Malpractice pitfalls

5 strategies to reduce lawsuit threats

by LIZ SEEGERT

When it comes to getting sued for medical malpractice, it is unfortunately more a case of "when" than "if."

It's no secret that physicians are at great risk of being sued by a patient sometime during their career. The good news is, doctors can take steps to reduce the risk of lawsuits, and improve the odds of a favorable outcome if they are sued.

While the frequency of claims and payments actually have declined over the past decade, physicians still have about a one in five chance of making a payment, whether through a trial or settlement.

There are events that occur every day in medical practices that may seem harmless on the surface, but can sow the seeds of a potential lawsuit. From adding an extra note to a patient's chart after a visit, to rushing through electronic health record (EHR) screens, a minute's worth of an innocuous action can lead to months of a physician defending his or her actions in court.

To help doctors protect their practices and professional reputations, *Medical Economics* consulted experts to learn the five biggest malpractice hazards facing physicians and how to avoid getting tied up in a malpractice maze.

1 Document everything

"Every doctor is taught that if you didn't put it in the chart, you didn't do it," says Steven Fox, MD, an internist and assistant professor of clinical medicine at the Keck School of Medicine at the University of Southern California. If it's not in the chart, you are deemed not to have done it for the purposes of malpractice litigation, he adds.

Fox advises documenting all conversations. This includes summarizing patient discussions, having patients verbalize their understanding of why something is important, explaining why any clinical alerts are dismissed and noting conversations with other providers or with family members.

Michael Ellenberg, JD, a malpractice attorney in New York City, advises physicians to note every action in the patient's chart, even if it's just to correct something accidentally entered in the wrong field. Include an addendum, but never delete or try to otherwise modify the existing record, he says.

It's easy to tell whether an existing record has been altered, he adds, and it can raise suspicions among juries that other things may also be amiss. Without thorough documentation, and thus only memory to rely on, a doctor is more likely to lose the case, he says.

PHYSICIANS HAVE A 1 IN 5 CHANCE OF MAKING A MALPRACTICE PAYMENT

2 Be transparent with patients

The shift to patient-centered care is designed to help patients be part of the decision-making process. But that requires openness and communication by the physician about information in the medical record.

One approach physicians can take to boost transparency and encourage more patient engagement is to share notes with their patients, says Nitin Damle, MD, an internist with South County Internal Medicine in Wakefield, Rhode Island, and president of the American College of Physicians.

Doctors may hesitate to do so out of fear that misunderstood comments could lead to lawsuits, but the idea is not unreasonable, he says.

While note-sharing can be tricky if done without appropriate context, it can be helpful when done under the right circumstances, Damle says. Discussing entries with patients promotes more engagement, and helps them become more active participants.

Whether shared in person or through an online portal, physicians should take time to explain what the notes mean, such as why a test or medication was ordered, he says. Additionally, patients should never be permitted to directly modify anything in their chart. If they do need to add information, it should go in as an addendum.

Note sharing helps physicians be more careful about using objective language when describing patient encounters. Damle says common sense should prevail when discussing a patient's record. Entries should be factual and not derogatory or personal in any way. Keep to the medical specifics of a visit, call or referral, he advises.

Robin Diamond, JD, MSN, chief patient safety officer for physician insurer The Doctors Company, points out that notes need to be objective and unambiguous. "Think about how you'd feel if you saw them projected on a six-foot screen in a courtroom or if they were in the family's or patient's possession," she says.

To increase clarity, she suggests including direct quotes from patients when documenting, especially if the patient seems upset or agitated.

Diamond also recommends that physicians and patients review the notes together. Not only does this practice ensure that entries are appropriate and objective, she adds, it helps patients better understand their situation and any required action on their part. That reduces the potential for claims arising from miscommunication or misunderstandings.

36 STATES HAVE "SORRY" LAWS PROHIBITING USE OF A PHYSICIAN'S APOLOGY AGAINST THEM IN A LAWSUIT.

3 Show empathy

While there's a natural inclination to apologize for mistakes, fear of lawsuits prevents many physicians from even expressing empathy if something should go wrong. Instead of sharing information with patients or families, they hesitate to discuss errors, leading to frustration and legal action.

Thirty-six states have so-called "sorry" laws, which generally prohibit using a physician's apology to patients or families against them in lawsuits. Specifics of these laws vary from state to state, but "showing compassion can sometimes ameliorate a situation over time," Ellenberg says.

Research from the American Bar Association and elsewhere concludes that apologies do reduce the probability of getting sued. Fox points out that if a case goes to trial, juries tend to be better disposed concerning the amount of liability when doctors are contrite, rather than denying responsibility or shifting blame.

Even with an apology, however, a patient or family may still decide to sue. So before speaking with the patient or family regarding the error, it may be prudent for a physician to seek guidance from their practice's medical director, hospital's risk management department or their insurance carrier, advises Carol Keohane, MS, RN, assistant vice president for patient safety at CRICO, a risk management firm that serves the Harvard University medical institutions.

It's important to assess where communication or other processes may have broken down so as to prevent a recurrence, says Keohane. Common problems include not clearly communicating the significance of test results, not following up on a referral or not providing all necessary documentation to a consulting physician, she says. When evaluating ways to reduce mistakes, take a look at office workflow and staffing as well as ways to educate physicians on process improvements.

4 Beware of EHR hazards

Widespread adoption of EHRs adds another layer of potential liability for physicians, according to David Troxel, MD, medical director of The Doctors Company.

Despite the increasing complexity of care, most patients and jurors hold physicians responsible for managing all of a patient's information. EHRs are supposed to solve information and documentation issues, but don't always provide correct or complete results, he says.

Providers may be tempted to use shortcuts, such as copying and pasting from templates, auto-filling fields and relying on computer-assisted documentation, he says. But that approach,

coupled with a lack of updated clinical decision support and "hold harmless" clauses absolving EHR manufacturers of responsibility for errors, leave physicians vulnerable to EHR-related legal problems.

Troxel, who specializes in EHR-related malpractice issues, cites drop-down menu selection errors as a common problem. Even if you know you accidentally selected an item on a menu, you may not be able to correct it. It's likely that the information already has been transmitted to other parts of the health record and will remain there.

"You basically have a time bomb on your hands," he says, because it opens the door for another doctor to pull up a different part of the record and act based on incorrect information, such as a missed drug allergy or the wrong dose of a medication. Be sure to make copious and visible notes regarding inadvertent errors so other doctors are informed.

In a 2015 CRICO analysis of common communication errors, the absence of the right information, including through EHRs, at a crucial point in the diagnosis or treatment process was a major contributor to patient harm. These types of communication errors are cited as a factor in 38% of all general medicine cases in the survey.

Another common practice, turning off computer-generated warnings, can also trigger liability issues, Troxel notes. Ignoring alerts is especially common when prescribing medications. Missed dosing errors or drug interactions resulting in severe side effects or overdoses can land a physician in court.

Under those circumstances, it's the physician, not the EHR manufacturer, who is liable for missing alert-generated warnings, especially if documentation is non-existent or incomplete, Troxel says.

Troxel also warns physicians not to develop their own workarounds for common EHR problems, no matter how frustrated they get. The danger is that data may not get included in other areas of the record, and if a problem arises, the physician could be held responsible for not using the EHR as it is intended.

ANOTHER COMMON EHR PRACTICE, TURNING OFF WARNINGS, CAN ALSO TRIGGER LIABILITY ISSUES.

Damle says his practice's system won't allow a physician to override an alert without a written explanation. He advises that any physician who deviates from clinical guidelines must be certain to document why, or risk being accused of providing suboptimal care.

5 Maintain good relationships

Physicians must maintain objectivity, even when patient or family dynamics are difficult. It's important to acknowledge and calmly discuss issues that could affect outcomes, such as noncompliance with the care plan. And of course, document any conversations.

Even if family members are involved, talk to patients directly but recognize that there might be problems with comprehension, cognition or memory, Damle advises. If a patient consents, having a family member or surrogate act as a listener and possible explainer can improve understanding and good will.

Sometimes, it's the family member who doesn't agree with the care plan, and that may lead to problems later, because that person may sue or coerce the patient into doing so. But spending a little extra time to explain the diagnosis or disease process can often defuse a tense situation, Damle says.

Part of managing the patient relationship is ensuring transparency and being realistic, Diamond points out. "Be clear with patients about expectations for treatment, follow up, medication," Diamond says. By helping patients understand their situation thoroughly, they will get better care and be less likely to sue because of a misunderstanding.

Conversely, doctors are more likely to get sued by a patient with whom they have a bad relationship, according to Fox. He adds that there's no obligation to continue treating patients when there's a bad relationship.

Good communication and strong relationships are goals physicians and staff members can and should work toward. But even so, "you can do absolutely everything right, make every right decision, do every right test and treatment and still get a bad outcome," Fox says, "because medicine is not certain." ■

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