OBG MANAGEMENT

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Malpractice risk management

Make patient safety a tool to keep risk in check

A well-thought-out, well-executed approach to patient encounters can be your best defense against a claim

Lawsuit filings have increased substantially in medicine over the past 10 to 15 years. So have indemnity payments—money spent in case settlements or in verdicts and awards in favor of plaintiffs. Specifically, there has been a rise in malpractice payouts higher than $1 million.[1]

Statistics on medical errors that are often the basis of actions are revealing:

- **Deaths in the thousands.** A 1999 report from the Institute of Medicine (IOM) concluded that 44,000 to 98,000 patients die annually from "preventable medical errors" in US hospitals.[2]
- **Dollars in the billions.** The annual cost of medical error has been estimated at $38 billion to $50 billion.
- **Surgery at center stage.** Subsequent studies suggested that more than half of deaths from preventable errors were related to surgical errors and failures.
- **Prevention is a lifesaver.** Other studies have supported IOM statistics, and suggested that as many as 70% of surgical adverse events are preventable.[3]

Received by the public as an indictment of the medical system, the IOM report and its offspring fostered a spate of research on public safety. Some invoked conclusions of NASA studies in the 1970s: Namely, it is a breakdown in communication, leadership, and teamwork that causes most commercial airline crashes—not a lack of skill.

Lesson from anesthesiology

The first transfer of NASA study methods to medicine involved anesthesiology. In the 1980s, one in 10,000 patients died in a manner related to anesthesia.[4] Once

A four-part series

This article is the third 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. Mr. Donnelly updated his comments in August 2006.

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If you can't read your writing...

A defendant physician who cannot read his or her own handwriting in a chart or notes is giving the plaintiff a gift. Illegible handwriting does not convey good organization, clear thinking, or an ability to communicate one's intent to others. The plaintiff's side may use this to make the physician seem poorly organized, rushed, and uncaring.

Surgeons must trust other staff members, including nurses, assistants, technicians, technologists, and physician-colleagues. Risk management, like good care, requires the surgical team to work in concert.

Collaboration should start no later than the patient's hospital admission and continue through discharge. Effective communication, both verbal and written, exhibits that.

Medical notes

One of the biggest problems in malpractice suits is the abysmal quality of a physician's written notes. This holds true in the hospital and especially after discharge and for follow-up office visits. Often such notes consist of single-line entries.

Lawyers see many cases in which the patient left a phone message explicitly stating that he or she was worried about something. The doctor's notes read, in full: "Talked to patient."

I'm handling 4 or 5 cases now in which physicians have not helped themselves at all—by acting as if anything that happened after surgery was an afterthought.

On-call notes made on nights and weekends provide equally poor evidence because they rarely exist. The absence of such notes presents problems from a risk-management and defensibility standpoint.

Surgeons do themselves a disservice by failing to document properly the advice they give to patients. Jurors accept timely notes made in the patient's record. They struggle a year after the fact to accept testimony such as, "I told the nurse X, Y, and Z. I know I told the patient to come in, or get something done, or go to the emergency room."

anesthesiologists had implemented safety programs and made patient safety a high priority, patient mortality from anesthesia fell—dramatically. The rate is now 1 in 200,000 and approaching 1 in 300,000.[4]

Trends in claims paid out by medical malpractice defense insurers support that emphasis on safety and quality of care improves outcomes and reduces lawsuits. Malpractice insurance premiums for anesthesiologists in many states have decreased significantly. Other medical specialties can expect to see similar results as they focus on patient safety and risk management.[5]

Fatigue and patient risk

Myriad risk-management issues come into play for physicians. Long hours for residents on duty, for example, are under scrutiny. We are starting to recognize the role of fatigue in surgical error, such as wrong-site surgery, and related issues, such as inaccurate transfusion.

Surgeons must keep up to date on innovations and advancements, including technical skills and equipment modifications. From a risk-management perspective, there is no excuse for not practicing surgery in a modern, effective way.

Specialty organizations are increasingly publishing and promulgating clinical guidelines. Most states allow documents such as clinical guidelines to be introduced before a jury; the defendant surgeon who has neglected to follow an approach to a procedure that is advocated by a relevant specialty organization will face an uphill battle in court.

Preoperative concerns

In selecting and preparing a candidate for surgery, these steps are integral for managing one's malpractice risk:

- **Patient selection.** Improper patient selection is an obvious arena for lawsuits. If you have any doubt about which approach to take, don't hesitate to refer the patient for a second opinion. Regardless of the conclusion, obtaining a second opinion in a difficult situation can only help you.
- **Documentation.** Informed consent and adequate documentation are crucial risk-management tools. The patient must understand exactly what you are recommending (see "If you can't read your writing...").
- **Laboratory work-up.** Making sure the patient obtains the requisite preoperative laboratory tests is vital (see "What do you do when managed care won't pay for a test?" page 56).
- **Know the results.** If a patient has other health issues that require medical clearance or warrant referral to an in-

What do you do when managed care won't pay for a test?

Even in managed care, the surgeon bears responsibility for any delay in obtaining approval for recommended tests. A surgeon who wants a test done but anticipates a roadblock from a managed-care company can't say, weeks later, "The insurance carrier didn't approve it."

You may not have much input, but blaming the system is a poor legal argument. You may have to ask the patient to do more to obtain approval or offer the patient the option to pay for the test out of pocket.

If managed care refuses initially or repeatedly to pay for important tests or procedures, you must document that you or your staff explained the situation to the patient and extended the patient an opportunity to pay for the test without reimbursement.

Plaintiff patients in this situation typically say, "Of course I would have paid X dollars for that CT scan." Such assertions ring true with jurors. Patients will never say, "I support the doctor who never told me about something because he thought my insurance wouldn't cover it."

In court, you can't blame managed care or remove an option simply because you personally thought some entity ought to pay for it.

***FAST** TRACK*

Evidence suggests that as many as 70% of adverse surgical events are preventable

ternist or primary-care physician, it's ultimately the surgeon's responsibility to see the patient gets the appropriate laboratory tests and to personally learn the results. Don't assume that someone else—a primary-care physician, an internist, another specialist—will do it. Don't be forced to say, "I referred the patient to somebody else for a work-up and assumed everything that happened was all right."

Intraoperative concerns

Most claims against surgeons focus on what happens in the operating room or immediately postoperatively. The Physician Insurance Association of America recommends several strategies to reduce or avoid operating room claims[6]:

- Obtain adequate **training** and supervision when using new surgical equipment
- Ensure that the patient gives **informed consent** for a procedure and that you have provided adequate information regarding risks and alternatives
- When working as an attending physician with residents or internists, make sure they are under proper **supervision**
- Participate in any hospital-sponsored **risk-management program.**

Postoperative concerns

Your liability continues after surgery. In the hospital, you must communicate clearly with nurses. Use the chart as a tool to enhance patient safety. Document your observations thoroughly.

If you bring in consultant physicians to deal with a preexisting problem or one that arose after surgery, be aware that all clinicians involved must communicate. "I never talked with my consultants. We communicated through progress notes," will not help a defendant-physician's case. Such notes, which tend to be terse and hard to read, should never serve as the main method of communication.

A surgeon must communicate fully with the patient, and with the family as well. At least a dozen reports have established that patients, or their family, filed a lawsuit simply because they felt that was the only way to find out what happened.[7,8] ■

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