

Don't Be a **Target** for a **Malpractice Suit**



Protect yourself with these tips from a family physician who has successfully defended his care and that of other physicians.

Edward G. Zurad, MD

As you know, being a family physician is an extraordinary challenge. Each day, we take care of patients who present to us with multiple complaints affected by an infinite number of unknown variables. In the precious few moments that we have with each patient, we discuss these issues, sort details from a data stream over which we have little control and develop what we hope is an accurate history. Then we perform an exam that is directed by the patient's complaints. We do our best to formulate a list of diagnoses and appropriate treatment plans, and in the vast majority of cases our best is fine. Unfortunately, most of us will have

a bad clinical outcome or a missed diagnosis at some point in our career. When we do, there is a chance we are going to get sued for it. (See "Malpractice in primary care," page 59, for information about common types of suits.) ➤



Complete documentation would limit our practices to only a few patient encounters per day.

Although 70 percent of malpractice cases are either dropped or dismissed by the plaintiffs,¹ being sued exacts a terrible toll. I won my own case at trial in 2002 after six years of litigation (see “About my case,” page 60), but not a day goes by that I don’t think about what I lost in the process in terms of the weeks spent reviewing, preparing, educating lawyers, being deposed and finally going to trial. In addition to practicing family medicine in rural Pennsylvania and teaching family medicine courses, I now do occasional work as an expert witness. As a result, I spend a lot of time thinking about risk and how best to manage clinical uncertainty. This article describes some of the risk reduction strategies I’ve learned along the way.

Documentation

I’ve seen firsthand that documentation can make or break a malpractice case. The importance of a legible, thorough and accurate progress note cannot be overemphasized. The quality of my note helped to win my case. Now I try to write every note like it’s eventually going to be read by the patient and many other people, including the patient’s spouse, his or her attorney and a 12-member jury panel. Here are some specific tips that should serve you well:

Record vital signs. Every encounter should include recording a full set of vital

signs (don’t forget to include the patient’s weight). They’re omitted from many charts I review that have gone to litigation, and they are extremely important in “failure-to-diagnose” cases. They are the only truly objective snapshot of the patient at the time of the visit and allow observers an immediate understanding of the patient’s physiology at that moment.

Include a carefully documented history and physical. Make certain that the chart contains an updated medication history and list of current diagnoses. Of course, an accurate past medical history, family history, social history and allergy list are also essential. Include a list of prescribed treatments and tests. It is important to incorporate direct patient statements regarding the history of the present illness along with pertinent signs and symptoms.

Write what’s important. Your medical records become the primary weapon against a possible lawsuit. When an attorney requests a copy of your records to review for consideration of litigation, he or she does not ask you to explain them and any possible deficits prior to filing a lawsuit. However, the assertion “If it wasn’t written, it didn’t happen” is overblown. We can’t document every aspect of a visit, even with the best technology. There are so many nuances to care in a single day of family medicine that complete documentation would limit our practices to only a few patient encounters per day. Your notes should be clear, concise and, when necessary, precise (e.g., always note the location of a breast lump). In addition, you should formalize your standard operating procedures so that if you fail to include an important detail in your note and find yourself embroiled in a lawsuit, you will be able to describe the care you provided but didn’t include in the note and say with confidence that you do not deviate from your standard practice (e.g., “Yes, I did an occult blood test. Every time I do a rectal exam, I do an occult blood test. It’s what I always do.”).

Make sure your notes are legible. As an

Seventy percent of cases are dropped or dismissed before settlement or trial, but all physicians who are sued lose much in the process.

Careful documentation can be the key to a successful defense.

Vital signs and history deserve more attention than many physicians give them in their documentation.

About the Author

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expert witness, I've reviewed many different kinds of notes – handwritten, dictated and transcribed, and EMR-generated notes – and I've seen notes annotated by plaintiffs' attorneys, magnified to 2,000 percent and shown to a jury on a large screen. The idea that illegible notes reduce risk because they obscure evidence is a common misconception. Not only do they provide no protection, plaintiffs' attorneys and juries view them as evidence of sloppy care. Legible notes detailing thoughtful and logical care provide the best malpractice defense. EMR-generated notes are usually the most complete. Notes that have been dictated and transcribed are also easy for others to interpret. Handwritten notes should be organized and legible so that others can easily read them. Sign and date every entry. There should be no doubt as to who wrote the note and when it was completed.

Don't be judgmental. Record patients' statements accurately. Use direct quotes when possible, especially regarding the chief complaint(s). If the patient smells like alcohol, don't write that the patient is drunk. Describe the smell and the patient's behavior. Don't

use exclamation points. If you catch yourself incorporating an emotional response in the chart, the note is probably not as objective as it should be.

Get informed consent. Informed consent requires adequate discussion of the proposed treatment. A signature on an informed consent document is not adequate communication. Lawsuits frequently arise from poor communication. I get informed consent for the endoscopy and skin procedures I perform. I include a statement in my note that the **Procedure, Risks, potential Consequences and Complications, and Alternatives** have been **Explained** to the patient, **Understood** and **Accepted** in detail (PRCCAEUA).

Document every test you order or recommend. The frequency of failure-to-diagnose cases is increasing in family medicine, and claims that a test was never recommended or ordered are common. Record your proposed diagnostic and treatment plan so that if the patient chooses to disregard your advice, you will have a strong written defense rather than relying on your memory. If you're unsure about the diagnosis, record a list of possible diagnoses and note that they are not definitive. You will be held to a definitive diagnosis if that's what you record in the chart.

You may also want to document diagnoses that you've ruled out and your reasons for ruling them out. Be sure to document your thought process, the advice you gave to the patient, discussions with other physicians and consultants, and your follow-up plan.

Document non-compliance. When patients don't comply with treatment, document it. Explain the risks of non-compliance, and document the specific admonition. If a patient refuses a diagnostic or treatment plan that you've recommended and you believe that a bad outcome could possibly result, have the patient sign a statement of refusal before leaving the office. If you can't live with the potential

■ Informed consent requires more than just a signature on a form.

■ Document your proposed diagnostic and treatment plan, as well as diagnoses that are tentative or that you have ruled out and what led you to these conclusions.

■ Non-compliance with diagnostic or treatment plans must be documented, and in some cases patients should sign a statement of refusal.

MALPRACTICE IN PRIMARY CARE

A majority of malpractice claims don't involve negligence – only about 23 percent do, according to one study. Using data from the Physician Insurers Association of America claims database, researchers from the Robert Graham Center studied 50,000 claims against primary care physicians that were settled between 1985 and 2000. Of the roughly 26,000 that were evaluated by insurers' peer review panels, 5,900 (23 percent) were judged to have involved medical negligence.

Acute myocardial infarction was the medical condition most commonly associated with negligent adverse events (cited in 5 percent of cases), followed by lung cancer, breast cancer and colon cancer (each cited in 3 percent of cases). Seventy-seven percent of claims were attributable to five underlying causes. Diagnostic error was most common (cited in 34 percent of cases), followed by failure to supervise or monitor the case (16 percent), improper performance (15 percent), medication errors (8 percent) and failure or delay in referral (4 percent).

Source: Phillips RL, Bartholomew LA, Dovey SM, Fryer GE, Miyoshi TJ, Green LA. Learning from malpractice claims about negligent, adverse events in primary care in the United States. *Qual Saf Health Care.* 2004;13:121-126.

outcome, consider discharging the patient from your practice.

Note insurance denials. If a patient's insurer denies a service that you believe the patient needs (an extended hospital stay, for example), tell the patient that you disagree with the decision and document these facts. If the patient wants to appeal the denial, provide as much assistance as you can, and document your efforts. Actively assist in pharmacy benefit denials and document these efforts as well.

Don't alter entries. You've heard this forever, but that's just a sign of its importance. Otherwise defensible cases can be lost over evidence of deceptive documentation, even when the medical facts indicate that you did nothing wrong. Plaintiffs' attorneys always hope that doctors have altered their records because if they can show deliberate changes in the record, the case is over. Plaintiffs' attorneys have much to invest in cases, and they're happy to spend it on forensic analyses such as infrared examination of inks. In addition to jeopardizing your case, you could cause your liability insurer to cancel your coverage, you could face criminal charges and you could lose your medical license for professional misconduct. If you feel compelled to add to a note, make the addition obvious. Do not squeeze it between lines or along the margins of an existing note. Always include the date

and time of the subsequent entry and explain why the information was originally omitted. If the addendum is a correction to a previous mistake in the record, indicate such important facts in the additional text.

Dictate or complete the note in the patient's presence, and indicate that you've done so. In my case, the fact that I had dictated my note in front of the patient helped, and I've seen the same effect in other cases I've reviewed. The details are fresh in your mind, and patients may learn from your explanations. This is far better than charting at the end of the day when you are tired, have 20 or 30 other charts to complete and are trying to make it home in time for family activities. (The reading list on page 62 includes articles that describe how to implement this strategy and others mentioned in this article.) I generate notes using Microsoft Word templates that incorporate check boxes and drop-down menus for the subjective and objective portions of the exam. I've heard this approach referred to as "EMR Light." I type in the assessment and plan as I'm talking with the patient. It usually takes me two to five minutes to complete the note. I've never had a patient complain about this approach, and many have said they're impressed because the note can be sent immediately to a specialist or an insurer (in the case of workers' compensation).

■ You should never alter a previous entry in a patient's record; subsequent entries, clearly labeled as such, must follow certain parameters.

■ Dictating in the patient's presence, and noting that you've done so, can improve quality and reduce risk.

■ Phone calls must be documented and reviewed.

ABOUT MY CASE

A carpenter at a worksite fell off the second rung of a stepladder that had been placed against a wall in an unsafe manner. He fell onto a concrete floor, injuring his upper back. Following the incident, he had a complete evaluation in the emergency department with a full spine X-ray series that a board-certified radiologist read as normal. He was then discharged from the ED with a diagnosis of cervical/thoracic strain. His back and neck pain persisted through three sequential visits (one week apart). An additional MRI and a neurosurgical consultation ordered by our office ultimately documented a cervical disk herniation with radiculopathy and a T3 compression fracture. He sued for the development of chronic pain, which the plaintiff's attorney claimed was a result of the alleged delay in diagnosis. The complaint incorporated a request for punitive damages (not covered by malpractice insurance) because my physician assistant had seen the patient. The complaint was delivered in 1996, exactly two years after the event (the statute of limitations was expiring), on my son's fourth birthday.

The suit was filed against the ED physician, the radiologist, the hospital and myself. After a 10-day trial just before Thanksgiving in 2002, the jury found all the defendants not guilty. A very insightful defense attorney noted during the jury deliberations, "No matter whether you win or lose, you die a little with every case." I know he was right.



Sometimes it's difficult to be nice, but it's easier than many other risk reduction strategies.

Document phone calls thoroughly. All calls of any significance should be carefully noted by your staff, reviewed by you and included in the patient's medical record. Don't forget about after-hours and weekend calls that you return. Establish a system to ensure that these get recorded. As much as possible, the patient's own words should be included in the documentation.

Follow-up

Careful follow-up will help ensure that your patients get the care they need, and it will also help prevent the types of claims for which family physicians are commonly sued. Failure-to-diagnose cases often focus on lab results, uncertain diagnoses or referrals that weren't followed up properly.

Close the loop on test results. When you order a test, don't make the patient wonder when he or she is going to get the results. Tell patients when the results should be available and when they can expect to hear from you or your staff. (In my office, we call patients with the results of every test, positive or negative.) Tell patients to call you if they don't hear from your office by the specified time. Document that you ordered the test. When the results arrive, review them, compare them with any previous results and sign them prior to placing them in the record.

Don't settle for uncertainty. I always ask the patient to schedule a re-check in one or two weeks if I feel uncertain about a tentative diagnosis. If I know I'm going to be out when the re-check occurs, I bring the midlevel provider into the exam room to explain the need for a re-check. I ask the midlevel to get in touch with me about the re-check findings, and I document our discussion in the patient's chart. If I can't come to a firm diagnosis in three visits, I involve another physician. Use the beautiful advantage of

continuity that family medicine affords.

Make referrals happen. In high-risk cases, it's not enough to refer the patient to a specialist and note that you've done so in the chart. Have a member of your office staff make the initial call to the specialist's office to introduce the patient. Note the call in your chart and have the caller initial the entry. Document the time and date of the visit. Arrange for the patient to get the necessary paperwork, lab work and X-ray reports to take to the visit.

Schedule regular follow-up visits for patients with chronic conditions. You should have standard operating procedures that govern how often you see patients with chronic conditions. For example, you might see patients with hypertension every three months and patients on statins every six months. Most patients with a chronic illness need follow-up at some regular interval even if they are not on any therapeutic regimen. Document the scheduled appointment interval in their charts, and systematize the scheduling of these appointments. You should also remind the patient to schedule an earlier appointment if his or her symptoms change or do not get better.

Manage medication changes actively. Negligent drug treatment is another common type of malpractice claim to which family physicians are vulnerable. Drug allergies and sensitivities should be prominently displayed in the chart, and all medication refills should be recorded as well. Patients on agents such as NSAIDs, antidepressants, chronic analgesics, cardiac agents, warfarin and any other chronic medication should be seen regularly. Warfarin management and NSAID-related GI bleeding are two areas of particular concern. Every time I prescribe a new medication, I explain the **Medication's Risks, Complications and Contraindications**, and I make sure the patient **Understands** and **Accepts** them and

■ Systematic follow-up of test results, uncertain diagnoses and referrals is essential for good patient care and malpractice risk reduction.

■ Patients with chronic conditions should be followed up on at regular intervals that are documented in the chart.

■ New prescriptions or medication changes should be handled carefully.

write **MRCCUA** in the chart. I also tell the patient when we need to see him or her again and to call if any problems develop, and I document accordingly. A common gambit of plaintiffs' attorneys is to suggest that if the patient had understood the risks associated with a certain medication, he or she would have never agreed to take it.

Records review. Review the patient's chart before the exam gets under way. If you have information from other physicians, such as records that have been transferred, review them carefully. I like to do this during the patient encounter. Patients seem to appreciate my thoroughness, and it makes it easy to ask them any questions I may have.

Communicate thoroughly with your staff and other providers who cover for you on weekends or during vacations. Continuity of care is so important, especially for patients with high-risk conditions or with uncertain diagnoses. When signing out to your colleagues, no matter how good your documentation may be, don't let the chart do all of the talking for you. Do a thorough hand-off, and try not to rush through it.

Supervise midlevel providers carefully.

Provide appropriate supervision for your midlevel providers, have detailed protocols in place and be available to answer their questions. Ensure that your supervision is in compliance with what your state law requires. Availability should be immediate, whether by face-to-face contact, phone or digital communication. If you are out of town, a substitute supervising physician should be available to the nurse practitioner or physician assistant. You never want a physician assistant you work with to say in a video deposition, "For two hours, I couldn't reach the doctor or the colleague who was covering for him while the patient's condition deteriorated." If a midlevel provider in your office sees a patient at two consecutive visits for the same complaint, make sure the provider discusses the patient's case with you while the patient is still in the office. If the case is confusing or complicated, a physician should see the patient at that visit.

Procedures

Malpractice suits that allege "negligent procedure" are another growing area of litigation for family physicians. I perform EGD and colonoscopy, and I teach other family physicians how to do these procedures, so I am particularly aware of the risks associated with this work. Two bits of advice are especially important to remember:

Know your limits. If I've been up all night with a hospitalized patient and I'm scheduled to do a colonoscopy at 7 a.m., I don't hesitate either to reschedule it or to find another physician to do the procedure. It's inconvenient for everyone but far better than a sigmoid diverticular perforation. If I do a colonoscopy and find a large sessile polyp, I refer the patient to a competent endoscopist who can do "piecemeal polypectomy."

Don't make it harder than it needs to be. Don't try to do a procedure if the patient is

■ Review of transferred records or reports from other physicians must be thorough.

■ When signing out, communicate directly with those who will be covering for you; don't rely solely on the patient's chart.

■ Working with midlevel providers requires a commitment to appropriate supervision.

■ Don't hesitate to reschedule a procedure if you are tired or the patient is less than cooperative.

FPM RESOURCES

For more information about the strategies described in this article, see these articles at <http://www.aafp.org/fpm>.

"EHRs in the Exam Room: Tips on Patient-Centered Care." Ventres W, Kooienga S, Marlin R. March 2006:45-47.

"Make Medical Notes Better and Faster With Macros." Knight M. September 2005:42-44.

"Terminating a Patient: Is It Time to Part Ways?" Willis DR, Zerr A. September 2005:34-38.

"A Sure Way to Improve Your Dictation." Flaherty RJ. January 2005:55-56.

"Four Principles for Better Test-Result Tracking." White B. July/August 2002:41-44.

"Seven Reasons to Dictate in the Presence of Your Patients." Teichman PG. September 2001:37-40.

"Electronic Paper & Pencil: Six Easy Steps to a Low-Cost Electronic Medical Record." Jue J, Jerant AF. May 2001: 33-38.

"Helping Patients Take Charge of Their Chronic Illnesses." Funnell MM. March 2000:47-51.

less than cooperative. For example, I use conscious sedation when I do EGD procedures, and occasionally the patient will have a paradoxical reaction to the benzodiazepine, causing excitation instead of sedation. I stop and reschedule the procedure with monitored anesthesia coverage or a different sedative agent. Again, it's inconvenient, but well worth the trouble in terms of preventing a potentially horrific outcome.

Patient relations

The common belief that nice doctors get sued less than others is true and has been well documented. Sometimes it's difficult to be nice, but it's easier than many risk reduction strategies. It's especially important to remember when you're feeling tired or hassled or you find yourself in a situation that you know has more than the average risk associated with it. Take a deep breath, and just be cheerful and friendly. You'll feel better, and it might keep you out of the courtroom some day. Here are some specific things you can do to show your patients that you care:

If you have to keep them waiting, tell them what to expect. Have your nurse or receptionist explain the reason for the delay and how long they'll be kept waiting. Even better, anticipate delays, notify your staff and have them try to reach patients before they leave home. Give them the option of rescheduling. When you finally see a patient, whether it's the day of the delay or the day of the rescheduled appointment, apologize for inconveniencing him or her.

Give the patient your full attention. Taking phone calls during the exam shows a lack of respect, particularly if they're from your realtor, your broker or your golf buddy. If you must take a call, apologize, briefly explain the reason to the patient and keep it short.

Don't interrupt. Listen carefully to what your patients have to say, especially when you're in a hurry. Bite your lip every time you try to interrupt the patient.

Respect patients' privacy. If you have to leave the exam room and the patient is undressed, don't leave the door open or invite

FPM ARTICLES ON MALPRACTICE

"Seven Reasons Family Doctors Get Sued and How to Reduce Your Risk." Roberts RG. March 2003:29-34.

"Understanding the Physician Liability Insurance Crisis." Roberts RG. October 2002:47-51.

"Depositions: Defending Your Care." Teichman PG, Bunch NE. July/August 2001:34-36.

"Coping With the Stress of Being Sued." Brazeau CM. May 2001:41-44.

"Documenting High-Risk Cases to Avoid Malpractice Liability." Davenport J. October 2000:33-36.

"Documentation Tips for Reducing Malpractice Risk." Teichman PG. March 2000:29-33.

others into the room without warning.

Treat patients as people, not medical conditions. A patient with potential breast cancer won't appreciate being referred to as "the breast mass."

Involve patients in decision making. Present options and ask your patients to help you decide on the best possible course of treatment so they will have ownership in the course of treatment.

Don't be critical of other treatment the patient has received. Physicians' criticism of other doctors who have taken care of the patient can give rise to lawsuits. If you're tempted to voice criticism, it may help to remind yourself that although you may think you know what happened, you weren't at the encounter. Listen to what the patient says and don't make a judgment. If you do say something negative and the case winds up in court, expect to be asked to testify against that physician as an uncompensated fact witness.

Ask patients what they think of your practice. Even an informal survey can alert you to malpractice risks you might not be aware of. Pay close attention to patient observations on HMO surveys that are returned to your office. Criticism is hard to hear, but you can learn a lot about your practice from patients.

Follow up with angry patients. If a patient leaves your office angry and threatens to switch doctors, have a trusted staff member call and try to find out why the patient is upset (or call the patient yourself). Your

Being kind is one of the simplest and most reliable risk-reduction strategies.

Anticipating delays and managing the day's schedule proactively demonstrates that you care about your patients.

Giving patients your full attention, avoiding interruptions, respecting their privacy and choosing your words thoughtfully are practices that patients value.

Patient satisfaction should be assessed formally and informally, and you should follow up with patients who leave the practice angry.

demonstration of concern may not change the patient's mind, but it may help you to avoid litigation down the road.

Make sure your staff members show patients the same consideration that you do. For better or worse, your staff members represent you to your patients. They must be fantastic at what they do. I have a great nurse and a great receptionist. Both can identify patients just by the sound of their voice on the phone. They also know when patients are sick enough that they require an office visit and when a phone conversation will suffice. This kind of personal attention goes a long way with patients.

Be yourself. Talk to your patients about your family and your hobbies. Let patients see your humanity. Use humor appropriately and effectively.

Consider patient dismissals. Some physician-patient relationships don't work no matter how caring and considerate you try to be or how excellent your care is. Noncompliance, missed appointments and long-overdue balances

should prompt you to consider patient dismissals. I have also fired patients because my staff and I have trouble dealing with them. Rather than sending these patients a certified dismissal letter that they might not sign for, I hand them the letter at their next office visit. I document in the chart that I've delivered it, so the information is available for the next physician who assumes the patient's care.

Don't let your guard down

Meaningful tort reform may help to stem the liability crisis that has driven so many good physicians out of practice and created access problems in the hardest hit parts of the country. Time will tell. While we wait, it is imperative that we take daily measures to ensure quality care and reduce our malpractice risk. **FPM**

Send comments to fpmedit@aafp.org.

1. Physician Insurers Association of America. *Claims Trend Analysis 2004*. Rockville, Md: PIAA; 2004.

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Your staff should be as committed to patient relations as you are.

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In some cases, it may be best to terminate the physician-patient relationship.