors Stats

- Unsure but still a problem
- Ultimately doesn't matter
- You don't want to be the one in trouble

Six in 10 adults with medical error experience say a medical problem was misdiagnosed and 4 in 10 say they weren't treated with respect.



Question: Again, thinking about the most recent time a medical error was made in [your care/the care of someone close to you], for each of the following, please indicate whether or not it is the sort of medical error that occurred.

Medication Errors

- FDA receives over 100,000 reports of medication errors per year
- 7 million American patients that have been impacted in some way by medical errors each year
- Approximately 530,000 injury incidents occur yearly in outpatient clinics due to medication errors
- 10% of the patients in every hospital will be part of a medication error.

Dennis Quaid

Root Cause Analysis (RCA)

- Popular and often used technique that helps people answer the question of why the problem occurred in the first place.
- It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:

1) Determine what happened.
2) Determine why it happened.
3) Figure out what to do to reduce the likelihood that it will happen again.

The 5 Why’s

5 Steps to RCA

Define	Define the problem
Collect	Collect the data
Identify	Identify possible causal factors
Identify	Identify Root Cause
Recommend & Implement	Recommend & Implement solutions

The Willie King Hospital Safety Act

The tragic case of Willie King—whose **wrong foot was amputated** in 1995 at a Florida hospital—sparked a wave of **policy reforms and safety protocols** that reshaped surgical procedures nationwide.

This case is still taught in medical ethics and patient safety courses as a powerful example of how **systemic failures—not just individual errors—can lead to catastrophic outcomes**. If you're building a safety framework or training module, I can help you map out a Cause Map or checklist based on these reforms. Want to explore that?

Key Safety Reforms Inspired by the Willie King Case

Mandatory Surgical Timeouts
Florida law now requires surgical teams to pause before procedures to confirm:

- **Correct patient**
- **Correct procedure**
- **Correct surgical site**

Site Marking Protocols
Surgeons must mark the surgical site while the patient is awake to prevent wrong-site surgery

Double-Check Systems
Hospitals implemented:

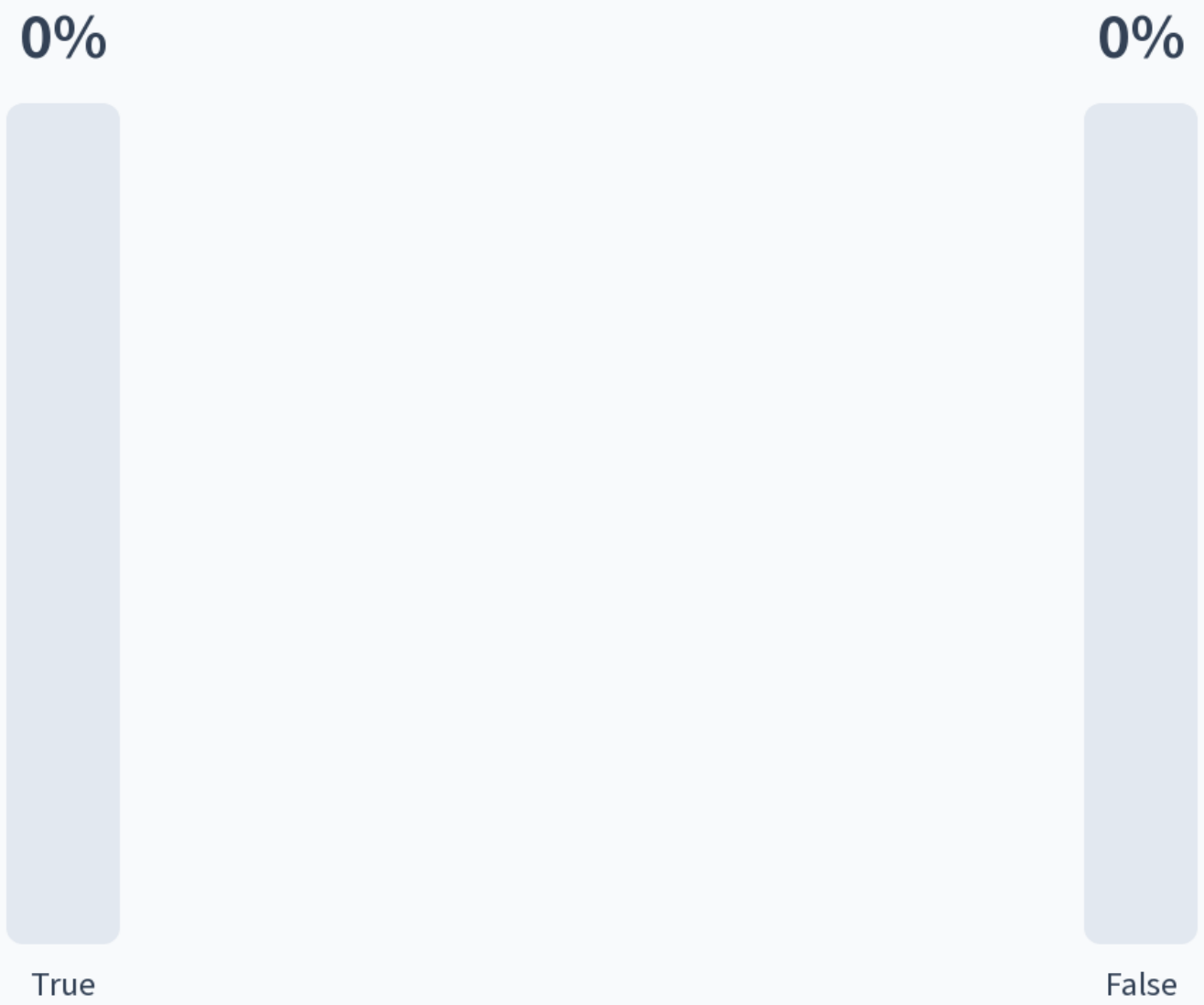
- **Computerized error-tracking systems**
- **Patient safety officers**
- **Redundant documentation checks**

Pre-Op Patient Interaction
Surgeons are now required to speak directly with patients before surgery to verify consent and site

Safety Around Eye Care Medicines

- Wrong patient details added to a prescription.
- Prescription written for the wrong eye.
- Eye medications prescribed which are not available locally (including those which are not on an agreed local formulary).
- Patient not advised about the expiry date of the product once it has been opened.
- Patient not advised about how to store the product appropriately

Younger Less Experienced Doctors Are More Likely To Make Medication Errors



Community Eye Health JOURNAL

2021; 34(111): 19–21. Published online 2021 Jul 20.

Safety around medicines for eye care

"The study found that more experienced doctors, including consultants, were just as likely to make prescribing errors as their more junior colleagues."

Safety Around Eye Care Medicines in Our Office

- Preserved formulation supplied instead of preservative-free.
- Wrong strength or dose.
- Poor communication with handover of prescribing responsibility.
- Expired drops-Therapeutic and Diagnostic
- Wrong drops
- Hydrogen peroxide
- Others?

Medication Errors in Office

- Expired drops-Therapeutic and Diagnostic
- Wrong drops
- Hydrogen peroxide

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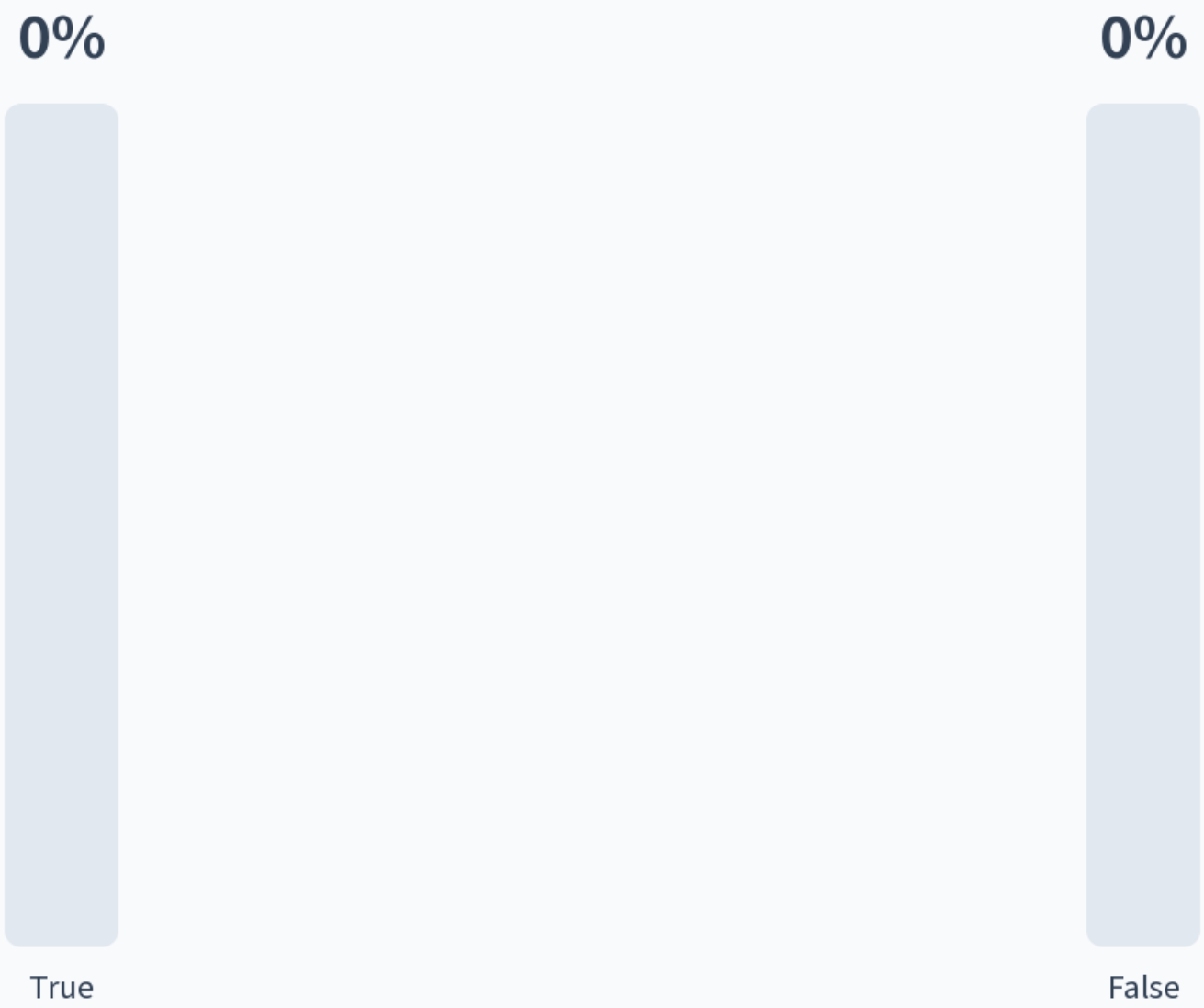
Do You E-Prescribe?



What is the average age of a person who files a malpractice compaint?


42

Does ERx Improve Medication Errors?

- 2019 NIH study found ERx reduced errors by 35%
- Another NIH study found:
  - omitting information is responsible for 60.7% of all e-prescribing errors and 50.9% of adverse drug events.
- Common Errors in E-Rx
  - Incorrect directions
  - Incorrect prescriber
  - Incorrect drug
  - Incorrect strength

Reduce E-Rx Errors

Fill out	Fill out patient information completely
Check	Double check names
Be	Be careful with autofills
Don’t be	Don’t be overly dependent

June 9, 2020

Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes

Sigall K. Bell, MD[1,2]; Tom Delbanco, MD[1,2]; Joann G. Elmore, MD, MPH[3]; et al

EHR Errors

Study Findings

- 21.1% reported a mistake in the record
- 42.3% reported that the mistake was serious
- My experience

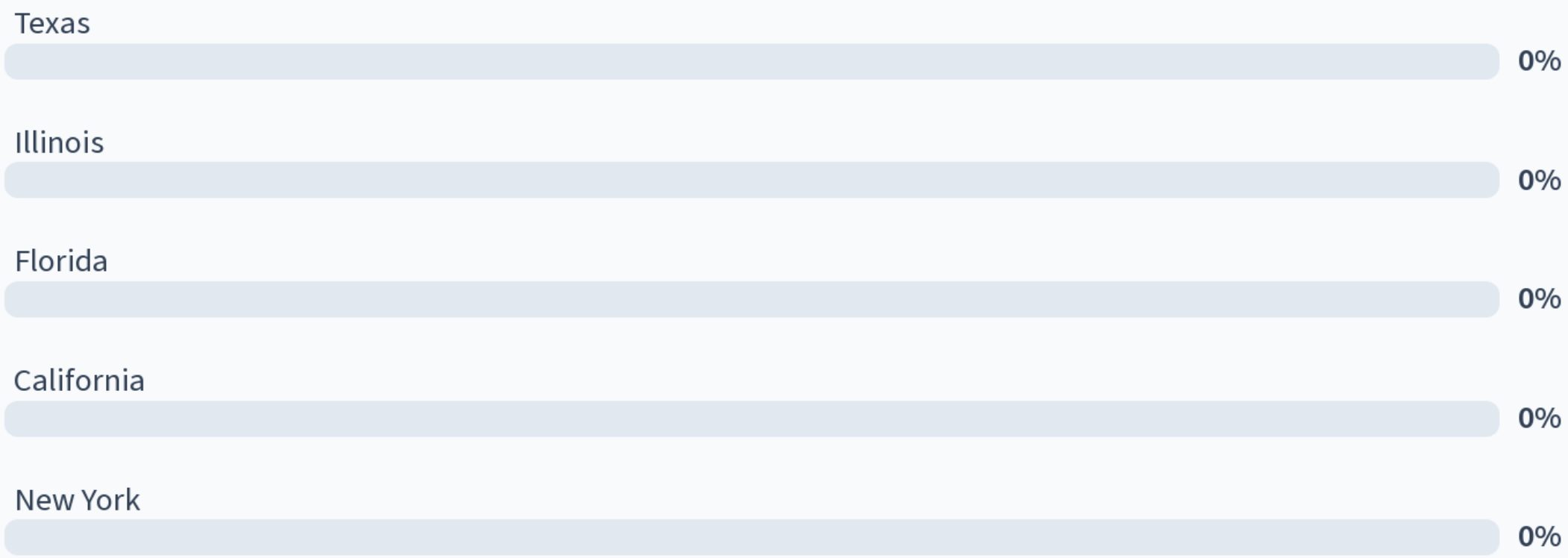
Optometry EHR Errors

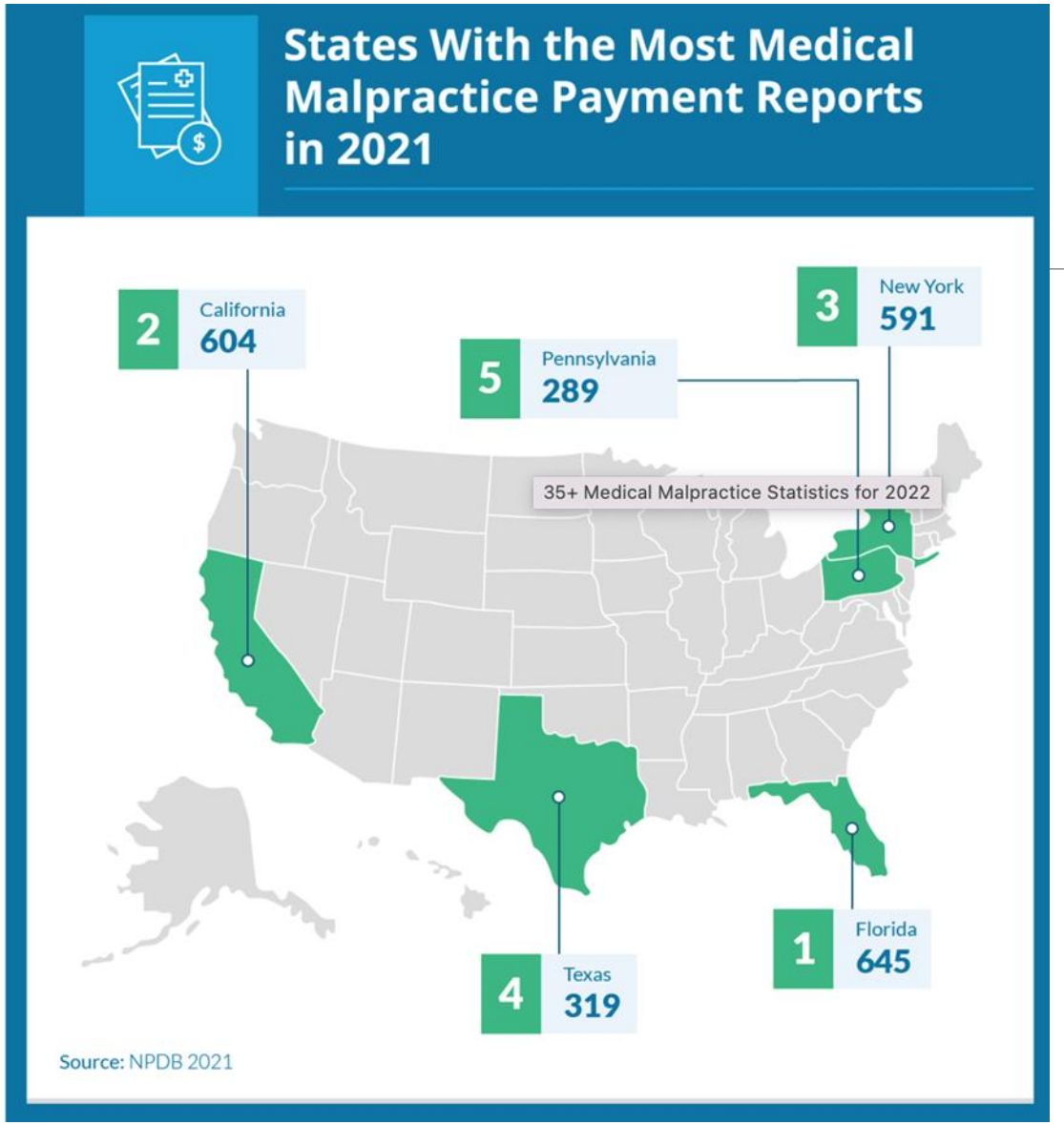
- Wrong Patient
- Wrong testing uploaded
- Wrong medical history

What percentage of malpractice claims resulted in a payment?


37%

What State had the Most Medical Malpractice Claims in 2021?




States With the Most Medical Malpractice Payment Reports in 2021
2
California
604
5
Pennsylvania
289
3
New York
591
35+ Medical Malpractice Statistics for 2022
4
Texas
319
1
Florida
645
Source: NPDB 2021

Medical Errors In Optometry

- Omission
  - Failure To Diagnose
  - Failure To Treat/Follow Up
  - Failure to Educate
- Commission
  - Wrong Rx
  - Failure to Follow Up
  - Failure to Refer
  - HIPPA Issues
  - Failure to Dilate
  - Records Release
  - Insurance Audits

📊 Malpractice Case Overview (2010–2020)

Metric	Value
Total malpractice cases	~2,813 cases [1]
Average per year	~140 cases [1]
Cases resulting in payment	~30% of total [1]
Most common allegation	Failure to diagnose (~45% of cases) [1]
Other frequent issues	Delay in diagnosis, wrong diagnosis, improper management, failure to refer [1]
Commonly missed conditions	Retinal detachment, glaucoma, tumors [1]

Here's a summary of **malpractice statistics involving optometrists in the United States** over the past decade

Optometry Malpractice Financial Impact

Average payout per claim: ~$242,000

Total payouts (2000–2020): Over **$10 million** for delay-in-diagnosis cases alone

Large claims ($500K+): Relatively stable over time

Out-of-court settlements: Average ~$425,000

Trial verdicts: Often exceed $1 million

Flroida Optometry Malpractice Case Volume (2015–2025)

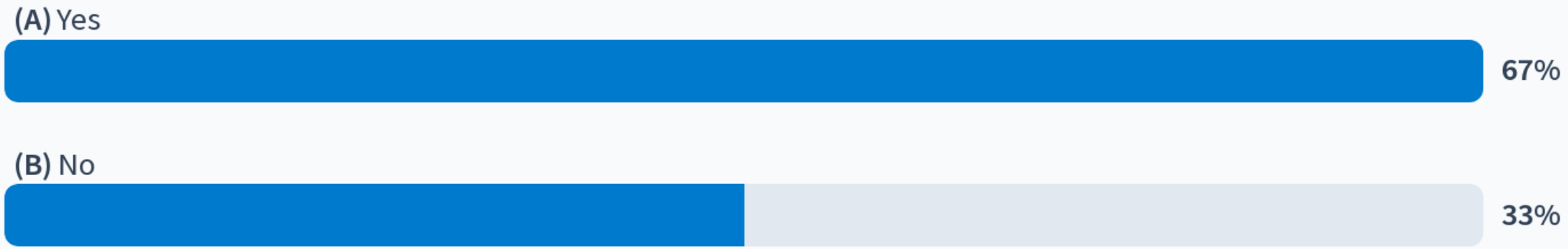
- **Estimated total cases involving optometrists:** ~250–300
- **Average per year:** ~25–30 cases
- **Most common allegations:**
  - *Failure to diagnose* (e.g. glaucoma, retinal detachment)
  - *Improper prescription* of lenses or medications
  - *Failure to refer* to ophthalmologists or specialists
  - *Inadequate documentation* or communication

These cases represent a small fraction of overall medical malpractice claims in Florida, which totaled over **1,200 payments in 2024 alone**.

Case #1

- Pt presented to office for comprehensive exam
- Pt's IOPs are 25mmHg OU
- No VFs or OCTs done
- Scheduled for annual comprehensive exam
- Pt returned to clinic for three years then stopped
- Pt. returned five years later with IOPs of 30mmHg
- Pt. referred to glaucoma specialist

DO You Think This Optometrist Did Anything Wrong?



Case #1

Pt. sued Optometrist successfully

Case comes to PCP

Sanctioned by Board of Optometry

What Type of Error?

Failure to Diagnose

Optometry Paid Claims 2000-2021

2839 adverse action report

817 medical malpractice payment report

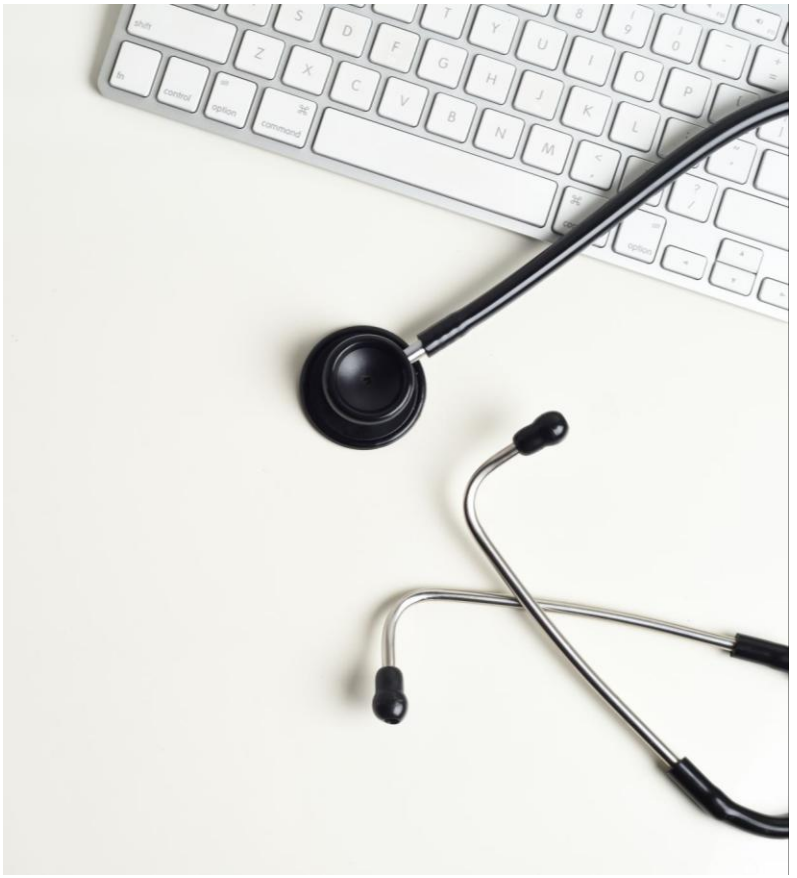
122 HHS OIG Exclusions

		14	2015	2016	20	2018	2019	2020	2021	Total
Action Type / Malpractice Payment Range	< $50,000	12	8	13	12	8	15	6	2	252
	$50,000 - $99,999	4	3	4	4	3	5	4	4	114
	$100,000 - $249,999	13	9	10	9	12	8	7	6	200
	$250,000 - $499,999	8	11	0	14	10	9	6	8	149
	$500,000 - $999,999	6	4	3	5	4	4	2	3	76
	$1,000,000 - $1,999,999	0	0	3	1	1	1	3	1	24
	>= $2,000,000	0	0	0	0	1	0	0	0	2
Total		43	35	33	45	39	42	28	24	817

Optometry Paid Claims 2000-2021

Medical Malpractice

- Any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice (**standard of care**) in the medical community and causes an injury to the patient.
- Duty to exercise the same degree of knowledge, skill, diligence and care that an ordinary competent physician would exercise in the same or similar circumstance.
- Negligence is the most common legal theory presented in a medical malpractice claim
- Other legal theories: wrongful death, battery, assault, abandonment and others



Standard of Care

What is it?

As technology and treatments change the standard of care will change

OCTs, VF, Myopia Management, AMD

“World Council of Optometry Passes Resolution Calling for a Standard of Care for Myopia Management” 4/13/2021

Doctor-Patient Relationship

Negligence

- Duty of Care
- Breach of Duty
- Patient Harmed
- Proximate Cause=Breach of Duty Caused Harm to Patient

Duties in the Exam Room

- Comprehensive exam (state board, insurances, community)
- Correct Diagnosis
- Proper Treatment
- Education
- Follow-Up
- Informed Consents and documented where needed

Case #2

New patient presented with headache complaints

Diagnosed with Migraines and History of Angle Closure Glaucoma

Follow-Up Scheduled for 6 months

Pt. Called Complaining of Continued Headaches

Nurse said to keep appointment which she missed

Diagnosed by another Ophthalmologist with vision loss from angle-closure glaucoma

No documentation that she spoke to nurse or that staff attempted to reschedule after no-show appointment

What Type of Error?

Failure to Follow-Up

Communication Failures

- 29% of claims resulted from failure of communication
- No documentation of informed consent
- Procedures
  - Punctal plugs
  - FB Removal
- Dilation
  - Importance
  - Risks of dilation and not dilating

Request for Treatment
Non-Dissolvable Silicone Punctal Plugs

I _____(print name) was evaluated by the doctor and have been previously informed that I have Ocular Surface Disease due to Dry Eye Syndrome. As a result, the doctor has recommended canalicular occlusion with non-dissolvable silicone punctal plugs.

Risks and Complications:

Non-dissolvable silicone plugs may cause tearing or watery eyes and while uncommon, irritation, infection, or allergic reaction may occur. If any of these complications arise, the plug may be removed using forceps to remove the plug from the punctum.

Possibility of Success:

Having responded favorably to testing, I realize that I probably will benefit from placement of non-dissolvable silicone punctal plugs. However, I realize that neither my response to the test, the doctor, nor the staff can guarantee the success of this treatment. It is not recommended to rub the eyes or lids after the silicone plugs have been inserted. They may become dislodged or fall out of the lid and be lost. The office is not responsible for replacing plugs that are displaced or lost.

Alternatives:

I may choose to use eye drops and decongestants to temporarily relieve the symptoms I am experiencing. However, these methods fail to treat the cause of the problem and require repeated use.

I may choose to do nothing for my condition. If left untreated, I understand that my symptoms probably will continue and might even get worse (tear production is reduced with age). Mild Dry Eye Syndrome may result in irritation of the eye. Severe Dry Eye syndrome can result in the loss of vision or the entire eye.

Argon laser and electrocautery are surgical procedures that may cause damage to tissue. These may be difficult to reverse should complications arise (irritation, infection, or watery or tearing eyes).

Informed Consent:

I have discussed and been encouraged to discuss my condition with the doctor. I have had all my questions answered. I understand my condition and the benefits and drawbacks of punctal occlusion using non-dissolvable silicone punctal plugs. I hereby request silicone plugs be placed in my tear drainage ducts to treat my dry eye condition. I will document my response to this treatment and, upon any eventual change in my condition, notify my doctor for evaluation and corrective action.

Patient _____ Date _____

Doctor _____ Date _____

Glaucoma Malpractice Stats

4-8% of all ophthalmology litigation cases

Over 60% of cases resolved in favor of defendant

Majority of cases come from medical management NOT surgical

Case #3

Pt with h/o POAG reported for one-day post-op after cataract surgery with IOPs of 31mmHg

OD confirmed patient's meds which included timolol

Pt was told to RTC in one week but was scheduled 11 days later

Case #3

Pt returned with IOPs of 40mmHg and referred to Ophthalmologist within group

Ophthalmologist tried various treatments with little improvement

Pt was referred to Glaucoma Specialist who performed a laser trabeculoplasty and Yag laser capsulotomy

Case #3

Pt only had island of central vision in OD and pt sued OD and Ophthalmologist claiming vision loss was a result of the delay in treatment (7 days vs. 11 days)

OD stated they wrote a note stating they wanted the patient to RTC in 7 days and did not know why pt was scheduled for 11 days

Pt claims they were never told about elevated IOPs and that they needed to be seen within 7 days, case was settled

What Type of Error?

Failure to Treat and Educate

Case #4

New pt. with complaints of reduced vision OD for several months

Last Exam was 10 Years ago

Diagnosed as Glaucoma Suspect

BCVA

- OD: LP
- OS: 20/25

Referred to Glaucoma Specialist

OD sued for failure to diagnose Glaucoma and Refer

Pt argued he was never educated that Glaucoma caused blindness

What Type of Error?

Failure to Educate

Glaucoma Malpractice

Protocols for Education and Documentation

- Have a protocol for educating patients on Glaucoma and the need for close follow-up (EHR)
- If you are not comfortable treating, then refer

Glaucoma Malpractice

- Most cases are from loss to follow-up and failure to diagnose
- Need
  - Referral process
  - Process for follow-up

- Think about your office flow
- Doctor directs-letter printed in exam
- Team directs-doctor alerts team to print letter and make referral
- Who determines if patient went?
- Designate one person
- Ultimately doctor’s responsibility

Processes and Protocols for No-Shows

Have a process

Designate one person

Ultimately doctor’s responsibility

Referral Process

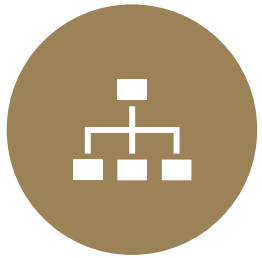
Referrals and Follow-Ups

- Doctor's Company surveyed small medical practices, large integrated delivery systems, hospitals and outpatient facilities
- 53% stated referrals and scheduling follow-up appointments were their top risk-management problems
- Study of over 2,000 claims showed:
  - 36% of patient injuries resulted from patient factors such as noncompliance with follow-up calls and not adhering to treatment regimens.
  - 24% of injuries from communication breakdowns between patients and health professionals.
  - 7% of injuries from communication failures among physicians
  - 7% of injuries from failures or delays in obtaining consultations/referrals

Other Diagnoses Where Referrals and Follow-Up Are Imperative

MACULAR DEGENERATION

NEUROLOGICAL CONDITIONS



CO-MANAGEMENT

CORNEAL CONDITIONS

SYSTEMIC CONDITIONS

OCULAR INJURIES

Case #5

Child presented with reduced vision in OD with all other exam findings recorded as normal

OD diagnosed amblyopia and scheduled follow-up appointment for one year

Pt returned in 11 months with LPO in OD

Case #5

Pt was referred to ophthalmologist and diagnosed with brain tumor compressing the optic nerve

OD did not do any VF or imaging at initial visit

Jury returned verdict against OD for $9.2M

What Type of Error?

Neuro Case

Failure to Refer

Neuro Malpractice

- If it doesn’t make sense get another opinion
- Order a test
- Schedule a follow-up to ensure your diagnosis is correct
- Ensure patient actually saw the doctor

Contact Lenses

Educational Tools

Fitting and Evaluation Agreement

- Contact lens modality
- Risks of non-compliance
- Schedule follow-ups

Processes and Protocols

Processes and Protocols

Intake Paperwork

- Comprehensive history
- Doctor reviews history
- Informed consent if having a procedure

Processes and Protocols

Work-Up Procedures

- Protocols = done properly
- Evaluate staff performing procedures
- Ensure communication to doctor if something doesn’t make sense or doesn’t look right
- Evaluate all tests

Delegating Tasks

Liable for all tests done by staff

Training

Who does it?

How often?

Education

Scripts

Processes-know when to get the doctor

Who Answers the Phone?

Newest employee?

Scripts

Training on Protocols

Processes and Protocols

Protocols for Consistency and Continuity

- AMD
- Glaucoma
- Neuro
- Contacts
- No Show/Cancellations
- Referrals

Processes and Protocols

Doctor Reviews

- History
- Medications
- Testing
- Documentation

Audits

Internal

- Standard Protocol
- Scheduled Regularly
- Evaluate the Outcome, Make Changes and Document

External

- Objective and may minimize liability
- Evaluate the Outcome, Make Changes and Document

Communication

- Effective (Usually Written)
- CANDOR
  - Apology laws
  - Have a process
- Training Doctor and Staff

Why Didn't Some Patients Sue?

"Patients who like their doctor don't sue no matter what their lawyer says."[1]

Hallmark Study from JAMA[2]

- Purpose: Identify communication behaviors associated with increased malpractice claims
- Videotaped office visits
  - 1.) Greater use of orientation statements that educated patients
  - 2.) laughter and humor
  - 3.) solicit patient's opinion, check understanding and encourage them to talk

Rapport

Other Office Processes and Protocols

- Check your insurance policies
  - General liability
  - Professional exclusions
- Objectively evaluate your property
  - Parking lot
  - Flooring
  - Accessibility
- Safety Protocols
  - OSHA
  - Train and educate staff
  - Monitor and audit for consistency

Golden Rule

"We have committed the Golden Rule to memory. Let us now commit it to life."

- Edwin Markham

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COPE Event 131128

COPE Course # 98747-EJ : Prevention of Medical Errors


THANK
YOU