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
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: ___/___/___

http://www.aafp.org/fpm/20030600/59focu.html
Case Study

FOR ___________________________ AGE _____________
ADDRESS ___________________________ DATE _____________

Pendil 20 mg # 120 /
20 mg p.o. Q6hr

Ferrum Sulfate 300 mg # 100 $
300 mg p.o. TID with meals

Humulin N
30 units SQ q2h AM

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

25

8-20-82 refilled Tyramine etc.
1-30-82 refilled 4% Desoto Carpine
refilled 3/10 Desoto Everbochol (3 refills)
11-2-82 refilled, 3/10 Desoto Everbochol (3 refills)
1-17-83 refilled Tyramine etc.

Prof. Roger

By Carl
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
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

250 mg and 500 mg tablets
125 mg/5mL and 250 mg/5mL oral suspensions

Q
Beep 7:35 pm 1/13/64

T 105°F
Poor appetite today but no other symptoms
Gave 1.2 ml acetaminophen @ 7 pm

Sponge bath

Come in in 2 pm 8:25 pm T 102°F P 64/2

E}no
2.16
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 Quiridng Jangle! I tell everyone I know or I 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!