Keeping Your Patients and Yourselves Out Of Litigious Situations

Many claims are brought against our physicians not because of poor medical care but because the physician's actions and documentation do not support an appropriate standard of care when there is an adverse outcome. Any physician's comments, actions or inaction before and after an unexpected or adverse outcome may prevent initiation of a claim, trigger a claim, mitigate damages or negatively impact the defensibility of a medical malpractice case. This article will focus on risk management practices that should be a part of your practice.

Excellent informed consent, documentation and disclosure will protect both you and the patient.
Making the patient a true part of the team will increase compliance and build more realistic expectations. Careful handling of communication, informed consent and disclosure can also build a higher level of confidence in the doctor-patient relationship.

A Vanderbilt University study conducted by Gerald Hickson, MD and James Pichert, PhD showed that about 8 percent of physicians, depending on specialty, produce 40 percent of all risk management complaints and cause 80 percent of the money spent on claims. The physicians most likely to be sued were the same physicians who generated the most complaints. Those physicians were also not rated high in competency. Another study of OB claims surveyed plaintiffs to identify the initial motivating reasons patients sued. Those surveyed initiated claims most often for the following reasons in order of frequency:

1. Plaintiff had been advised to call an attorney by an "influential other"

2. Plaintiff needed money

3. Plaintiff believed there was a cover-up

4. Plaintiff believed the child would have no future

5. Plaintiff needed information (looking for answers)

6. Plaintiff wanted revenge.[1]

Wallace Rubin, MD of Metairie, Louisiana wrote a letter to Medical Economics commenting on an article written by Lee J. Johnson, JD "When another doctor messes up." Dr. Rubin commented that practically every malpractice suit he is aware of resulted from one physician stating that another had done something incorrectly.[2]

Assess the Issue Carefully
It should not come as a surprise that the comments of a subsequent treating physician actually triggered many suits. Honesty is always essential, but criticizing another doctor's care is not a good idea. You were not there, you may be wrong, and you have just recommended that someone needs to be blamed; perhaps without knowing all the facts? You may just have become an expert witness.

Assigning blame to another provider is not beneficial to the patient in most situations. When blame is placed, anger and distrust are intensified. Focus your attention on future treatment options. Even if suspicious of former treatment, tell the patient if questioned that you cannot comment on another doctor's decisions without reviewing the medical record and their rationale. Then follow through. Speculation is not appropriate without the facts to back up your suspicions.[3]

Address a Real Problem

Jury Verdict Research has shown that even though jurors tend to be sympathetic towards the plaintiff, they hold the physician in the highest regard of any party to a suit. But some perceptions can be damaging. Jurors react negatively when they believe that the physician failed to see what was in plain sight, was self serving, ignored the obvious, did not follow-up or put his/her self interest over the patient's.[4] Additionally, there must be no perception that the physician tried to cover-up an event. Inappropriate actions negatively impact perceptions and may even lead the parties toward litigation. One way we can help our patients and ourselves is by improving the actions we take before and after clinical events and to make these changes a permanent part of medical practice.

Informed consent is the proactive form of disclosure.

The more the patient knows the better able they can make logical decisions, accept responsibility for an unexpected outcome and comply with your recommendations. The physician should document in the medical record what activity occurred, including the content that was discussed. Encourage your patients to ask questions. Both you and your patients may be upset when results do not equal expectations, so relate information that leads to realistic expectations. Don't stop at the risks alone. Inform them of the inconveniences too. Document informed refusal if the patient chooses to refuse a recommendation.

CASE EXAMPLE 1

A young man underwent abdominal surgery. He complained of intermittent abdominal pain well after the procedure. One weekend he presented to the local Emergency Department where an abdominal film revealed a foreign object, likely a surgical instrument. The emergency physician informed the surgeon of the findings, but did not inform the patient. The surgeon examined the patient and told him they didn't know what was wrong and would need to perform exploratory surgery. During surgery they found a small clamp, but didn't tell the patient or document the removal. At a later date, the patient became aware of the radiology report and was very angry. He felt betrayed by the provider and brought suit. The physician was charged with separate counts of malpractice, battery and civil fraud. A large settlement payment was made because the physician's failure to disclose the truth and the lack of documentation were judged indefensible. (Criminal charges such as fraud are not usually covered under a medical malpractice policy.)

Sometimes, when a provider conceals an error, the statute of limitations for bringing a malpractice claim will not begin to run until the concealment is discovered. Additionally, in some states, courts may allow punitive damages because covering up a mistake is considered particularly dishonest.

Don't be afraid to apologize if something goes wrong. Often there was no error, but an unexpected adverse outcome. You should disclose that without admitting liability. When there was a definite error, tell the truth in a factual manner. Apologize specifically, sincerely, timely and in a proper setting. Predetermine, if possible, who will be present and consider your demeanor as you plan your conversation.

It is important that you first acknowledge the harm the patient has suffered. Admitting unexpected adverse outcomes, conveying bad news, accepting a patient's anger or hurt is difficult. If the outcome was an unpleasant but known risk of a treatment or procedure, your apology should reflect the informed consent process. "I am sorry to tell you that your father has developed a blood clot in his leg, and we are treating him for this."

Apologize precisely, especially if there is an obvious error. "I am sorry to tell you that you have a retained sponge, and we will have to take you back to surgery to remove it." Then document the disclosure. In a case where the liability is clear, instruments left behind after surgery or wrong site surgery; you probably have nothing to lose by apologizing and may even have something to gain. We also encourage you to call MAG Mutual to report a serious incident.

When an error occurs, quickly initiate any needed treatment to correct the condition. Following treatment, there are some key points to remember when disclosing adverse events.

- Be honest and don't be afraid to say you don't know how or why something happened

- Don't guess
- Don't draw conclusions about an event when you don't know
- Do not attempt to cover up an error by omitting known details
- Don't blame someone else
- Don't blame the nurses for not calling you sooner, the patient for not speaking up, the resident for not beginning the correct treatment
- Do not criticize other providers with your words or expressions

CASE EXAMPLE 2

A patient underwent a biopsy of a skin lesion. No one from the office emphasized the importance of follow-up or called her with the positive results. When she returned to the office six months later, she was diagnosed with metastatic disease. The physician told her, "I only wish you had come to me sooner." This was an attempt to transfer blame onto the patient. Deflecting blame does not protect the physician and can cause further emotional stress for the patient.

CASE EXAMPLE 3

A radiologist failed to appreciate a secondary finding on a chest X-ray. When asked to review the film later, he acknowledged his obvious error and said, "The patient probably would have died anyway." Self-serving documentation and comments like this have the ability to inflame patients and juries. In a separate incident the attending physician told the family of a deceased patient that the death would not have occurred if he'd been there, the residents were at fault.

CASE EXAMPLE 4

A 61-year-old male was followed long term by his primary care provider for episodic illness and complaints. The patient had progressive urinary complaints and agreed to have a PSA level checked. Results were reported as elevated, but were filed (systems error) before the physician saw them. The patient was seen five times over the next 18 months, and on the last visit the physician noted the elevated PSA. The patient was referred immediately, but died within weeks. His widow sued, but the claim was not reported to his insurance company nor was any response made to the court. This caused the physicians' insurance coverage to be at risk and severe penalties to be applied by the court. ***It is very important to notify MAG Mutual immediately if you receive a summons or notice of intent to file a lawsuit.***

Once a claim has been made, the medical record is your most important defensive tool.

Document objectively even if the patient or family reacts with anger. Simply describe what you told them and the details of any follow-up plan.

The do's:

- Document so that another provider can take over care and know what has been done
- Include equipment and medication identifiers as appropriate
- Only add an addendum that is needed for continuing patient care
- Date and time addendum at the time they are made and specify the time of the action
- Use wording that is unemotional and precise
- Record only what you know. Do not speculate
- Use quotation marks when reporting information given by the patient or family member
- Write legibly and sign all dictation and reports
- Document use of results and reports to the patient

- If uncertain, state your plan to follow-up or refer. Don't document a question and leave it hanging. (May be..........., without recommending further workup)

The don'ts:

- Don't document speculation or guesses
- Never alter a record. Don't add, subtract or try to correct
- Do not create an addendum merely because you are trying to defend or justify your care
- Don't point fingers at others including the patient./ I would have treated this differently./ Who did this to you?/ We could have done something if you had come to us sooner. (the subsequent treating physician is often a major initiating factor in claims)
- Avoid vague language. Probably benign means you need to document the need for further study/Rx to be sure
- Don't tell a patient I called my attorney/ called and talked to malpractice carrier/ discussed at Quality Assurance meeting
- Don't make judgmental statements against the patient such as patient is difficult/ beyond help/ patient is a malingerer

Do make necessary changes to your processes to prevent the same mistakes from happening again

Conclusion

Informed consent, documentation and disclosure will protect you and the patient. Take time to compose your thoughts and outline what you need to convey so you can do it simply, without blaming and without claiming negligence. Plan your conversation and prepare for the encounter. Document the encounter. Remember, making the patient a true part of the team will increase compliance and will build more realistic expectations. For you and your patients, healing is aided by the caring relationship you nurture.

[1] Patient Complaints and Malpractice Risk Vol. 287 No. 22, June 12, 2002 Gerald B. Hickson, MD; Charles F. Federspiel, PhD; James W. Pichert, PhD; Cynthia S. Miller, MSSW; Jean Gauld-Jaeger, MS; Preston Bost, PhD JAMA.

[2] Malpractice Consult, Medical Economics December 9, 2002 Lee J. Johnson JD When Another Doctor Messes Up

[3] (Rick Fuentes PhD, R&D Strategic Solutions, from a presentation to the defense Attorney Seminar in Atlanta, Georgia on September 18, 2002.)

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