Seven Reasons Family Doctors Get Sued and How to Reduce Your Risk

By adopting a risk-management mind-set, physicians can avert not only malpractice claims but also patient injury.

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ILLUSTRATION BY ELIZABETH LADA

With medical malpractice insurance premiums rising sharply across the nation and at least a dozen states facing an insurance crisis, physicians and policymakers are debating vigorously how best to respond. Tort reforms that would cap awards are among the proposals and have proven effective at moderating premiums in several states. [See "Understanding the Physician Liability Insurance Crisis," *FPM,* October 2002, page 47.] But while physicians await legislative action or an upturn in the economy to soften the impact of insurance hikes, there is something doctors can do: better manage risk.

Risk management involves more than just reading a journal article, listening to a lecture or filling out a workbook. It is a style of practice that endeavors, first and foremost, to prevent patient injuries; second, to avoid malpractice claims; and third, when a claim does occur, to reduce malpractice claim losses.

First prevent patient injury

A while back, I was involved in the care of a four-year-old boy who was admitted with status asthmaticus. He was very ill, requiring intubation and ventilatory support. ➤

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Risk management is a style of practice that endeavors, first and foremost, to prevent patient injuries and, second, to avoid malpractice claims.

Develop a routine of reviewing the sequence of care for unexpected or unwanted outcomes.

The most common malpractice allegation is failure to diagnose in a timely manner; the most common disease for this allegation is breast cancer.

Two things that often get family physicians into trouble with obstetrical patients are the use of oxytocin and the failed handoff.

We were at his bedside literally breath by breath through the night. The child bounced back, fortunately, as children often do, and within three days he was home.

The following week at grand rounds, the senior resident presented the case. I opened the question and answer session that followed by asking the group, "How did we fail this boy?" A long silence ensued. One of the second-year residents responded, "I don't understand what you're talking about. You saved this kid's life. At every turn you made exactly the right decision."

And I said, "Yes, but how did we fail this boy?"

Finally, a first-year resident raised her hand and offered, "Well, he shouldn't have been in status asthmaticus in the first place." And that's the answer.

One of the things physicians need to ask whenever a patient is admitted to the hospital is "How did the outpatient management fail?" In this instance, should we have spent more time with the child's mother, emphasizing how important certain environmental changes were for her son? Was this a medication compliance problem? Develop a routine of reviewing the sequence of care for unexpected or unwanted outcomes. While we weren't negligent for anything we had done in the care of this boy – indeed, our hospital care was excellent – we had failed to prevent an avoidable condition, status asthmaticus. Our failure violated rule number one of risk management: prevent patient injury.

Why FPs get sued

Patients sue their physicians for many reasons. Here are the seven most common ones for family physicians and tips for avoiding them.

1. Failure to diagnose or a delay in diagnosis. The most common allegation is failure to diagnose in a timely manner; the most common disease for this allegation is breast cancer. A frequent reason for a failure or delay in diagnosis of breast cancer is excessive reliance on a falsely negative mammogram. A palpable lump or breast complaint should be taken to diagnosis. Mammography may be an adequate screening tool, but it is a poor diagnostic tool with false negative rates of 20 percent.

While we weren't negligent, we had failed to prevent an avoidable condition.

KEY POINTS

To prevent, first and foremost, patient injuries and, secondarily, malpractice claims, physicians should:

- Follow their patients' complaints to full diagnosis,
- Prepare themselves mentally before procedures,
- Know when it's time to consult with a colleague or make a referral.

Diagnosis may mean simply following the patient for a month and determining whether the lump resolves with the next menses; or it may require needle aspiration; or it may need excisional biopsy. Whatever it takes, the lesion should be followed to diagnosis.

2. Negligent maternity care practice. Two things that often get family physicians into trouble are 1) the use of oxytocin, especially when a baby is distressed while the physician continues pushing the drug, and 2) the failed handoff. The classic story of the failed handoff is the Friday night catastrophe that occurs while the patient's usual doctor has gone away for the weekend and the covering physician is inadequately informed and has no prior relationship with the patient. Developing a routine of signing out pregnant patients, especially those near term or with problems, can go a long way toward reducing the risk of a failed handoff. Sign-out need not be in person; voicemail systems and electronic methods can facilitate such communication.

3. Negligent fracture or trauma care. Patients with wrist "sprains" and snuffbox tenderness should be assumed to have navicular, or scaphoid, fractures until proven otherwise. A thumb spica cast is a reasonable approach until symptoms resolve or later X-rays resolve the question of fracture. Another situation to watch for is the patient with a popliteal fossa injury, usually resulting from impacting the knee against the dashboard during a car crash. Check and document that the patient's distal circulation is intact with palpable pedal pulses. Popliteal artery embarrassment can easily go unrecognized, and the limb is placed in jeopardy.

MYTHS ABOUT MALPRACTICE

1 This is a new problem.

The first malpractice case recorded in the United States was *Cross v Guthery,* a 1794 Connecticut case in which a man sued his doctor over his wife's death following surgery. Since only appeals court decisions are usually recorded, the first malpractice case may well have occurred before the founding of the country. Historical accounts from the Civil War era document instances of surgeons refusing to do certain procedures because of concerns about being sued.

2 The current legal system works well.

Some would argue that the United States has the best legal system in the world. However, if the goals of the tort system are to make the injured whole, to punish those who commit negligence and to deter future negligence by others, then the current system is not working well.

3 It's about money.

Many doctors believe that patients sue primarily because of money, but for the vast majority of patients, money is not the primary motivation. Instead, patients often sue because they want to prevent similar incidents from happening in the future, want an honest and clear explanation as to how and why the injury occurred and want the staff or organization to be accountable for their actions.[1]

4 The number of lawyers is the root of the problem.

The number of lawyers in an area does not predict the number of medical malpractice lawsuits. It is the number of doctors that predicts the number of suits.[2]

5 Lawyers decide the standard of care.

In every jurisdiction, a lawyer is able to file a medical malpractice suit only with a statement from an expert that negligence occurred. That expert has to be a physician.

6 Frivolous suits are the root of the problem.

A General Accounting Office report showed that less than 10 percent of the time does the plaintiff have an injury that would be regarded as "insignificant."[3] In the majority of cases, plaintiffs have serious problems that no one would want for themselves or their loved ones. Whether the bad outcome was the result of doctors' negligence may be debatable, but medical malpractice suits for frivolous reasons are uncommon.

7 There is nothing one doctor can do.

Perhaps the most powerful predictor of the likelihood of being sued is how well the doctor relates to patients. The more honest and empathetic a doctor is, the lower the likelihood of suit.[1]

8 Judges and juries favor plaintiffs.

In fact, judges and juries generally favor doctors. In 2000, defendants won 62 percent of all medical malpractice cases brought before a jury.[4]

9 All tort reform is good.

Some kinds of tort reform have proven effective, such as California's 1975 Medical Injury Compensation Reform Act (MICRA); others have not and, in fact, may make things worse.

1. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *The Lancet.* 1994;343:1609-1613.

2. Danzon PM. The frequency and severity of medical malpractice claims: new evidence. *Law Contemp Probl.* 1986;49:58-84.

3. *Medical Malpractice: Characteristics of Claims Closed in 1984.* Washington, DC: General Accounting Office; 1987.

4. *Medical Malpractice: Verdicts, Settlements and Statistical Analysis.* Horsham, Pa: Jury Verdict Research; 2002.

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Money is not the primary motivation for most patients who sue. Instead, their motives are to prevent future incidents, seek out an explanation and hold someone accountable.

The number of doctors, not lawyers, in an area determines the number of malpractice suits.

According to the General Accounting Office, less than 10 percent of plaintiffs have injuries that would be regarded as "insignificant."

Doctors who are honest and empathetic toward their patients have a lower likelihood of being sued.

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To avoid claims alleging a failure to consult in a timely manner, the author recommends the rule of three: If you haven't figured out and corrected a patient's problem within three visits, enlist help.

Drug-related iatrogenic injuries cause thousands of hospital admissions each year, many related to the use of warfarin.

Negligent procedures tend to occur not because physicians are doing procedures they were not trained for, but because they find themselves doing procedures when they're not at their best.

Avoid claims of failure to obtain informed consent by documenting that your discussions with patients included expected outcomes, potential risks and reasonable alternatives to the proposed care plan.

4. Failure to consult in a timely manner. I try to follow the rule of three: If I haven't figured out and corrected a patient's problem within three visits, I enlist someone to help me. It may be my partner across the hall, a specialist down the road or someone else. Why do I use three as my cutoff? Because it's as good a number as any, and it keeps me from temporizing forever while the patient continues to have problems. In primary care, it can be a challenge to diagnose vague symptoms for early-stage disease at the first visit. By the second visit, the story becomes better clarified. By the third visit, a clear diagnosis and plan should be decided. The main point is to set a plan for diagnosis, treatment and expected improvement; when these have not occurred as planned, then get help.

When patients do not pay their bills, it may be a signal that they were not happy with their care.

5. Negligent drug treatment. Drug-related iatrogenic injuries cause thousands of hospital admissions each year. Many of these injuries are related to the use of warfarin, perhaps the most dangerous prescription drug in America. Because of the drug's very narrow therapeutic window, the clinical care team needs to use a protocol to ensure that patients are well educated about using warfarin and are getting their International Normalized Ratios checked regularly. [See "Improving Anticoagulation Management at the Point of Care," *FPM,* February 2002, page 35, and "Reducing Risks for Patients Receiving Warfarin," *FPM,* July/August 2002, page 35.]

6. Negligent procedures. The most common problem family physicians face with procedures is not that they are doing procedures they were not trained for, but that they find themselves doing procedures when they're not at their best – when they're tired or mentally distracted – and then the procedure goes badly. Although this may sound basic, the best way to prevent these types of injuries is to be prepared physically, mentally and emotionally for the procedure. Sleep depravation increases the risk of poor performance. Distractions such as pressing personal problems might be good reasons to reschedule or have another physician perform the procedure.

7. Failure to obtain informed consent. If failure to obtain informed consent is the only allegation a plaintiff makes, it usually suggests a weak case on the merits, and the physician has a good chance of winning the claim. Still, it's best to avoid this risk by documenting that discussions with patients included expected outcomes, potential risks and reasonable alternatives to the proposed care plan.

The four Cs of risk management

Developing a risk-management style of practice involves four Cs: compassion, communication, competence and charting.

Compassion. When patients do not pay their bills, it may be a signal that they were not happy with their care. Our practice sends three dunning letters to patients who don't pay. The first letter is fairly mild, the second is more blunt in tone, and the third says, "We're sending you to a collection agency." This third letter isn't sent without the doctor being made aware, and we endeavor to speak personally with the patient before the third letter is sent. It is surprising how often the reason that patients aren't paying is because they are angry – angry about the way the nurse acted or something the receptionist said. For these patients, not paying the bill may be their last chance to express their displeasure. Take advantage of these risk-management opportunities. Patients appreciate the chance to have their grievances heard and addressed. Once heard, they are often more willing to work out payment terms. At the least, they are usually happier. Happier patients are less likely to sue.

Compassion

Communication. Physicians practice as part of a care team. Communication across teams can be a challenge. It is sometimes tempting, for example, to engage in jousting in the chart: A nurse writes one observation, a physician notes a conflicting observation, and a consultant offers yet a third observation. Stay away from those kinds of games

because no one wins except plaintiff's lawyers who seek to divide and conquer. Instead, be honest and open yet discreet with communications, not only with colleagues but with patients and staff as well.

Communication

Competence. Physicians are keenly aware of the need to stay up-to-date on the latest evidence and clinical recommendations, yet no one can remember everything that is needed for the care of every patient. Flow sheets, protocols and other tools can reduce the chance that important factors are overlooked. A low threshold for consultation can be enormously helpful when the patient isn't getting better as quickly as expected or wanted; when the patient or the patient's relative expresses dissatisfaction with the care; when the patient's presentation is atypical or the diagnosis obscure; or when the patient is critically ill or dying.

Competence

Charting. The greatest charting mistake physicians make is that they fail to note what is important. Often, doctors believe that there is a need to write volumes. Write what's important. I recall one instance where I dictated a history and physical for a patient with chest pain admitted to rule out myocardial infarction, and the transcriptionist clocked me at 250 words a minute with gusts up to 350. When I later reviewed the transcribed note – and I do read every single transcribed note – I realized I had forgotten to mention anything about the heart! This can happen to anyone, and courts will forgive such clerical mistakes so long as they are detected and corrected. We're not expected to be perfect scribes, but we are expected to be honest and thoughtful in how we approach documentation. Follow these simple rules:

The greatest charting mistake physicians make is that they fail to note what is important.

• Be honest. Never go back and surreptitiously alter a record. I was once an expert witness in the case of a pediatrician caring for a child with H. flu meningitis. The care the pediatrician provided was excellent, but the patient had a terrible outcome and his family sued the physician. Because one normal white blood cell count result had not been incorporated into the patient's chart, the physician got nervous and rewrote the entire two years of well-child and other visits to include this white count. The plaintiff's lawyer obtained the original records and saw they were all written, without a single error, in the same colored ink. The lawyer had the ink analyzed and proved that the ink was not even manufactured until after the patient's claim had been filed. The physician had a perfectly defensible case but panicked and ruined her credibility. Be honest with record keeping. Recording errors, when they occur, are best managed by a single strike through line that is initialed, dated, timed and identified as an "error." More extensive or significant errors (e.g., "wrong patient") may require more detailed explanation.

• Be objective. Write the record as though the patient will read it. For example, avoid adjectives such as "drunk and obnoxious' to describe a difficult patient. Instead, use more diplomatic language: "Patient is combative; ethanol-like odor noted." In this case, the patient may be in a state of diabetic ketoacidosis, not alcoholic intoxication, and our description of early impressions will be less likely to haunt us later should our care be challenged as inattentive. The point here is not to sidestep the truth but to choose language that is descriptive, objective and respectful.

• Be legible. Some physicians actually believe that illegible notes are a good way to prevent lawsuits because they hide any evidence of wrongdoing. In reality, illegible notes provide no protection

Charting

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Unhappy patients are a risk-management opportunity; patients are less likely to sue if you simply listen to their grievances and address them with compassion.

Communication across teams can be a challenge, but it is essential to providing high-quality patient care.

A competent physician knows when to seek consultation, for example, when the patient isn't getting better as quickly as expected or when the patient's presentation is atypical or the diagnosis obscure.

The greatest charting mistake physicians make is writing volumes but failing to note what is important.

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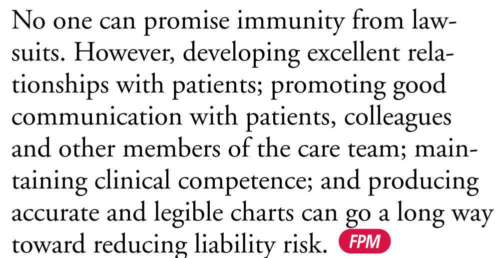
Write the record as though the patient will read it, avoiding comments that could be interpreted negatively and later used against you.

Illegible notes provide the physician no protection in malpractice cases and may even suggest sloppy care, so make sure your notes are legible and logical.

and are viewed by juries as reflecting sloppy writing and, perhaps, sloppy care. Years later, when the case finally gets to the jury, the medical record can be the doctor's best, and often only, friend as memories fade over time. Legible and logical notes detailing thoughtful care provide the best malpractice defense. Best is to use an electronic medical record system (it brings a wealth of information to the point of care); next best is to have notes dictated and transcribed. If notes must be hand written, make certain they are legible.



Bottom line

No one can promise immunity from lawsuits. However, developing excellent relationships with patients; promoting good communication with patients, colleagues and other members of the care team; maintaining clinical competence; and producing accurate and legible charts can go a long way toward reducing liability risk. FPM

Send comments to fpmedit@aafp.org.

FPM ARTICLES ON MALPRACTICE

The following articles from the *Family Practice Management* archives address the topic of malpractice. All articles published after March 1997 can be accessed from the *FPM* web site at www.aafp.org/fpm.

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

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

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

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

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