

Top Reasons Physicians Are Sued for Malpractice

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A primary, if not preeminent, goal of every physician in practice today is the avoidance of a lawsuit for medical malpractice. In pursuit of that goal, the hard reality of practice dictates that risk management of medical malpractice claims falls directly upon, and is ever present with, every physician throughout each moment of rendering care. Understanding where the highest risk areas lie, and taking affirmative and aggressive measures to risk manage those prioritized threats, will provide physicians with the greatest protection toward avoiding a claim and/or being prepared to defend, and defeat, a claim that arises in spite of these measures.

Creating Medical Records That Are Not "Self-Protective"

The initial "triage" of a potential medical malpractice claim is normally carried out by a physician or nurse retained by the attorneys representing the patient. These attorneys, seeking a financial recovery/gain, are not desirous of investing large sums of capital, resources and time into a claim which presents with a strong, defensible set of medical records. However, records that are insufficient in detailing the actual care and treatment rendered, illegible, self-conflicting with other practitioners and/or fail to defend the physician will encourage a claim.

Failing To Pursue a Patient's Medical History

In initiating care, many physicians (or their staff upon patient intake) "lower their guard" and fail to aggressively pursue and/or document critical information regarding a patient's medical history - such as prior or concurrent care (especially medications), conditions unrelated to the presenting complaint and/or names of other treating doctors. Moreover, securing the identity and contact information of other past or present treating physicians, and thereafter securing records from those physicians and/or communicating prospective care with that physician, will dramatically strengthen the defensibility of the care rendered.

Ignoring Past Developments in Subsequent Interactions

Many physicians will properly make note of a new complaint or a new clinical presentation yet then fail to revisit those developments in subsequent interactions with the patient. In certain cases, diagnostic studies are also properly ordered to evaluate the new development yet the physician will fail to document his or her review of and reaction to those studies (returned post-visit) and any measures undertaken in response (or the lack of any need to undertake any measures).

Failing To Adopt, and Abide by, a "Tickler" System

Throughout patient care, countless diagnostic, laboratory and/or radiological tests are ordered by treating and/or consulting physicians. Logically, these tests are completed post-visit or consult and the results are provided thereafter. Unfortunately, many practices are failing to adopt a strict and uniform "tickler system" to insure that these tests are received, evaluated, acted upon - and that each responsive measure is properly documented within the medical record. The structure of such a "tickler system" can vary however, the core should be (a) track ordered tests and referrals (b) ascertain why

reports are not received on a timely basis and secure same. Once the report is secured, the system/protocol should also require that no test can be "filed" by the practice until it is reviewed (and that review is documented) by the ordering physician.

Breakdowns in Communications

The treatment of patients today involves a growing number of practitioners in an increasing myriad of roles (treating physicians, specialists, consulting physicians, care extenders, etc.). Proper "cross-communication" between those carrying out these roles can actually serve to increase the defensibility of a potential claim; however, the failure to properly communicate can, and does, result in conflicting care, ignored recommendations and/or delays in addressing significant medical conditions and/or developments. Physicians must review all aspects of the medical record and document their evaluation.

Errors in Medication Administration

Consistent throughout all national studies of medical malpractice is the prevalence of prescription errors and their dramatic adverse impact upon care. A thorough understanding of each patient's present and past medication regime is critical for every physician seeking to avoid a claim for malpractice. These errors not only include the failure to properly document dosages and refills but also include the failure to document the evaluation of issues such as poly-pharmacy concerns, the basis for the issuance of the prescription itself and the discussion with the patient as to potential side-effects and how to respond to the manifestation of the same.

Improperly Obtaining Informed Consent

Today, every physician should be aware of the need to provide, obtain and document informed consent from a patient prior to rendering care and/or treatment. However, many physicians (and other practitioners) have begun to treat the informed consent process with high-threat casualness - failing to secure witness signatures, conduct the discussion in the presence of a witness, sign as the treating physician, date the informed consent, complete the patient information, etc. Moreover, physicians must also understand that the need to secure informed consent does not only apply to complex in-patient surgical procedures but also to a large and growing number of forms of care and treatment rendered in an in-office setting.

Lack of Formalized Roles

Damaging issues can arise when the role between consulting and treating physicians are not clearly defined. Every referring physician should speak directly with the consulting physician regarding the patient's history and expectations for the consultation. Once these discussions have occurred, a formal letter of referral should be sent to the consulting physician and contain the reasons for the referral, the patient's history, any diagnostic studies performed and a specific definition of expectations. The referring physician should document discussions with the patient and with the consulting physician in the patient's medical record. In order to secure the benefit of proper communication, physicians must abandon the use of undocumented bedside, hallway or even telephone consultations.

Poor Documentation of Patient Instruction and Education

Throughout the rendering of care, and especially at critical points such as discharge, post-procedure home care, etc., patients are routinely provided with detailed instructions as to what to expect, how to respond and what further medical care is

needed. However, the documentation of these discussions and/or instructions remains consistently poor, thereby resulting in not only non-compliance, misunderstanding and patient frustration but also a resulting desire to seek the evaluation of a claim for malpractice. Moreover, written instructions are routinely issued in support of these discussions; however, copies of those materials are rarely retained yet could be invaluable to the alter claim that such instructions were not provided.

Inadequate Consideration of the Role of Patient-Relations

Many patients who seek out the advice of a malpractice attorney do so based strictly upon emotion rather than medicine. Anger at the non-medical treatment received by staff, the perception of inattention by a physician and/or the imposition of delays in treatment or responses are the most common reasons patients initially seek to file a claim. However, many of these initial reasons are quickly cast aside if the plaintiff's attorney they have consulted can discern a potential medical/legal basis for a claim. Training of staff in proper "patient-management" methods is critical to creating a positive perception with patients and thereby reducing the motivating "anger" that can be the impetus for a later claim of malpractice.

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In conclusion, every physician's ability to reduce the risk of a medical malpractice claim lies within their own willingness to act. Taking the time to step back and evaluate each aspect of the physician's care and treatment through a focused prism to determine whether those methods are accompanied by adequate self-protective measures will provide the greatest form of risk management toward avoiding a claim for medical malpractice in the future.

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