Ever wish you had a can of lawsuit repellant? Well, now you do. Follow our easier-than-you-think advice to reduce your chances of ever being sued for malpractice.

When Larry Russell, a family practitioner in Hendersonville, N.C., recalls the best three moments in his life, he winces. They are not, in his estimation, what they should be.

Moment No. 1, he says, was the birth of his first child, a son.
Moment No. 2 was the birth of his second child, a daughter.
But Russell recalls Moment No. 3 with a sigh. It was the day he learned a jury had declared him not guilty of medical malpractice after he was accused of failing to diagnose lung cancer in a patient in 1991.
“It was a miserable time,” says Russell. “The case — which was really about a chart my associate had signed off on — dragged on for two and a half years, causing major stress. Sadly, getting the results back on that trial ended up being one of my most significant memories.”
If you think that what happened to Russell will never happen to you, think again. Statistics show that almost half of physicians will be sued twice during their careers. The good news, say experts, is that there are measures to take to reduce the chances of having that happen. And those measures are not at all complicated.
Larry Veltman, a retired OB/GYN in Portland, Ore., can relate. He was sued in 1995 when a very large baby he delivered developed shoulder dystocia. The case took five years to make it to court. During that time, Veltman says, he was a wreck any time he had to attend a deposition, take a call from his attorney, participate in a settlement discussion — or anything else that pertained to the lawsuit. As the trial approached, he even got into two small car crashes, which he blames on overwhelming stress and distraction.
Veltman won the case, but he still shudders when he’s reminded of it: “It’s a very traumatic event that makes you think more than anything: How can I prevent this from ever happening again?”
There are no guarantees, of course, but there are things you can do. And “it really isn’t brain surgery,” says Kenneth Hertz, senior consultant for the Medical Group Management Association (MGMA). “It involves simply developing standards and protocols so there is consistency and clarity in everything the practice is doing.”
How to start?
Peter Dayton, an OB/GYN in Stuart, Fla., who has been sued five times, puts it this way: “Put a little lawyer on your shoulder, walk around your practice, and see how that changes your behavior.”

Talk to me
Malpractice attorneys say enhancing doctor-patient communication is the first cornerstone of risk management. Ask yourself: Do you take the time to really listen to patients? Do you answer all of their questions? Do you fully explain all the risks involved in procedures before performing them? Not taking care of these things as a matter of course with each patient can land you in a heap of trouble.
“After doing this for more than 20 years, I think most lawsuits come about because of a lack of clear communication,” says Scott Whonsetler, a medical malpractice attorney with the Louisville, Ky.-based law firm Whonsetler & Johnson PLLC. “The physician hasn’t communicated well with the patient, or there’s been a misunderstanding or unrealistic expectations because the two of them didn’t talk enough.”
Whonsetler says that managing patient expectations and detailing a procedure’s risks are of particular importance.

“Be open, be honest, explain all the risks up front before going into something like a surgery,” says Hertz. “Make sure the patient really understands what you’re saying and that what you said to them is documented.” And it doesn’t hurt to have a witness present. This person can sign off to attest that
you laid out all of the risks to the patient beforehand. Possible risks and adverse outcomes should also be clarified for patients’ families. Imagine your father is in surgery. You’re waiting for hours, and no one gives you an update. You’re worried, upset, and, in the absence of any information, you start conjuring up worst-case scenarios. Hertz says he was in such a situation. He assumed his father’s surgeon was busy performing the procedure, but he says he would have been greatly relieved if a staff member had at least spoken to him from time to time to keep him informed. “I can imagine that people in that situation would then want to blame the doctor if, in the end, there is a bad outcome,” he says.

**Train your staff**

Better-trained staff could have remedied that situation, just as well-trained staff can set a positive tone for routine office visits, says Waldene K. Drake, vice president of risk management and patient safety for the Los Angeles-based medical liability company, Cooperative of American Physicians. “The staff interacts more with the patient than anyone else, and they are the least-trained people in medicine,” says Drake. “It’s imperative that the physician spend time training them.”

That applies not only to office processes, but also to general courtesy. If staff members aren’t pleasant to patients when they arrive at your office, a negative pall is already cast over their visit before they even see a physician — and that doesn’t bode well if there’s a bad outcome, says Drake. Of course, if physicians themselves don’t respect their patients, that only compounds the risk. “I’ve had situations where, after the trial is over, the plaintiff said to me, ‘If your client had been a nicer person, this would not have happened,’” says Monty Warren, a trial attorney and a founding member of the law firm Coel and Warren PL in Boca Raton, Fla. “Often a doctor will get sued for a bad outcome because he didn’t express the right amount of concern or show the patient enough attention.”

Drake adds that how physicians communicate bad results to patients is crucial. If things go awry with a procedure or an encounter, it’s best to be upfront and handle it right away. “We tend to be afraid of people who are complaining,” says Drake. “But if you just step up and say, ‘We’re so sorry. What can we do to fix this?’ a lot of trouble can be derailed.”

As someone who’s been there, Veltman agrees. After the conclusion of his lawsuit, he went on to chair the American College of Obstetricians and Gynecologists’ professional liability committee. Today he is a risk-management consultant. If you’re not sure how to communicate negative test results, or if your attempts only result in further inflaming the situation, Veltman advises seeking help. Talk to your legal advisers at your affiliated hospital, or call your malpractice insurance carrier, both of which should be able to offer detailed counsel.

The upshot is that sustaining positive communication throughout patient encounters and maintaining unwavering courtesy while addressing patient concerns can go a long way toward keeping lawsuits at bay. “It’s just human nature,” Veltman explains. “It’s a lot harder to sue someone when you’ve bonded with them.”

**Write it down**

Veltman says the second cornerstone of robust risk management is maintaining complete documentation of patient encounters. Note everything that occurs during each patient visit, including your detection of symptoms or the lack thereof, your diagnosis and how you arrived at it, the course of action you suggest to the patient and your rationale for it, details of the risks and benefits of the treatment options you discussed with the patient, the patient’s response to your assessment, and — if necessary — proof of the patient’s informed consent to any procedures you’ve proposed.

This should become part of the patient’s medical record, which, if a lawsuit is later filed, will be closely scrutinized, first by a medical expert who will determine if there are grounds for a case, then by attorneys, and ultimately by a jury. Physicians who fail to dot all their i’s and cross all their t’s in individual patient records can leave themselves vulnerable. “Three-fourths of the lawsuits I get are affected either positively or negatively by how things were documented,” affirms Whonsetler.

Dayton, who says he’s been through the “medical malpractice grinder,” is currently waiting for the fifth lawsuit to be filed against him to go to trial. He says that based on his experience, Whonsetler is right. “Disputes are lost all the time over lack of documentation in the medical record,” Dayton says. “I have become obsessed with the documentation.”

Dayton and his physician partners invested $250,000 in an EMR system to help them achieve what
they hope to be flawless documentation. Now, Dayton says, when he’s with each patient, he spends an extra four to five minutes checking off items on what he likens to a pilot’s checklist, asking each patient the same series of questions. “Do you have bleeding?” “Do you have discharge?” etc. He says the process is tedious and sometimes redundant, but it gives him needed protection. “It pins the patient down to respond to each question and provides a document trail of what was asked,” Dayton explains. So if a patient later argues that she told Dayton during a visit that she was bleeding and he didn’t address it, he can now produce proof to the contrary. The situation can’t devolve into a “he-said-she-said” lawsuit.

Don’t have $250,000 for a fancy EMR? Don’t worry; experts say that although EMRs help make patient documentation more seamless and watertight, it’s also possible to achieve the same effect the old-fashioned way — writing it down or recording dictation for later transcription. But remember that years may pass before you’re asked to produce a specific patient record for a lawsuit. At that point, you may not even recall the patient, much less the details of your consultation. So regardless of method, make sure you keep all details of all patient visits at hand and organized.

Of particular importance when documenting patient encounters is the physician’s rationale in determining the diagnosis and suggesting treatment options.

After his brush with malpractice litigation, Russell became a medical expert in such lawsuits. He now examines potential medical malpractice cases and advises attorneys and plaintiffs on whether or not their cases have merit. “What you’re looking for is the doctor’s thought process,” he explains. “You want to see: How did this doctor end up making that diagnosis? What was he thinking? Often that is not in the documentation.”

Russell adds that when a patient is noncompliant, the physician must take special care to document the situation. For example, Russell says that if one of his patients refuses care or refuses to go to the ER when Russell advises that he do so, Russell requires that patient to sign a statement acknowledging his refusal. Russell files these signed statements in his patients’ charts.

Is such added documentation truly necessary? It isn’t legally required. But Russell says it would go a long way toward showing attorneys and a jury that he made an extra effort to emphasize the importance of treating a patient who, in his professional opinion, needed immediate medical attention. If, for instance, a patient later suffered a heart attack after refusing a trip to the ER, he’d have a hard time making a case against Russell.

The added upside to this is that about half of his patients, when handed “refusal of care” documentation to sign, will grasp the gravity of the situation and agree to accept treatment or go to the ER.

Follow through
The scenario is all too common: A physician does a Pap test on a patient, and the results — which indicate a problem — get lost in the shuffle. Or a physician orders a mammogram, the patient has the procedure, and a radiologist detects a mass — but the results never make it into the patient’s file, and the patient never receives a call that would have allowed her to enter early treatment. Or a doctor examines the results of a prenatal ultrasound performed earlier by a technician and detects a birth defect — but the mother is never notified.

“There are lots and lots of cases like that, where things fall through the cracks,” says Hertz. “This is one of the biggest malpractice risks: failure to diagnose.”


“We need to embrace and leverage technology to assist us with this,” says Hertz, adding that pricey EMRs have tracking capabilities that can keep lab reports from ending up lost or misplaced. Staff members are alerted to lab results via a visual signal on their computer screen. That signal won’t go away until the staffer calls the patient with her results. Is such capability confined to EMRs? No, says Hertz. Lower-cost software can do essentially the same thing.

Drake says that handling lab results is such a sensitive, vulnerable area that she has nine full-time risk managers who regularly visit her company’s 9,200 physician clients to ensure their lab report systems are airtight.

Drake’s risk managers advise practices to do away with the all-too-common practice of telling patients, “If you don’t hear from us, that means your results are negative and everything’s fine.”

Drake says practices can never be completely sure that this is the case; positive results could be stuck in the wrong file.

Following up with chronic care patients who require regular testing presents another challenge. Drake suggests that physicians or their administrators take the time to teach staff how to identify such patients and then enter their names into computer systems that can generate mailings when
patients are due for testing. Or staff can instruct the systems to generate monthly lists of such patients, whom they can then call. Even a manual log or accordion file can serve this purpose, says Drake, provided dedicated staff keep careful track of the system.

Drake says another common process prone to mismanagement is phone logs. Staff must document calls to patients to follow up on lab reports or anything else, she emphasizes. “In many lawsuits, in the medical record, you see phone messages the physician never saw,” Drake explains. “Staff may not have thought it was important, or maybe they laid it on his desk, but he never saw it. Unfortunately, all those little things really do add up, and they are indefensible in court.”

Dayton says he feels protected in this area. His EMR records all calls to and from individual patients, documenting them by time and automatically recording them in patients’ medical records. If a patient calls and wants a call back, a pop-up appears on Dayton’s computer that shields the rest of his screen until he returns that patient’s call.

The bottom line on all risk-management efforts? Be organized, conscientious, and thorough with every patient, every time. No exceptions.

“If you have all your ducks in a row like that,” says Hertz, “it goes an awful long way toward avoiding a lawsuit.”

Suz Redfearn is an award-winning healthcare writer living in Falls Church, Va., who has written for a variety of publications including The Washington Post and Men’s Health. She can be reached via editor@physicianspractice.com. This article originally appeared in the June 2007 issue of Physicians Practice.

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