10 things that get physicians sued

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Not all medical liability suits filed against physicians are prompted by medical errors. Patients often cite interpersonal aspects of care, such as poor communication or feeling rushed, as central to the decision to initiate litigation. [1]

"Patients do not necessarily file lawsuits because they believe they were harmed by a medical error. They sue because they believe they were harmed by a medical error and something else happened during their care," says Jane Holeman, vice president of risk management at TMLT.

This publication will describe 10 common errors that can increase the risk of a malpractice suit, and offer risk management techniques to address these issues.

1 Failing to listen to patients, spend adequate time with them, and communicate empathetically with them

Research on why patients sue physicians has repeatedly shown that basic interpersonal skills such as listening and showing respect can be just as important as clinical skills in preventing lawsuits. [1] However, given the time and economic constraints placed on physicians, it is easy to see how these skills can become overlooked.

"Eye contact and attentive listening are important and can go a long way toward building a relationship with the patient," says Jill McLain, senior vice president of claim operations. "And patients who have a good relationship with their doctors will be less likely to sue if a bad outcome occurs."

According to Holeman, a key factor in patient satisfaction involves the quality of time spent with the physician, not just the quantity. "Short visits can be effective if the physician will sit down, listen to the patient, and ask the appropriate questions. If the physician spends the entire visit with his or her hand on the doorknob, the patient may feel rushed and may not give complete information to the physician. This is inefficient for everyone," Holeman says.

Patient's name

Date of birth

Main reason for today's visit:

Other concerns I would like to discuss if there is time:

Please check all that apply:

______ I have prescriptions that need to be refilled

______ I need a school or work excuse

______ I need a referral for my insurance company

______ I need the attached forms filled out

This form can help prompt patients to state the reason for their visit.

But many physicians rightfully ask, "How can I improve a patient's perception of a satisfactory visit when time is limited?" Holeman offers the following tips.

- Schedule appointment time based on patients' needs.
- During the appointment, spend time connecting with patients via non-medical conversation.
- Before patients are in the exam room, have them complete a form (see above) that prompts them to state the reason for their visit.

2 Maintaining illegible or incomplete documentation

Accurate, legible, and complete documentation can be the best defense against a malpractice claim. What would your medical records look like to another physician, a plaintiff's attorney, or a jury? Poor documentation practices can impede care and may signal to the patient that the physician is careless or does not care to follow the patient closely.

"Poor documentation alone will not generally send a patient to an attorney, but could lead to a suit once the attorney sees the records," McLain says. "Poor documentation also makes the case more difficult to defend." Physicians should also be aware that the Texas Medical Board can discipline physicians if their medical records

are incomplete or illegible. The rules for medical records as governed by the TMB include the word “legible” in their description of an adequate medical record. The TMB rules for medical records are as follows:

“165.1.Medical Records
(a) Contents of Medical Record. Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an “adequate medical record” should meet the following standards:

(1) The documentation of each patient encounter should include:
  (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
  (B) an assessment, clinical impression, or diagnosis;
  (C) plan for care (including discharge plan if appropriate); and
  (D) the date and legible identity of the observer.
(2) Past and present diagnoses should be accessible to the treating and/or consulting physician.
(3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
(4) The patient’s progress, including response to treatment, change in diagnosis, and patient’s non-compliance should be documented.
(5) Relevant risk factors should be identified.
(6) The written plan for care should include when appropriate:
  (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
  (B) any referrals and consultations;
  (C) patient/family education; and,
  (D) specific instructions for follow up.
(7) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
(8) Any amendment, supplementation, change, or correction in a medical record not made contemporanously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
(9) Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient’s medical records.
(10) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient’s status. Paragraphs (1)-(10) of this subsection may be modified to account for these variable circumstances in providing medical care.” [2]

Another documentation pitfall involves “correcting” medical records after an unexpected outcome or notice of a claim. Altering the medical record after the event — even if you believe the information will assist in your defense — is detrimental. An addendum to the medical record may be allowed if done in a timely manner and clearly identified. Include the date and time, a reference to the date and time of the actual encounter, reason for the addendum, the added information, and author’s signature.

“Remember that part of good patient care is maintaining complete and legible documentation that is available for review by the primary physician and any consultants,” McLain says.

3 Failure to establish standards of conduct for office staff

Rude behavior by office staff and a bad outcome may be all it takes to initiate a lawsuit — even if the poor treatment and the bad outcome have nothing to do with each other. These behaviors can include rudeness, insensitivity, or inattention to patients.

To address this problem, develop a policy and procedures manual for the practice. This manual can ensure that staff act in accordance with the policies in place. A policy and procedures manual can also reinforce staff accountability and serve as a staff orientation tool.

"Staff must be adequately trained and monitored," Holeman says. "Make them aware of the policies and procedures through regular training. Document this training and address unacceptable behavior when you see it." Maintain an office culture that is patient friendly. To evaluate the "friendliness" of your practice, consider using patient satisfaction surveys or have a friend or colleague call or visit and report the experience to you.

4 Being inaccessible to patients

Perceived "inaccessibility" can occur when patients experience the following: long wait times for appointments; failure to return phone calls and messages; long automated phone messages when calling the office; and inattention during hospitalization.

"Such inaccessibility may be interpreted by patients that the physician does not care," Holeman says. She urges physicians to have policies in place for returning patient phone calls. It is also important to tell patients what to expect regarding returned calls and to meet those expectations. Many practices use prompts that tell patients when they can expect returned phone calls.

"Long, automated phone messages and menus are by nature annoying, but in some practices they are necessary. If you must use such a message, give the caller the option to speak to a person early in the message," Holeman says.

To minimize wait times for patient appointments, instruct staff on triaging and assigning priority appointments. "Scheduling every patient for the same brief visit can be inefficient for everyone. Staff can ask callers a set of standard questions and then schedule appropriate appointment times," Holeman says. Patients who cannot be accommodated by the physician should be referred to another physician or to the emergency department (ED).

"The accessibility of the physician when a patient is in the hospital is another huge issue," McLain says. "Family members may wait all day at the hospital to ask the doctor questions. When they do see the doctor, they often feel rushed and their questions are not fully answered." This can be addressed by clear communication with the family about what to expect, when the physician will be there, or by arranging a time to talk to the family.

5 Failure to order and follow up on indicated tests or delay in ordering such tests

Employ a tracking system to ensure that patients have obtained recommended tests. A tracking system can minimize exposure to allegations of failure to diagnose and treat and can lead to better patient care.

"Sometimes patients just need a reminder. Maybe they could not make it to the lab on the day of the appointment and then they forgot that they needed lab work. A tracking system can remind both patients and physicians that tests need to be completed," McLain says.

According to Holeman, a tracking system does not need to be complicated. "It can be as simple as a box of index cards or a 'tickler' sheet that staff use to make phone calls. Also, some electronic medical records have a tracking feature that can be used. The important thing is to make tracking a routine procedure in your practice," she says.

Along with tracking, have a written procedure for handling test results when they are received, and for following up on results that have not been received. This procedure should specify that test results are to be thoroughly reviewed before they are filed in a patient's chart. Ideally, the reviewer should initial and date the reports and document what needs to be done.

Sometimes patients who have sued their physicians claim that test results were never communicated to them, or that the physician was delinquent in providing those results. Timely notifying patients of their test results should be a high priority. Routinely noting in the record that the patient was provided with those results, and including the date and initials of the person who contacted the patient, can help to prevent such allegations.

6 Failure to refer when appropriate, failure to track referrals, and failure to communicate with referring physician

While it is true that patients have a duty to comply with their physicians' recommendations, including following through with referrals, it is common for them to claim that the physician either did not stress the importance or did not explain the reason for the referral. In fact, they sometimes claim that they were given an option, as opposed to a recommendation, to see a consultant.

Implementing a system to track referrals can improve patient care and reduce liability exposure. The system can provide a method for: verifying that the patient keeps the appointment; confirming receipt of the consultant report; prompting a call to the consultant if a report is not received; making sure the physician sees the report; and arranging for a follow-up appointment if necessary. If the patient fails to keep the appointment with the specialist, the staff can then contact the patient with a reminder of the importance of following through with that recommendation. These steps should be documented in the patient's chart.

As with reports of test results, written procedures for handling consultant reports can prevent problems and improve patient compliance. Initialing and dating reports after careful review can provide useful documentation if a lawsuit is filed.

"Another problem we see frequently involves communication between physicians. While written communication will often suffice, there are some situations in which a discussion needs to take place," says McLain. "It is also important to document your discussions with other physicians and any joint treatment plans resulting from the referral."

7 Inappropriately prescribing medications

When patients experience adverse reactions to or lack of benefit from prescribed medications, lawsuits can result. These suits allege such errors as: failing to check the patient's chart when prescribing medication; prescribing improper dosages; failing to consider and advise patients of potential side effects or interactions with other drugs; prescribing drugs outside the physician's specialty; and prescribing drugs for nonpatients.

Given the significant amount of direct-to-consumer advertising of prescription and over-the-counter drugs, physicians frequently receive requests from patients for drugs they have seen advertised. Physicians would be well advised to resist patient pressure for drugs with which they are not familiar. There are a number of information sources available. Physicians who use reliable sources to educate themselves about the drugs they prescribe will be better able to explain their rationale if they should be sued individually, or as a part of mass tort litigation.

When possible, it is helpful to provide the patient with information about the drug, and to document discussions and any handouts given. Documenting the information provided can be helpful if the physician's actions must be defended in litigation.

To avoid allegations related to improper prescribing, consider the following guidelines.

- Check the patient's medical record when prescribing or refilling a medication. Request that the patient come for an office visit, if appropriate, before authorizing a refill.
- In the patient's chart, record medications and allergies in a central location. Update this information at each visit.
- Be familiar with the drug prescribed. Refer the patient to a specialist if he or she requires a drug that is outside your scope of practice.
- When prescribing drugs off-label or in dosages exceeding those recommended, document your rationale. Also document that you discussed the risks and benefits of the treatment with the patient.
- When a patient calls with complaints of unusual symptoms, the prescribing physician should be alerted.
- If a pharmacy calls to question a prescription, check the original order.
- Make sure handwritten prescriptions are legible and that dosages are correctly noted.

8 Improper care of patients during emergency situations

Treating patients by phone when an examination is warranted can be risky. Patients can be poor historians and may inaccurately describe their symptoms. Additionally, the physician cannot assess the patient's appearance, body language, or symptoms by phone.

"Treating patients over the phone is not a problem per se. In some cases it may be appropriate. Careful judgment should be used when deciding whether phone advice and treatment is sufficient," Holeman says. "When possible, check the chart. Determine if the patient has ever experienced this problem before? When was the patient last seen in the office? Is this a recurring issue for the patient?"

Implement written protocols for telephone triage that include:

- which staff members can answer patient questions;
- specific questions to ask the caller;
- when to notify the physician; and
- which calls warrant a visit to the office or ED.

Document the patient's request, symptoms, and any advice given. If the patient is told to go to the ED, document this directive in the medical record.

Another situation that warrants discussion involves interaction between treating physicians and the caregivers in the ED. "We have received a number of claims in which plaintiffs alleged that the patient's primary care physician or specialist inappropriately relied on the ED physician or resident because the physician did not want to come to the hospital," McLain says.

Other claims involving emergency care have alleged lack of adequate communication between the physicians at the hospital, such as emergency physicians or residents, and others such as radiologists or specialists.

When contacted by an ED physician, documenting any advice given over the phone can later serve to correct any confusion about what was communicated. The ED physician is probably documenting the conversation, but sometimes that documentation is inconsistent with the recollection of the physician calling in. Additionally, if you are asked to fax copies of medical records or reports, confirm that the ED received the materials. Document the confirmation in the medical record.

9 Failure to obtain informed consent

"Informed consent is not a piece of paper. It is a discussion between the patient and the physician regarding the risks and benefits of a procedure, treatment, test, or medication," Holeman says.

In Texas, informed consent is governed by statute and is overseen by the Texas Medical Disclosure Panel (TMDP). The panel includes six physicians and three attorneys who review all treatments and procedures to determine which procedures require informed consent and which do not. Procedures and treatments are then assigned to a list. Those requiring disclosure of risks and benefits are put on List A. Those that do not require disclosure of specific risks are identified in List B. The panel periodically examines new treatments or procedures and assigns them to one of the lists. The lists, TMDP rules and forms can be viewed at Title 25, Texas Administrative Code, Part 7 at http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac.

When offering any treatment or procedure to a patient, the physician must make these determinations:

- if the treatment or procedure appears on List A, then disclosure specified by the panel must be followed;
- if the treatment or procedure appears on List B, no specified disclosure is legally required;
- if the treatment or procedure does not appear on either List A or List B, the physician must then disclose all material and inherent risks which could influence a patient in making decisions.

"It is also important to realize that informed consent is a non-delegable duty. The physician is responsible for discussing the risks and benefits and obtaining consent," Holeman says. "A signed form is not a substitute for a detailed discussion."

Additionally, it is important to note that, by statute, the TMDP may not require disclosure of the risks of certain surgeries, procedures or medications. However, it is best to disclose those risks that a reasonable person would want to know in making the decision.

A final piece of advice regarding informed consent — document the discussion in the medical record. The notes should indicate that the patient was informed of the risks, benefits, and alternatives of the offered treatment, and that the patient expressed a desire to proceed.

10 Allowing noncompliant patients to take charge

These situations can include a patient leaving the ED when the physician suggests admission or a patient leaving the hospital before his or her condition is stabilized.

"Physicians should resist attempts by patients to talk them into anything other than what their best medical judgement deems appropriate," says McLain.

Physician recommendations and patient noncompliance should be objectively and adequately documented. If a patient suffers a bad outcome as the result of his or her noncompliance, that patient may try to shift the blame to the physician. "Patients often claim that the physician did not explain the severity of their condition or the potential consequences of going against medical advice. Thorough, contemporaneous documentation can help dispel these allegations," says McLain.

Another risk management strategy for these situations includes requiring that the patient sign informed refusal or "Against Medical Advice" forms.

References

1. Ambady N, et al. Surgeon's tone of voice: a clue to malpractice history. Surgery. 2002; 132:1; 5-9.
2. Texas Medical Board. Board Rules Chapter 165.1-165.5 Medical Records. Available at http://www.tmb.state.tx.us/rules/rules/165.php.

TMLT risk management publications and resources

The following risk management publications are available at www.tmlt.org/rmresources

***the Reporter* newsletter**
Published bimonthly, the Reporter contains the latest information on the medical malpractice environment and how to reduce risk in the medical office. Readers can also earn CME credit by completing Reporter CME activities.

***the Reporter* specialty editions**
Specialty editions of the Reporter feature closed claim studies and articles related to specific medical specialties.

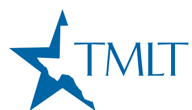
TMLT Risk Management Guide for Physician Practices
This manual has been developed as a guide for physicians, their administrators, and management staffs. The information is intended to enhance your knowledge of risk management, reduce your exposure to claims, and assist in your defense should a claim occur.

Rx for Success: Communicating to Reduce Risk
This publication uses real-world examples to solve some of the most common patient relations issues, including appointment management, complaint resolution, and treating the noncompliant patient.

Health Information Release for Ambulatory Health Care Facilities
This guide will introduce medical office staff and physicians to the federal and state laws governing the release and confidentiality of health information.

Informed Consent: the Third Generation
This handbook has been developed as a reference to understanding the legal doctrine of informed consent and how it applies to medical liability.

TMLT Risk Management Medical Errors, Disclosure and the Role of Apology: A Tool for Physicians
This pamphlet discusses the role of apology when patients experience adverse outcomes.



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