

Avoiding the Courthouse:

10 Practice Pitfalls

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Avoiding the Courthouse

- Recognize 10 common practice pitfalls that can increase your risk of being sued
- Identify strategies to protect yourself from common pitfalls in medical practice

Case Study

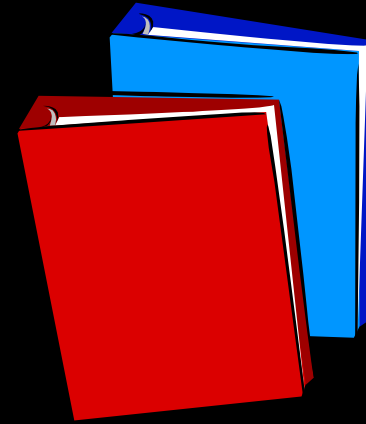


Pitfall:
Don't supervise your staff.
(They know what they're doing)

25% of malpractice suits involve staff.

- Medication errors
- Triage of patients
- Overstepping professional scope

Develop a Policy & Procedure Manual



- Staff orientation tool
- Practice consistently
- Staff accountability

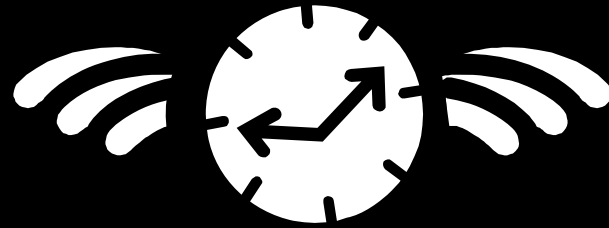
Pitfall: *Spend less time with your patients.*



Primary care physicians that have never been sued spend on average 18.3 minutes with each patient.



Physicians with 2 suits or more spend only 15 minutes with each patient.



- Does this mean I need to spend more time with my patients?
- How can I do that with shrinking reimbursement, etc.?

Satisfaction with time spent with physician is strongly correlated with longer visits.

How do you improve patient's perception of satisfactory visit time when time is limited?

- Allow scheduling flexibility based on patients' needs.
- Spend time connecting with the patient via non-medical conversation.
- Ask simple questions about the patient's visit before they are in the exam room.

Help decrease the chance that the patient will wait to tell you the *real* reason for exam until the last 30 seconds of their visit.

Today's Visit

Main reason for today's visit:

Other concerns I would like to discuss if there is time:

Check all that apply:

I have prescriptions that need to be refilled.

I need a school or work excuse.

I need a referral for my insurance company.

I need the attached forms filled out.

Patient's name:

Date of birth: ___/___/___

Case Study

FOR _____

AGE _____

ADDRESS _____

DATE _____

NO REFILLS

REFILLS

LABEL

Pendil 20mg # 120 - ✓

20mg P.O. Q6hr

Ferron Sulfate 300mg # 100

300mg P.O. TID c meals

Humulin N
30 units SQ QAM. 472

PRODUCT SELECTION PERMITTED

DISPENSE AS WRITTEN

D.E.A. #

Pitfall:
Don't worry about good documentation.

What would your charts look like to:

Another doctor?

A plaintiff's attorney?

A jury?

You, at deposition or on the stand?

As long as the physician and staff can read the note, the note is adequate.

True or False?



If it's not in the chart, or you can't read it,

IT DIDN'T HAPPEN!

Legibility

AUG 4 1982

Order
Qty 25
7/17/82

40

8-20-82 refilled tympanic gts.
1-30-82 refilled 4% Drops Carpine
refilled 3010 Drops Carbocel
11-2-82 refilled 3010 Drops Carbocel (3 refills)
1-17-83 refilled tympanic gts.

-6-

1023
9/20/82
Drops
2-16-83 refilled 4% Drops Carpine

Treatment Rationale

- Explain your reasoning & document.
- Good notes will help even if you made a questionable decision.

Details sometimes “fall through the cracks”

Document Patient Instructions

- When should the patient return?
- Medications?
- If condition worsens?
- Preventive care?

Case Study



Pitfall:
***"Correct" your records when
something goes wrong.***



Alteration of Records

Alteration of Records

Never make changes after a record has been requested.

- Impossible to defend, even if your intentions were pure.
- Alterations are always discovered.
- Plaintiff's attorney will portray your changes as "cover up".

Record Addendums

If you need to make additions:

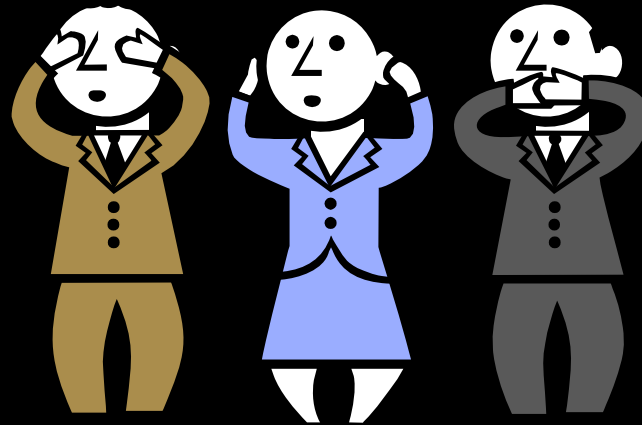
- new note
- label as "addendum"
- current date
- sign

Case Study



Pitfall:

*Trust that once orders are written,
your responsibility is finished.*



Truth:

Tracking results and referrals minimizes exposure to allegations of failure to diagnose and treat.

- Ensures lost reports are identified
- Identifies noncompliant patients
- Maximizes patient safety

Tracking System Development

- Delegate duty to staff
- Develop formal procedures & incorporate into your policies
- If applicable, implement tracking feature in electronic records
- Ask to be informed by other physician or facility if patient doesn't comply
- Document informed refusal (if appropriate)

Barriers to Tracking

- Time consuming (= \$\$\$)
- Resent patient “hand holding”
- Requires extra documentation

Case Study



Pitfall:

Don't document informed consent discussions regarding medical and surgical treatment.

Texas informed consent is governed by statute and overseen by the Texas Medical Disclosure Panel.

TMDP rules and forms may be viewed at Title 25, TX Administrative Code, part 7

Informed Consent

- Informed consent is a **non-delegable duty**.
- Forms are not a substitute for detailed discussions.
- Document consent discussion for both office & hospital procedures in medical record.

Barriers to informed consent

- Educational level/literacy
- Language
- Impaired mental status
- Disability e.g.hearing/vision impaired

Case Study



Pitfall:
***Don't document patient's refusal or
noncompliance.***



Don't forget to document patient's "informed refusal".

- Recommended diagnostic tests
- Treatment plan
- Preventive health (colonoscopy!)
- Treatment delays
("I'll go after the holidays...")

Informed Refusal

Sample Informed Refusal

Your Letterhead

In order to diagnose/treat my condition, _____ (Test/Procedure) was ordered for me on _____ (date). The reasons for ordering this test/procedure have been carefully explained to me. I understand the potential benefits are: _____

_____ and the alternatives include _____

in addition, Dr. _____ has informed me of the risks involved in not having a _____ (test/procedure) performed.

These risks include: _____

_____ After careful consideration of the benefits and risks concerning the above, I am refusing _____ (test/procedure).

My reason(s) for refusing is(are):

Signed this _____ day of _____ by:

Patient Signature:

Witness Signature:

Case Study

708
250 mg and 500 mg tablets
125 mg/5ml and 250 mg/5ml
oral suspensions



(2)

Beep 7³⁵ pm 1/13/94

©

Sms
22 lbs

T105®

Poor appetite today but ^{no} other symptoms

Gave 1.2 ml acetaminophen
@ 7 pm

Sponge bath

Come in in AM

8²⁵ pm T102⁶ p bath

Pitfall:

*Don't worry about documenting phone calls.
(Medical advice given by phone doesn't count)*





Phone Call Documentation

- Date & time
- Caller's name
- Patient problem/complaint and allergies
- **Advice given/action taken**
- Caller's response
- Initial/name of staff taking call



Telephone Guidelines

- Patient's request, symptoms, and any advice given should be documented.
- Avoid prescribing for new complaints.

Errors in phone diagnoses could be fatal-
e.g. heart attack, stroke.

Written telephone triage protocols should include:

- Which staff members are designated to answer patient questions
- Specific questions to ask caller
- Appropriate responses to patient inquiries
- When to notify the physician
- Which calls warrant a visit to the physician's office or the ED

You receive an urgent call from a patient at 2 am. You instruct the patient to go to the ED. This is not medical advice.

True or False?



Case Study



Pitfall:
Don't check the chart when prescribing.

- Use a central location to record medications/allergies
- Update at each visit



Refilling Medications

- Have written Policies & Procedures
- Check the chart
- Record the refill
- Physician should co-sign refill request



When pharmacy calls to question a medication order...
check the original order!

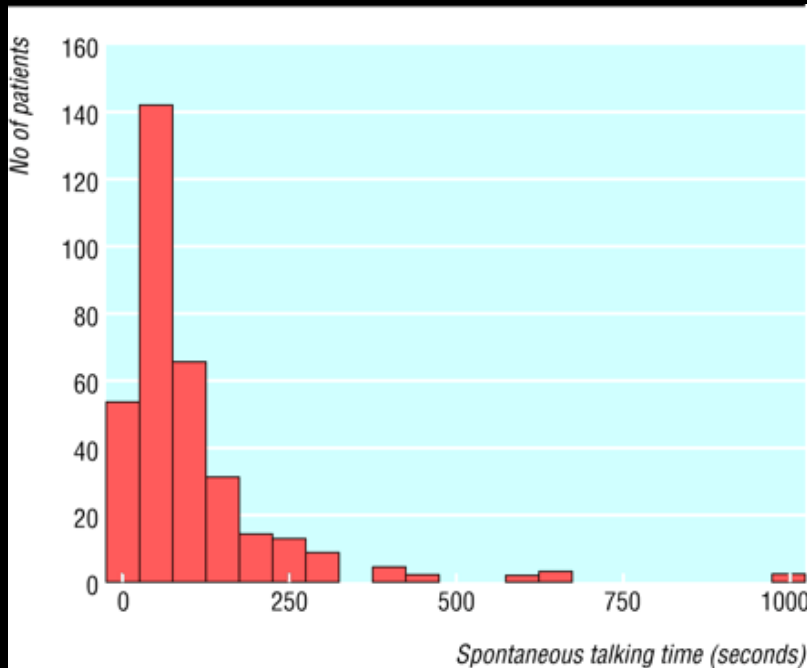


When a patient calls with complaints of unusual medication side effects...
doctor should be made aware!

Pitfall:
Don't care if your patients like you.

Listening skills can be just as important as clinical skills in preventing lawsuits.

How long will they talk?



Spontaneous talking time of 331 patients at start of consultation in outpatient clinic

Spontaneous talking time at start of consultation in outpatient clinic: cohort study

BMJ 2002;325:682-683 (28 September)

Common Patient Complaints



- Leaving patient waiting indefinitely with no explanation
- Accepting phone calls while in the exam room (especially from a spouse, broker, golf buddy)
- Leaving the exam room door open when patient is undressed
- Treating the patient as a medical condition instead of a human being. "So, you're the diabetic, right?"
- Failure to explain or apologize if a patient is upset.

Patient Satisfaction Survey



Another good example of how patient satisfaction surveys can be helpful...

COMMENTS: Please take the time to tell us about any particularly good or bad experience at our office.

Dr. _____ saved my life. I call him my
Quisda 'nagle! I tell everyone I know or
meet what a wonderful doctor he is.

Name: _____ (optional).

PITFALLS

- Staff supervision
- Time spent with patients
- Good documentation
- "Correcting" records
- Tracking test results & referrals
- Informed consent
- Informed refusal
- Phone call documentation
- Medication management
- Likeability

Thank You!