Key Legal Principles for Hospitalists

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In a hospitalist system, when a patient leaves the hospital, he or she will return to a primary care provider (PCP) for follow-up and continuing care. The hand-off after discharge can compromise communication with the PCP. Physicians have a legal duty to provide follow-up care to patients with whom they have a relationship. The obligation to provide follow-up care endures even when the patient misses a scheduled appointment or does not adhere to the follow-up regimen. In general, the physician who began the care must fulfill that obligation. An essential component of follow-up care includes educating the patient about what symptoms require follow-up care and why it is important. The duty to provide adequate follow-up care is shared by the hospitalist and the PCP. Virtually no malpractice case law considers the obligations and practices of hospitalists. This article uses cases involving follow-up care for patients treated in an emergency department and general cases regarding liability for follow-up care to examine the potential legal obligations of both hospitalists and PCPs for follow-up care, including circumstances involving pending test results and incidental findings.

In the hospitalist model of care, after a patient leaves the hospital, he or she returns to a primary care provider (PCP) for follow-up and continuing care. The hand-off after discharge can cause a "voltage drop" in information, creating what has been called the Achilles heel of the hospitalist model.[1] This article examines the potential legal obligations created by the deliberate interruption in care after hospital discharge. I first consider the extent of a physician's legal duty to provide

Dis Mon 2002;48:197-206.
0002-9343/01/$20.00 + 0
doi:10.1067/mda.2002.125272

follow-up care and then analyze how hospitalists and PCPs might share that responsibility.

The malpractice liability of all health-care providers is governed by general negligence principles.[2] These principles require that the patient, as the plaintiff, show that the physician had a duty toward the patient, that the duty was breached, and that the breach caused harm with ascertainable damages. The hospitalist model challenges this doctrine by reconfiguring the physician–patient relationship and some of the duties that flow from that relationship. The deliberate interruption in the relationship between the patient and the PCP, and then the patient and the hospitalist, may lead to a heightened standard of care for follow-up or ongoing care after hospital discharge.

Virtually no malpractice case law considers the obligations and practices of hospitalists.[1] However, cases involving follow-up care for patients treated in an emergency department and general cases regarding liability for follow-up care illustrate some potential liability issues for hospitalists and hospitalist systems.

Duty to Provide Follow-Up Care

For some time, whether a physician's legal duty toward a patient included any obligation to provide follow-up care was in question. It is clearly established that for the duration of a relationship between a patient and a physician, the physician is obligated to give the patient all necessary care, so long as the patient's condition requires attention. However, many courts assumed that the physician's duty was limited to diagnosis and treatment. Several courts have now concluded that a physician's duty also encompasses instructions regarding care after treatment, or follow-up care. For example, a physician who diagnoses a breast lump as benign should counsel the patient about appropriate breast examinations and future screening. Failure to do so might result in legal liability if the patient never returned for mammograms and developed breast cancer in the future. The duty to provide follow-up care, as part of what the law calls "the obligation of continuing attention," frequently factors in when the physician who performed a procedure must continue to care for the patient until the threat of complications has passed.[3] These cases involving general follow-up care have several important lessons for hospitalists.

In *Shirk v Kelsey*, a gynecologist performed an abortion on a woman at 9 weeks gestation. Although competently performed, the abortion did not succeed in terminating the pregnancy. Pathology reports on a scant tissue sample indicated that the woman might still be pregnant. She missed a

follow-up appointment and did not contact her regular obstetrician until she presented at the hospital in labor. The physician who attempted to terminate the pregnancy did not call the patient after receiving the pathology report even when the patient missed her follow-up appointment. Although the jury found that the patient bore some responsibility for the lack of follow-up care, the physician who had performed the procedure was found negligent for failure to provide the continuing attention that the patient required.[3]

This case illustrates 3 aspects of the duty to provide follow-up care. First, a physician has an obligation to provide follow-up care even when the patient misses a scheduled appointment or does not adhere to the follow-up regimen. Second, the physician who began the care must fulfill that obligation. In the *Shirk* case, the gynecologist who performed the procedure, rather than the patient's usual obstetrician, was liable for follow-up complications. Third, an essential component of follow-up care includes educating the patient about what symptoms require follow-up care and why such follow-up is important. The duty to provide follow-up care includes counseling patients about the risks of failing to receive ongoing care and attempting to contact those who miss follow-up appointments.

Obligations of Hospitalists

Because the patient leaves the hospital and resumes care with the PCP, the hospitalist and the PCP share the duty to provide adequate follow-up care. How should obligations be distributed to ensure the best care for the patient after discharge? The hospitalist's duties are 2-fold. First, he or she must provide the patient with information about the ongoing care required and the risks of not receiving such care. Second, the hospitalist must ensure that the PCP has enough information to provide high-quality care when the patient presents in clinic. The hospitalist's obligation to the patient is the primary legal and ethical duty. The obligation to the PCP is a subsidiary duty that serves the best interests of the patient by ensuring a smooth transition from hospital to clinic.

Information About Diagnosis, Treatment, and Ongoing Therapy

If the decision to discharge the patient is sound, the hospitalist is obliged to give the patient 2 kinds of information at discharge. (If the decision to discharge is flawed, the hospitalist could face liability for premature discharge or abandonment, but these topics are beyond the scope of this article.) First, the hospitalist must provide the patient with information

about his or her diagnosis and treatment at the hospital and any instructions about ongoing therapy. Many hospitalists use written materials to meet these obligations. For example, a patient discharged after an asthma exacerbation may receive written information about medication regimens, including inhalers, antibiotics, and how to taper oral prednisone, as well as instructions to return to the emergency department for a specific peak flow value. Although written materials can help decrease legal liability, they may not completely discharge the hospitalist's ethical obligation to ensure patient comprehension, especially when they are too complicated or convoluted for some patients to understand. One study found that the reading material provided to emergency department patients was beyond the literacy level of approximately half the patients.[4] A 1992 study of adult literacy confirmed that 21% to 23% of adults in the United States have extremely limited literacy skills.[5] Furthermore, multiple or voluminous forms or a patient's difficulty synthesizing information given at discharge could compromise the follow-up plan outlined by the hospitalist. The hospitalist must also counsel the patient about the importance of follow-up care and the risks of missing ongoing treatment or close clinical follow-up.

Pending or Changed Test Results

The interruption in care that is fundamental to the hospitalist model creates particular problems when information changes after the patient leaves the hospital. For example, a patient could be discharged with results of a preliminary pathology report indicating a benign condition, but the final report might show a previously undetected malignancy. Such situations may become more common if patients spend fewer days in the hospital (allowing less time for information from laboratories or specialists to reach the hospitalist or be shared with the patient).[6] What is the hospitalist's obligation to provide information about pending test results? The closest analogy comes from the definitions of relationship and duty between emergency department physicians and their patients. Like hospitalists, these physicians see patients for a defined period without contemplating a future relationship with them. Courts have held emergency department physicians and their consultants liable for failure to follow up when these physicians failed to inform patients of test results received after the patient was discharged.

After a 4-year-old girl injured her arm, her parents took her to the hospital.[7] The treating physician ordered and read x-rays, concluded that there was no fracture, and sent the patient home. Early the next day, a radiologist read the x-rays and diagnosed a fracture of the distal portion

of the humerus near the elbow with an 8-mm displacement. He dictated his findings for transcription, but neither the emergency department physician nor the PCP received the report. Several months later, the parents learned that their daughter had had a broken arm. By then, she required an open reduction, and her physicians were concerned that she could have permanent deformity and require additional surgeries. Her parents sued several defendants, including the emergency department physician and the radiologist.

The trial court in this case concluded that because the radiologist had never met or examined the patient, he had no obligation to disclose the results. The appellate court reversed. It held that all physicians involved in a patient's case share, to the extent of their involvement, in the same duty and responsibilities as the PCP. That duty includes the responsibility to ensure sound communication and coordination of care. "It is incumbent upon these medical professionals to coordinate their efforts in a manner that best serves their patient's well-being," the court concluded.[7]

Cases like this suggest that hospitalists must accept responsibility for ensuring that the patient and PCP receive accurate information about tests or diagnostic procedures undertaken while the patient was hospitalized. Individual hospitals also may adopt policies that establish these physicians' obligations. For example, a hospital may designate which physician is responsible for communicating new information when the patient leaves the hospital or when physicians change during or immediately after the hospitalization.

In *Siggers v Barlow*, another case involving a misread x-ray in the emergency department, the radiologist noted the discrepancy between his finding of a scaphoid fracture and perilunate dislocation and the emergency department physician's diagnosis of a sprain. The radiologist reported the discrepancy to the emergency department nurse. Written hospital policy stated that when the report reached the emergency department, the physician on duty was obliged to notify the patient of a misdiagnosed x-ray. The emergency department physician on duty when the report arrived had never seen the patient. The physician attempted to locate the patient but never found him. Although this physician never participated in the patient's care, hospital policy transferred legal responsibility for follow-up information to him.[8] Similarly, a hospitalist who took over for another hospitalist in accordance with hospital policy might also assume responsibility for communicating information about test results that arrive after the patient is discharged.

Cases such as that of the girl with the missed fracture suggest that specialists who consult with hospitalists share liability if they find new

information. A policy that charges a hospitalist with responsibility for contacting a discharged patient to provide new information might be sound; however, regardless of who might bear abstract legal responsibility, hospitalists are most likely to have a better patient-tracking system, a more significant relationship with the patient, and a stronger motivation to communicate with patients and PCPs than such other inpatient physicians as subspecialists, consultants, or radiologists. Hospitalists develop relationships with hospital staff, discharge planners, specialty consultants, and outpatient physicians.[9] Some hospitalists may use a follow-up service to see patients briefly after discharge,[1] and this service could help coordinate the transfer of information about test results to patients and their primary physicians. Other hospitalist groups may hire physician assistants or inpatient clerks to provide continuity or to locate charts and test results.[1] The cases involving miscommunication between inpatient and outpatient physicians indicate that information fumbles predate hospitalist systems.[10] Hospitalists, by virtue of their experience coordinating consultants and hospital services and their dedication to improved communication, may improve patients' access to pending or changed test results. Hospitalists at academic medical centers may have the added assistance of residents to review test results and communicate with patients or PCPs.

Incidental Findings

The cases discussed above impose strong obligations on hospitalists to provide an accurate diagnosis for the patient's presenting complaint. The duty to diagnose correctly is among the physician's core obligations in the doctor–patient relationship. If new information becomes available about a diagnostic procedure or laboratory test ordered while the patient was hospitalized, that information might directly address the reason that the patient sought care from the hospitalist. However, a hospitalist may also discover incidental findings, such as a pulmonary nodule on a chest x-ray of a patient admitted for gastrointestinal bleeding, or a stool positive for occult blood in a patient admitted for pneumonia. Less clear is a physician's obligation to diagnose a problem unrelated to the primary reason the patient sought care. Here, again, the hospitalist model has the potential to expand traditional ideas about the relationship between patients and physicians and the responsibilities that follow.

The legal duty to work up incidental findings will depend on the standard of practice among other physicians who care for hospitalized patients. In almost every state, expert testimony must establish the standard of practice in the particular case, as well as proof that the

defendant physician deviated from that standard of conduct.[11] Treatment of incidental findings raises an issue of what standard of practice should be used to measure a hospitalist's conduct. Expert witnesses usually come from the defendant's specialty or area of practice.[2] Because hospital medicine is not currently recognized as a discrete medical specialty,[12] hospitalists may be held to the same standard of practice as other internists, including PCPs, in working up incidental findings. A physician who follows patients into the hospital and then continues to care for them after discharge would be likely to work up any incidental hospital findings. Whether hospitalists will be held to a similarly high standard is not yet clear.

Although the legal duty to pursue incidental findings remains ambiguous, the hospitalist's ethical obligation to act in the patient's best interests is self-evident.[13] The hospitalist who becomes aware of an incidental but important finding should clarify whether the work-up will be completed in the hospital or in the ambulatory setting before discharge. For many patients, it may be more convenient and comforting to have a computed tomographic scan or a colonoscopy performed while in the hospital. This work-up may spare the patient an additional trip to the medical center, anxiety while waiting for the outpatient tests, and the consequences of a lengthy delay if the patient or PCP miss opportunities to follow-up on the finding. Furthermore, evaluating the finding in the hospital uses the hospitalist's expertise in coordinating care among specialists and services.[6] Therefore, if the patient prefers an inpatient work-up and it can be completed expeditiously and safely, it is reasonable for the hospitalist to pursue it. On the other hand, some patients may prefer that their PCP explore the findings, particularly if they are anxious about receiving bad news (eg, a cancer diagnosis) or are reluctant to undergo additional interventions in the hospital.[14] Such work-ups may be deferred, but the hospitalist should ensure that the primary physician has accepted responsibility to follow up the finding. Moreover, the patient should be informed of the finding and the importance of following up with the PCP. Hospitalists may have special obligations for patients who lack a PCP. These patients will require a referral for follow-up care with a physician outside the hospital.

Obligations of Primary Care Physicians

Once the PCP has been notified of the patient's hospitalization and a follow-up appointment has been scheduled, the PCP not only accepts the patient hand-off, but also inherits a legal obligation to ensure that the patient receives follow-up care. Again, the legal boundaries of the PCP's

obligation will be defined by the prevailing standard of practice, but a few general responsibilities will almost certainly attach. The most common problems for PCPs are likely to be missed or inadequate follow-up appointments caused by incomplete information about the hospitalization.

Most follow-up care malpractice cases involve a physician's failure to see the patient soon enough, to require the patient to return, or to request additional tests.[11] A PCP who knew (or should have known) that a patient had recently been hospitalized and then missed a follow-up appointment might be faulted for failing to contact the patient and urge him or her to return for follow-up care. The extent of the physician's efforts to find the patient will depend on the severity of the patient's condition and the potential harm that a delay in medical care could cause. At the very least, the patient should be contacted, either by telephone or mail, and the appointment should be rescheduled if possible.[15]

Problems can also occur if the PCP lacks sufficient information about the hospitalization to take good care of the patient. One appellate case involved a PCP who never received records of tests that the patient, on his own initiative, underwent at an outside facility. The PCP diagnosed this patient with irritable bowel syndrome, unaware of the results of a barium enema and sigmoidoscopy at the outside facility. (The physician had urged the patient to obtain information about his bowel studies from the facility but did not try to retrieve the records himself.) The patient was later diagnosed with metastatic colon cancer and died. The jury found no malpractice liability, but the appellate court reversed the decision. It concluded that the trial court should have allowed expert testimony about a physician's obligation to follow up on a patient who did not obtain medical records as the doctor directed.[11] It would follow from this case that if information from the hospitalization, including test results, were unavailable, the PCP should at least counsel the patient about the importance of obtaining the pertinent information. In an ideal practice, the physician would obtain the information from the hospitalist or health-care system.

The Best Interests of the Patient

Malpractice law as it relates to hospitalist systems is still emerging, and therefore this analysis extrapolates from existing law and standards in comparable clinical situations. Nevertheless, it is clear that the law will place obligations to provide thorough follow-up care on both the hospitalist and the PCP. The best risk-management strategy after discharge will be to provide the patient with comprehensive, clear information and to ensure good communication between the hospitalist and the

TABLE 1. Key Recommendations

- Both hospitalist and PCP assume responsibility for discharged patient
- Inform patient of importance of follow-up care
- Inform patient and PCP of pending or changed test results or diagnoses
- Hospitalist and PCP coordinate contacting patients who miss follow-up care

PCP = primary care provider.

PCP (Table 1). Additional information should be given to the patient and the PCP as soon as it becomes available. The hospitalist does not discharge ongoing obligations to the patient by discharging him or her from the hospital. Nor is the PCP excused from responsibility for obtaining information about the hospitalization. Both groups of physicians have powerful legal motives to communicate effectively and reliably, both with the patient and among themselves. Hospitalist systems may want to unambiguously assign responsibility for postdischarge communication to the hospitalist on service when the information becomes known, the hospitalist who discharged the patient, or to a follow-up service designed to care for patients immediately after discharge but before they can see their PCP. Effective communication about and with the patient will promote the patient's best interests and resolve most of the potential legal liabilities that result from the patient's return to the PCP's care upon hospital discharge.

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