

# HOW TO REDUCE YOUR Malpractice Risk



Recognizing  
warning signs and  
documenting with  
care are two keys.

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Approximately 5 percent of family physicians and 7 percent of all physicians are sued for malpractice in the United States each year, according to a recent study.<sup>1</sup> The incidence of lawsuits is much greater in some surgical subspecialties, with annual rates approaching 20 percent among neurosurgeons and cardiothoracic surgeons. For low-risk specialties including family medicine, the annual incidence of claims resulting in compensation to patients or their families is only about 1 percent. Still, an estimated 75 percent of physicians in lower-risk specialties will face a malpractice claim by age 65.<sup>1</sup>

Trends suggest that the incidence of claims against family physicians is declining.<sup>1</sup> One possible explanation may have to do with changes in tort law

with caps on noneconomic awards. Some claimants may not be able to find a lawyer with the resources to accept the case on contingency. As a result, more complaints are being processed by medical boards, which may result in no action, a letter of reprimand, probation, or in rare cases, revocation of the physician's license to practice.

Using case examples and information drawn from my [Dr. Achar's] experience as an expert witness and reviewer in malpractice lawsuits, this article will help you identify situations that have the potential to increase your liability and ways to practice that will reduce your risk.

### What a plaintiff must prove to win a malpractice case

To win a medical malpractice case, a plaintiff must prove four findings, according to the tort of negligence:

**A duty of care was owed.** The doctor-patient relationship means that a duty of care was owed by the doctor to the patient. In most malpractice cases, this is easily established, and it is best to work on the assumption that a duty of care is owed.

Duty of care is less clear-cut in cases involving physicians who volunteered their care or advice. In one case, a physician was sued and lost a malpractice case involving a patient who complained to him at a party about her leg having been swollen for three months. He suggested that it was probably nothing serious if the leg had been swollen for three months and advised her to see her primary care physician. She neglected to seek her doctor's care, had a pulmonary embolus, and died. The patient's family was able to establish that the physician who advised her had a duty of care.

Sidewalk consults with other physicians are also complex. Juries are finding that physicians who are consulted informally,

for instance during hospital rounds or at a social event, do not have a duty of care when their advice may have influenced the actions that led to the malpractice suit. If you need another specialist's advice on a case, be sure to arrange for a formal consult and get his or her opinions in writing.

In some cases, you may have a duty of care even if you are not being paid for your expertise. For example, a team physician may have an established duty of care even if the position is voluntary. This may be especially important for physicians who travel outside of their state of licensure to perform their established duties as team physicians.

Good Samaritan acts receive certain protections under state law. In general, to be afforded these protections, the physician must not have a pre-existing duty to care for the patient. The physician has legal immunity to claims of ordinary negligence, but not to gross (willful, wanton, malicious) negligence. (For more information, see "What You Need to Know When Called Upon to Be a Good Samaritan," *FPM*, April 2008, <http://www.aafp.org/fpm/2008/0400/p37.html>.)

**A duty of care was breached.** The plaintiff must prove that the physician breached his or her duty to the patient. A physician is not necessarily negligent if his or her efforts are unsuccessful or if he or she makes an error. This is where the standard of care – what prudent peers would ordinarily do in the same situation – comes into play. Plaintiffs must establish that the standard of care was not met.

A case in California highlights the importance of standard of care. A young dentist was seen after a witnessed syncopal episode. Workup in the emergency department was unremarkable, including negative cardiac enzymes and ECG. The emergency physician wanted to admit the patient. The hospitalist decided instead to send the patient home

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■ The incidence of claims against family physicians may be declining.

■ To win a malpractice case, a plaintiff must prove that a duty of care was owed and breached by the physician.

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## If your note doesn't indicate how you arrived at a differential diagnosis, you're asking for trouble.

with a plan for outpatient cardiac stress studies and follow-up with his family physician. The patient never made it to either appointment and died from an aortic dissection. A case was filed and settled in arbitration. The award was high enough to require review by the California medical board. In the administrative hearing, the judge heard credible expert testimony from the director of the DeBakey Institute that most patients with aortic dissection are not picked up and are sent home where they ultimately meet catastrophe. The administrative law judge noted that had the hospitalist admitted the patient he might have survived and received timely surgery to correct the aortic dissection. However, the judge did not feel that this error was below the standard of care because, unfortunately, well-meaning physicians across the country often do not make a timely diagnosis of aortic dissection. Because the standard of care was not breached, the hospitalist did not receive any letter or sanction from the medical board.

Standard of care is generally the same no matter where you live, but not in every case, and it can be especially variable where the use of medical devices for testing is at issue. For example, defendants have successfully argued that a 64-slice CT scan is the standard in their community, even if a 128-slice CT scan is common elsewhere.

**Proximate cause.** The plaintiff must prove that the physician's action led to a damage. For example, in the case described earlier, the plaintiff proved that the failure to diagnose deep-vein thrombosis resulted in pulmonary embolus.

**Damages.** The plaintiff must also prove that the patient suffered harm as a result of the breach of duty. For example, if the deep-vein thrombosis hadn't led to pulmonary embolus and death, the case might not have been successful.

### Burden of proof

The burden of proof in medical malpractice cases is lower than in criminal cases, which

require guilt beyond a reasonable doubt. Plaintiffs in malpractice cases must prove guilt based on a preponderance of the evidence. If there is more than a 50 percent chance that what the plaintiff did was wrong, then a jury should find the defendant guilty.

### Diagnostic errors

The five types of cases that most commonly result in malpractice lawsuits for family physicians all involve errors in diagnosis, according to a 1999 report from the Physician Insurers Association of America (PIAA).<sup>2</sup> A more recent review of the PIAA database concludes with similar results.<sup>3</sup> The diagnoses are myocardial infarction, breast cancer, appendicitis, lung cancer, and colon cancer. Seventy-seven percent of all malpractice cases against primary care physicians in the United States happen to be in these five diagnostic categories. The mnemonic device "Listen to BACH"<sup>2</sup> (Lung, Breast, Appendix, Colon, Heart) can help you to remember these high-risk diagnoses as you see patients:

**Lung cancer.** The most common cases in malpractice for lung cancer are all delay in diagnosis cases. Often the plaintiff is a young patient whose coughing was attributed to bronchitis and who might not have received a chest X-ray. The standard of care for ruling out a lung cancer diagnosis is, unfortunately, to do more invasive testing, such as bronchoscopy or a CT scan. Plain chest X-ray tests are too insensitive to identify a mass early.

**Breast cancer.** Delayed diagnosis is also the most common basis for lawsuits involving breast cancer. Malpractice cases involving delayed breast cancer diagnoses often involve women under age 50 who receive false-negative results from screening mammograms or who don't receive diagnostic mammograms they should have. Radiologists and imaging centers have sided with plaintiffs and been dropped from suits as they help make the case against physicians by saying the physicians did not provide the necessary clinical information

The plaintiff must prove that the physician's action led to a damage and that the patient was harmed.

The plaintiff must also prove guilt based on a preponderance of the evidence – a lower standard than in criminal cases, which require guilt beyond a reasonable doubt.

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to help the radiologist select the best test or make the correct diagnosis.

**Appendicitis.** Appendicitis often presents as nondescript abdominal pain, so physicians sometimes attribute it to gastroenteritis and miss the follow-up. When this results in a malpractice suit, juries are not saying that the doctor should have made the diagnosis immediately or ordered a CT scan for this and every patient with appendicitis-like symptoms. Rather, the physician should have talked to the patient about the risks of appendicitis and what to do if the symptoms worsen, established a plan for follow-up, and documented accordingly.

**Colon cancer.** In cases involving delayed diagnosis of colon cancer, it's common for hematochezia to have been attributed to hemorrhoids. Sometimes patients have hemorrhoids and colon cancer at the same time, so even if you document hemorrhoids on an anoscopy, a high-risk patient may still need a colonoscopy. A note that simply lists a diagnosis of hematochezia or hemorrhoids will be almost impossible to defend in court. It is better to discuss the possibility of colon cancer with the patient and develop a plan for follow-up in the event the symptoms don't resolve, and document this effort. For example, "Most

likely hemorrhoids. Discussed colon cancer, which I think is unlikely because [why]. Told the patient that if the problem persists, he is advised to see me in a week or two and I will order a colonoscopy for him." That's a note you can defend through closing arguments.

**Heart conditions.** About half of all lawsuits involving emergency medicine are related to heart conditions. Younger patients with negative past histories are most likely to file a lawsuit for missed myocardial infarction (MI). Patients with classic chest pain or abnormal ECGs are easy for us to help. It's the patients with atypical histories or who are younger or don't have as many risk factors that we're most likely to misdiagnose. In one case that I [Dr. Achar] am familiar with, a male patient died of an acute MI after being sent home on two different occasions in a two-week period by two physicians who had both documented normal cardiac exam findings. The second physician missed subtle elevations in the patient's ECG at a morning appointment and diagnosed chest pain with gastroesophageal reflux disease (GERD). When the patient called back that day to report that he was not improving, the nurse relayed the message to the physician, but the patient died late that afternoon at home before the physician returned his call. The physician saw 40 patients that day, which did not help her case.

Seventy-seven percent of malpractice claims against primary care physicians involve lung cancer, breast cancer, appendicitis, colon cancer, and heart conditions.

When making a differential diagnosis, document your reasoning.

## PROBLEMATIC ABBREVIATIONS

These are just some of the abbreviations that can lead to errors.

Abbreviation	Intended meaning	Misinterpretation
<b>Medications</b>		
AZT	zidovudine	azathioprine
DPT	diphtheria-pertussis-tetanus	Demerol-Phenergan-Thorazine
HCT	hydrocortisone	hydrochlorothiazide
MgSO4	magnesium sulfate	morphine sulfate
5-ASA	5-aminosalicylic acid	five tablets of aspirin
<b>Dosing</b>		
o.d. or od	once daily	right eye
t.i.w. or tiw	three times a week	t.i.d. (three times a day)
SC	subcutaneous	sublingual
q.d. or qd	every day	q.i.d. (four times a day)
q.h.s. or qhs	at bedtime	every hour
IU	international unit	IV or intravenously
per os	orally	left eye
mcg	microgram	mg (milligram)

## Documentation

Careful documentation can mean the difference between a guilty verdict and a case being thrown out. It's worth the trouble to make sure you do it right.

**Document your thought process.** If your note doesn't indicate how you arrived at a differential diagnosis, you're asking for trouble. In the absence of contrary evidence, juries will assume the worst. For instance, if your patient has chest pain, do more than simply listing GERD as your diagnosis. Instead you might write, "Likely GERD; with this atypical history, less likely to be acute coronary syndrome or musculoskeletal chest pain, etc." Then go down the list and document that you talked about it with

the patient. Also, avoid false certainties. A good example is the patient who turns out to have appendicitis when the doctor has documented simply “gastroenteritis.” A more complete documentation of the doctor’s thought process would probably be something like this: “Abdominal pain – unclear etiology. The risk of appendicitis is low, and given that a CT scan would expose this young person to a lot of radiation, I think the risks of doing the CT scan outweigh the benefits. Therefore, we’re going to monitor for improvement and then proceed with [plan] if necessary.”

**Document shared decision making.** If you practice shared decision making with your patients, be sure your notes reflect it. If your notes convey physician-centered decision making, they may offer less protection in a lawsuit. (The benefits of shared decision making go well beyond malpractice risk reduction. To learn more, see “Involving Patients in Medical Decisions,” *FPM*, September 2001, <http://www.aafp.org/fpm/2001/0900/p50.html>.) Shared decision making involves explaining the alternatives open to the patient, along with their risks and benefits, and agreeing on a plan. The discussion and agreed plan should be documented. Specificity is important; a boilerplate note such as “risk-benefit assessment discussed” is no longer adequate protection in a malpractice case.

Writing consistent notes can help to reduce your risk for malpractice. Peter Teichman, MD, MPA, advises using a variation of the SOAP note format that demonstrates shared decision making and encourages other risk-reduction techniques: SOOOAAP (Subjective, Objective, Opinion, Options, Advice, Agreed Plan). (To learn more, see “Documentation Tips for Reducing Malpractice Risk,” *FPM*, March 2000, <http://www.aafp.org/fpm/2000/0300/p29.html>.) The same format with E added to capture Education is a similarly effective documentation format.

**Document goals and expectations.** A study of primary care physicians in Colorado and Oregon noted that physicians who use more orienting statements, such as explaining what will likely happen next, are less likely to be sued.<sup>4</sup> Document any warnings given or risks discussed. A useful phrase in communication and documentation is “recheck if not better.” Asking for the patient’s opinion and checking his or her understanding dur-

ing the visit also reduces liability.<sup>4</sup> End with a concise phrase such as “patient understands and agrees.” At our clinic we give patients an “after visit summary” that includes the diagnosis made, orders given including phone numbers for consultations and testing, and patient instructions. If you give the patient an after visit summary or any other information to take home, be sure to document it.

**Dictate or type your note in the patient’s presence.** This is another technique that can help to produce more thorough and supportive documentation. You can document the patient’s agreement with what you’ve discussed (e.g., “This note was dictated in the exam room with the patient”) and reassert your plan.

### Prescribing problems

A 2002 study of medication errors in 36 health care facilities found that 19 percent of doses given were in error.<sup>5</sup> The most frequent errors were giving the medication at the wrong time or not at all. Incorrect dosages and unauthorized drugs accounted for 21 percent of mistakes. Critical errors also occur with controlled medications. Today, more patients die from overdose of controlled medications than heroin and cocaine combined.<sup>6</sup>

Medication errors have many causes, some outside of the physician’s ability to control. E-prescribing provides some protection, but it is still important to take steps to ensure that your prescriptions are clear.

Dosing abbreviations can lead to problems. For example, qhs (at bedtime) can be misinterpreted as every hour, and qd is easily mistaken for qid. As a resident during a month-long tropical medicine rotation in Thailand, I [Dr. Achar] was involved in a case where quinine was prescribed for a young medical student’s malaria. We indicated over the phone that it was to be given once a day, but it was given qid. The overdose resulted in temporary blindness due to retinopathy; fortunately, the patient recovered.

Using drug name abbreviations can also increase liability risk. Be sure to provide the complete drug name for those with abbreviations that can be misinterpreted, such as HCT (hydrocortisone) and HCTZ (hydrochlorothiazide) or MgSO<sub>4</sub>, magnesium sulfate, which can be mistaken for morphine sulfate. One case I reviewed involved a patient with diabetes

Shared decision making can help to reduce malpractice risk, especially when documented.

Helping the patient know what to expect and documenting his or her understanding and agreement with your plan can mitigate malpractice risk.

Medication errors are a high-risk area in part because of dosing and drug name abbreviations.

## A boilerplate note such as “risk-benefit assessment discussed” is no longer adequate protection in a malpractice case.

and sepsis who was given Zofran rather than Zosyn for a full day before the mistake was detected. (See more examples in “Problematic abbreviations” on page 24, and “Simple Strategies to Avoid Medication Errors,” *FPM*, February 2007, <http://www.aafp.org/fpm/2007/0200/p41.html>.)

### Referrals

■ Referrals can help you or hurt you, depending on how they are handled.

■ It helps to document your explanation of the reason for the referral.

■ If a patient tells you he or she won't follow through on your referral, offer an alternative and document it.

Documenting referrals and their results can reduce your liability risk, but referrals must be handled carefully. Referrals are particularly important in the following situations:

- **When two consultants disagree.** This is a red flag. Always seek a third opinion.
- **When target goals are persistently not met.** For example, if a patient with chronic pain who is taking narcotics continues to report 10 out of 10 pain, refer the patient back to the physician who prescribed the medication or ask another specialist for help.
- **When the patient disagrees with your findings and plan and threatens to sue you if the outcome is not good.** Arrange for a consult, and document the patient's comment. Be assured that anything you document outside of the record in preparation for a legal defense is privileged information.

A note about noncompliance: Of course it's not possible to ensure that patients follow through with the referrals or tests we order. Here again, documentation can be your best defense. For example, rather than documenting simply that you ordered an echocardiogram, you might write, “Explained to patient that it's important for him to receive an echocardiogram to assess potential heart failure.” If the patient doesn't follow through, a good lawyer should be able to defend you effectively with this note.

When a patient indicates his or her refusal to follow through with a test that you recommended (e.g., a patient refuses a colonoscopy that's needed to rule out colon cancer), your documentation becomes even more important. You must very carefully document what you said, why the test was needed, and that you

offered a specific alternative, such as referring the patient in our example to a gastroenterologist colleague. If the patient refuses the alternative course of action you've suggested, you'll still be in a more defensible position for having offered it. If the patient sees the gastroenterologist and still refuses the test, this will further reduce your risk.

### Conclusion

Even though family physicians are at lower risk for malpractice lawsuits than physicians in other specialties and the incidence is trending downward, the stress of a lawsuit when one is filed is still as great as ever. Understanding common causes of lawsuits may help family physicians reduce lawsuits by focusing attention on these critical areas. Communication that includes slightly longer consultations focused on patient education, more orienting statements, and even some humor, which allows patients to feel more comfortable, will also help to reduce family physician liability,<sup>4</sup> as will careful documentation. Finally, we should always remember *Primum non nocere*: First, do no harm. **FPM**

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