COMMENTARY

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It is not the critic's voice that should count

During my 25 years as a defense attorney, I have seen the traumatic impact that the allegation of medical malpractice can have on healthcare providers. And I have seen many times that in the aftermath of a case it remains difficult, if not impossible, for the practitioner to return to the clinical setting unscarred by the process. Although vindication by the jury provides some solace, by itself it does not create healing. Instead, the critic's voice continues to resonate long after the trial.

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Vindication provides some solace, but the critic's voice can resonate long after the trial

During a lawsuit, physicians and other providers are commonly confronted with incidental imperfections in the care they provided, errors in their documentation, or both. Consequently, a provider's perception of events and ultimately the meaning derived from the experience is shaped less by the valid defenses and opinions of the supportive defense experts than by the inconsequential flaws and errors that can often be found in any medical record.

A RECENT CASE

Recently, I defended a hospital team consisting of a hospitalist, trauma surgeon, three residents, and a nurse. The case involved a 74-year-old man who was admitted to the hospital with pancreatitis of unknown cause. Six days after admission, he died of complications of acute respiratory distress syndrome. The team was accused of causing the patient's death. Specifically, the plaintiff alleged that although the patient's liver enzyme levels were improving, his condition was deteriorating, and he ultimately developed hemorrhagic pancreatitis. It was the plaintiff's contention that proper ongoing evaluation, including computed tomographic imaging, would have led to treatment that would have avoided the worsening of pancreatitis, development of an ileus, and ultimately the insult to his bowel and lungs that they claim caused acute respiratory distress syndrome and death. The patient was survived by his wife and their three children. After his death, hospital representatives and the hospitalist met with her in an effort to explain the events that led to her husband's death. Unfortunately, these discussions did not ameliorate her feelings of loss and anger. She filed a lawsuit, and 4 years later, the case went to trial.

During the trial, the plaintiff's attorney highlighted errors in the electronic medical record. Entries had been cut and pasted, saving time, but without updating information that had changed in the interim. The inaccuracies included "assessment: worsening pancreatitis" on a day it was considered to have improved. Another entry contained "persistent fever" on a day when no fever was present. Other mistakes involved notes that contained care plans made after morning rounds that were not revised later in the day after changes in the patient's condition necessitated a change in the plan. In fact, most references to medication dosing in the progress notes on the last 2 days did not match the medication dosing documented in the medication administration record.

In the end, the plaintiff's counsel did not convince the jury that the healthcare team had been negligent, but unfortunately, she planted doubt in the minds of the caregivers themselves. Perhaps in part, these doubts were the result of having to defend a bad outcome

doi:10.3949/ccjm.83a.15105

in the face of criticism that was based solely in retrospect. But the providers' doubts seemed mostly to emanate from the inadequacies in their documentation as they observed how every entry in a far-from-perfect medical record was scrutinized and then manipulated to challenge its textual integrity—and to portray the healthcare team as unengaged and substandard clinicians.

Despite the team's high level of engagement and the quality of care they provided, any imperfection—whether a documentation error or a minor omission in some aspect of the care provided to this complex patient—became a source of self-doubt and self-criticism.

THE ELECTRONIC MEDICAL RECORD: A MIXED BLESSING

Documentation failures have long been used to "prove" that physicians are disconnected from the clinical situation. The electronic medical record has not proved to be a strong shield against malpractice allegations. In fact, because the electronic medical record absorbs more of the physician's time and that of the care team's members, efforts to save time through workarounds and shortcuts have increased the risk of errors in entering information.

For instance, drop-down menus have led to wrong selections. Cutting and pasting has led to entries that contain data superseded by clinical events, thus creating contradictions within the record itself, and worse, with the physician's own testimony pertaining to the basis of the clinical decision-making. And boilerplate language has created difficulties when the language does not completely fit the context or when inapplicable verbiage that fills itself in automatically goes unedited. An emergency department physician I represented at trial had to awkwardly explain that some of the data reported in his physical exam findings were inaccurate because of programmed language and should have been deleted; he had no explanation for his oversight.

But my experience has been that juries can forgive imperfections in documentation and even incidental aspects of care. They want to trust that the clinician was there for, and there with, the patient. This emphasis is what allowed us to defend the case involving the patient with pancreatitis. Clinical judgment means being engaged enough to choose what you pay attention to and to process the data you receive.

Unfortunately, the electronic medical record seems designed more for billing and for guarding against claims of fraud than for communication among clinicians or documenting clinically significant events. Many clinicians believe that redundancy and standardized phraseology have weakened the meaningful use of the medical record, as the clinical information is now of questionable reliability or value or is simply hard to find. Consequently, the electronic medical record has become less effective as a communication tool for providing continuity of care.

More importantly, the electronic medical record too often places the physician in front of a computer, so that the computer becomes the focus, not the patient. Studies suggest that the way the electronic medical record is currently used in the examination room affects the quality of physician-patient communication as well as the physician's cognitive processing of information. Unless the physician is alert and attuned, the electronic medical record can be a barrier to connection. This not only creates the potential for mistakes, but it can also cause patients to question the quality of care they are getting and to distrust the level of the provider's engagement. In this context, the likelihood that the patient retains an attorney increases when a bad outcome occurs, avoidable or not.

The electronic medical record has not proved to be a strong shield against malpractice allegations

WHAT PATIENTS WANT FROM PHYSICIANS

When I first began seeing my own primary care physician, her office was 5 minutes from my home. Then she relocated to a practice 15 minutes away. And then, because of office consolidation and acquisition, her office was relocated 40 minutes away.

So why do I still go to her? Her training is not better than that of most internists, and my medical history is not so complex that I require more care than most 55-year-old men. I am only speculating, but I would guess that she is not the most financially productive physician in her group. I know that her transition to the electronic medical record has been difficult.

Recently, I asked her about it. Except in some situations, she does not type while taking a history, and she stays totally away from the computer while in the examination room with me. She sits a couple of feet from me, and it feels like the days before the electronic medical record. She is clearly more comfortable listening and taking notes first and worrying about the electronic record later. I imagine she stays later to do her notes than most of the other physicians, or she finishes them at home.

The reason I continue to see her as my primary care physician is that she remains totally engaged during my office visit. What tells me that is not just her avoidance of the computer or her body language, but the depth of questions she asks. My responses often prompt her to look back at an earlier office note, and she will then ask follow-up questions to confirm what she had previously recorded. Her examination is thorough, with testing to confirm and retesting to be sure. Doing this may mean that she has difficulty meeting financial or administrative benchmarks established by her practice. I don't know. But I have no doubt that the likelihood of her missing something in her clinical care is small, and what I suspect is even smaller is the risk that one of her patients would bring a lawsuit against her, given the time she takes to listen and remain connected throughout the office visit.

Be the attentive, compassionate healer you hoped to be when you first entered practice

STAYING CONNECTED, IN SPITE OF EVERYTHING

My point is not to suggest that everyone must conform to the same practice philosophy, particularly with the economic pressures in the medical field. What I am suggesting is that it is not easy to stay connected in a healthcare system in which the system's structure is driving physicians and other members of the healthcare team towards disconnection. Quality healthcare means making every effort to remain engaged at all times with your patient's care, which will reduce the likelihood of a bad outcome and may preserve the physician-patient relationship even when a bad outcome occurs.

In the end, perhaps it is not possible to avoid being named as a defendant in a malpractice case, just as it is not possible to avoid all bad medical outcomes despite exceptional care. In law, as in medicine, there are always factors beyond your control. My aspiration is to find a pathway to get providers through the system unbroken—also not an easy task. But one thing I know is true: the more you can stay engaged in the care you provide and in your documentation, the more you will preclude a plaintiff's attorney from exploiting the effects of the forces within the system that drive providers toward disconnection. As long as you stay engaged and supported by the knowledge that the care provided was appropriate, it is my hope that the voice of the critic will not count as much in the aftermath of a malpractice case. But more importantly, it may allow you to draw meaning and reconciliation from the fact that throughout the patient's illness, undeterred by the complexities of today's healthcare system, you remained the attentive and compassionate healer you hoped to be when you first became a healthcare professional. ■

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