

## Malpractice risk management

# Avoid these common errors in self-defense!

Thorough documentation is an essential tool of risk management. The onus—always—is on you.

In my work analyzing malpractice claims against physicians in 4 states, I (and my colleagues) have found that problems for defendant physicians can often be traced back to their failure to document the care and advice they provide. The 5 most common errors occur (and recur) when physicians are dealing with:

- results of tests
- informed consent
- informed refusal
- patient education
- postop follow-up discussion.

The good news is that, with some attention to detail, you may be able to avoid all these problems. Here is how.

### Know the test results

When someone other than the ObGyn surgeon has ordered preoperative tests, that surgeon may say: “I didn’t order them, so I don’t need to review them or sign off on them. The primary care physician (PCP) will tell me whether the patient is ready to have the operation.”

This is a dangerous assumption. It’s your duty to make certain not only that the patient has medical clearance for the operation, but also that the chart proves it. We urge the ObGyn surgeons with whom we work to provide evidence in the chart—by initialing results—that they have reviewed preoperative tests.

If a cardiologist, pulmonologist, or other specialist has been asked to help clear a patient for surgery, the chart should include a consultation report that you review. Add your own notes or initial the report as evidence of your review.

## Malpractice risk management in 4 parts

This article is the second in a series of 4 derived from a symposium on malpractice risk management at the 91st Clinical Congress of the American College of Surgeons, San Francisco, Calif, in October 2005. Ms. Dobbs updated her comments in October 2006 and February 2007.

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### FAST TRACK

**Always make certain yourself that the patient has medical clearance for an operation and that the chart proves it**

## Reduce your exposure to liability with the best use of prenatal and antepartum records

It goes without saying that prenatal and antepartum records are vital to obstetric care. But those records can, regrettably, increase your liability if you don't document information clearly or if you fail to monitor what you've entered in the record—a necessity made more of a challenge by an often cumbersome layout. Here are helpful hints for maintaining prenatal and antepartum records so that they are useful and reduce your exposure:

**Use the record to alert physicians and staff to a high-risk patient.** Use red ink or a highlighter or adhere bright stickers to the prenatal record—anything—to draw attention to vital data about risk factors, and thereby prevent injury.

**Document sonographic findings and other diagnostic results on the prenatal form.** Don't bury this significant information in the chart—especially when findings are abnormal and must be monitored through the pregnancy. Then draw the reviewer's eye to findings by, again, using red ink or a highlighter.

**Document each prenatal visit completely—just as you would any office visit.** Why limit your observations to the many check boxes on the prenatal form or to the one line provided for "Comments"—especially when the patient's complaints are beyond what you would consider part of a "routine" prenatal examination? Instead, document any extra-routine notes on a separate sheet of paper. These notes should include her subjective complaints and your

observations, assessment, and plan for care and follow-up.

**Document any discussion you have about informed consent and informed refusal.**

Memorialize the informed consent communication in a progress note, but avoid documenting informed consent on the single line found on the prenatal form. Use a consent form to supplement your oral discussion.

Clearly document a patient's informed refusal—whether it be of a significant diagnostic test (HIV,  $\alpha$ -fetoprotein, amniocentesis, chorionic villus sampling), of hospital birth (in opting for home birth), and so forth. Ask her to sign a refusal document to supplement your oral discussion.

**Make certain the complete prenatal record is sent to the hospital's labor and delivery suite or operating room before the date of delivery.** Some physicians periodically (eg, at the end of the second trimester or the beginning of the third trimester) submit the prenatal record in preparation for a patient's delivery. This is an excellent practice: It provides pertinent information when a colleague is called to labor and delivery because you are off-call.

**Ensure complete documentation of all vital communications and actions.** Don't take shortcuts simply because you're using the prenatal form to document antepartum care. Document significant telephone calls with patients and consultants, referrals to specialists, missed appointments, and so on.

Also, document in the chart the details of any telephone communication you had with other physicians on the team.

### **Don't disregard a questionable finding**

When a test reveals an incidental suspicious finding—such as a shadow on a chest radiograph or an abnormality in blood work—the surgeon is responsible for following up, even if someone else ordered the test. You cannot ignore such a finding or assume the internist or PCP will follow up.

In addition, you should notify the patient about any such problem—even if it is unrelated to the reason the patient is seeing you. If the finding is incidental to the surgery, you must tell the PCP and follow up with the patient.

We have seen situations in which diagnostic test results fall through the cracks. Cases that arise from such a lapse are, ultimately, indefensible and often involve shared responsibility or liability among the surgeon, the physician who ordered the test, and the primary care physician. Never put yourself in a position to have

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## Expert advice

## Telephone calls to and from patients: A right way to keep records

**D**ocumenting the date, time, and content of your telephone calls with patients demonstrates competent management and provides evidence of your decision making in all aspects of patients' care. Some guidelines:

- Always include the **date, time, and content** of the call.
- Document your advice to patients to come in for a **follow-up appointment**.
- **Don't let medical assistants offer independent medical advice.** They should repeat your orders and nothing more. The notes should read, "Per Dr. Jones, advised patient to do X, Y, and Z," and should be initialed by the staff member who spoke with the patient.
- **Document follow-up calls**—whether you're on the telephone in the middle of the night or during office hours. Write in the chart what you advised the patient to do and what her response was.

Don't give any patient the ability to say, "If the doctor had told me that, I would have gone to the emergency room"—when that is precisely what you said, but you can't prove it.

- **Document missed appointments**, especially postop, in the chart—not in the appointment book. Such chart notes show that the patient interrupted the treatment that you recommended. Later, if the patient claims, "My injury is a direct result of the physician's failure to provide proper care," you'll be able to respond: "I can demonstrate that I asked you to return, but that you failed your appointment here, rescheduled it there, and made it almost impossible for us to provide good care."
- **Establish a mechanism for notifying patients to return** after a postop no-show. Ensure that your staff returns the chart to you so that you can decide what to do next.

to say, later: "I saw that but didn't do anything about it."

### Be meticulous about informed consent

In documenting informed consent, your language reveals your attitude toward the process. For example, we've often heard physicians say "I consented the patient" instead of "the patient gave me her informed consent."

I recommend that you document your discussion with the patient in the chart, instead of relying on a form. Typically, this is done on the history and physical, the consultation report, or the initial progress notes. Note which family members are present during the discussion: At some point, counsel may need to ask family members what they heard or what you said.

Sometimes we see informed consent discussions documented in the operative report. This is inappropriate because it represents an event after the fact. In-

formed consent that has been recorded after the procedure can look self-serving to a third-party observer—such as a plaintiff's attorney. (For more advice on obtaining informed consent, see Part 4 of this series, upcoming in the June 2007 issue.)

### Write it down when a patient won't cooperate

Likewise, I recommend that you document informed refusal—whether or not the state in which you practice requires you to do so. This can dispel difficulties that may arise when a patient claims she would have consented to the surgery if you had discussed the risks properly with her. (See the March 2007 installment of this series for an in-depth look at informed refusal.)

### Avoid a casual approach to patient education

Another deficiency that we encounter again and again is physicians' failure to

#### FAST TRACK

**Informed consent shouldn't be documented in the operative report, where it represents an event after the fact**

Expert advice

## Save those e-mail messages!

Physicians' offices increasingly use e-mail to communicate with patients. Saving those e-mail messages is as important as documenting a telephone call in the chart.

Print both the patient's e-mail and your response to it. Keep those pages in the chart to provide a running history of your management.

document their efforts to educate patients, orally and by written word. Consider that you and your peers spend a lot of time educating patients about surgical and nonsurgical options; discussing their comorbidities, smoking, and weight; and asking them to review videos, read pamphlets, and fill out lengthy questionnaires. Then, many fail to document their efforts!

Notes enable defense attorneys to assert, with confidence, that, on a given date, patient and physician had a conversation or reviewed a handout, or that the nurse showed the patient a videotape. A record of this activity in writing makes it harder for the patient to claim, "The surgeon didn't tell me any of these things." The documentation can be as simple as a note stating: "Am CA Soc pamphlet reviewed with patient & husband; gave breast cancer booklet; nurse ran lumpectomy video."

### Keep postop notes specific

We've often found postoperative progress notes to be thin on detail. Typical notes are: "Wound looks good." "Patient happy with results." "Wound WNL" [within normal limits].

I recommend that you be specific in these notes. Describe the presence or absence of, for example, swelling, redness, adhesions, hematoma, drainage, fever, and regular urinary or bowel patterns.

When a patient claims negligent postop management, we often find sparse notes—sometimes a few words in the hospital chart or on the follow-up re-

cord. Nursing staff may identify fever, pus in the wound, and elevated laboratory values—yet the physician notes "Doing well."

Without complete notes indicating the surgeon's awareness of the patient's condition, it's impossible to convince a judge or jury that the surgeon was on top of the situation. Having inadequate notes makes the defense attorney's job difficult.

### Make the call, then write the note

Another gaping hole in documentation is poor notation of postoperative or post-treatment telephone calls during which a patient reports a significant change in her condition. Your policy may be "We never document telephone calls; we tell the patient to come in for a follow-up visit," but what if the patient doesn't show for the follow-up? There's no evidence that an appointment was scheduled or that the patient failed to cancel or reschedule.

We've also seen situations in which the patient calls to report a problem and the medical assistant gives medical advice on the surgeon's behalf because she (or he) has worked for the physician for, say, 15 years and "knows exactly what the surgeon would say." We have seen that advice backfire because the assistant did not tell the surgeon what the patient said or because the staff member failed to ask how to respond to the patient's concern.

And here's another common scenario: The patient talks to the surgeon, who gives verbal advice but doesn't document the discussion.

These are all dangerous areas in the use of the telephone. We advise physicians that telephone communication, including conversations after hours or when the physician is on call, must be documented. You simply cannot, ever, afford a gap in your documentation. (See "Telephone calls to and from patients: A right way to keep records," page 31, and "Save those e-mail messages!") ■

### FAST TRACK

**Be specific, and don't be sparing, in postop progress notes. "Wound looks good" does not suffice**