

Malpractice: Role of the medical record

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What qualifies for a malpractice suit?

Medical malpractice occurs when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient. The negligence might be a result of errors in diagnosis, treatment, aftercare or health management.....The patient must prove that the negligence caused the injury.

What are the 4 D's of medical negligence?

- The **four Ds of medical malpractice** are duty, dereliction (**negligence** or deviation from the standard of care), damages, direct cause. Each of these **four** elements must be proved to have been present, based on a preponderance of the evidence, for **malpractice** to be found.

A new study reveals that the cost of medical malpractice in the United States is running at about \$55.6 billion a year- \$45.6 billion of which is spent on defensive medicine practice by physicians seeking to stay clear of lawsuits.

The amount comprises 2.4% of the nation's total health care expenditure

Exhibit 1

Estimates of National Costs Of The Medical Liability System

Component	Estimated cost (billions of 2008 dollars)	Quality of evidence supporting cost estimate
Indemnity payments	\$5.72	Good as to the total; moderate as to the precision of the split among the components
Economic damages	\$3.15	
Noneconomic damages	\$2.40	
Punitive damages	\$0.17	
Administrative expenses	\$4.13 ^a	Moderate
Plaintiff legal expenses	\$2.00 ^a	Good
Defendant legal expenses	\$1.09	Moderate
Other overhead expenses	\$3.04	Good
Defensive medicine costs	\$45.59	Low
Hospital services	\$38.79	
Physician/clinical services	\$6.80	
Other costs		
Lost clinician work time	\$0.20	Moderate
Price effects	— ^b	Low
Reputational/emotional harm	— ^b	No evidence
Total	\$55.64	

- By 45 years of age, **36%** of physicians in low-risk specialties and **88%** of physicians in high-risk specialties are likely to have had at least one malpractice claim.

- By 65 years of age, **75%** of physicians in low-risk specialties and **99%** of physicians in high-risk specialties are likely to have had at least one malpractice claim.

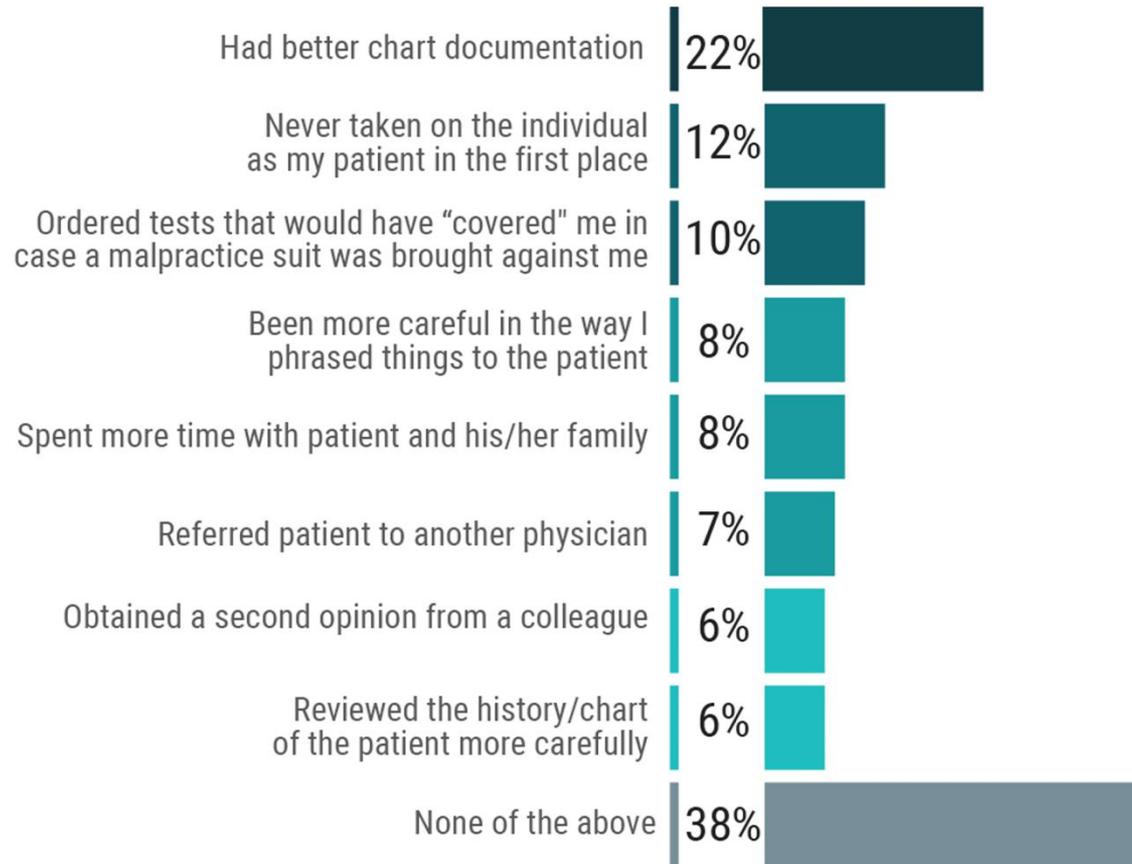
What is the most common reason for malpractice?

The top five reasons for malpractice suits were:

- Failure to diagnose a patient's medical condition...
- A patient injury during treatment, often resulting in disability or death...
- Failure to treat a patient's condition....
- Poor documentation....
- Medication errors...



What Would Physicians Have Done Differently?



Hindsight is 20/20, and looking back, physicians who are sued say they would have done things differently to avoid the suit. Better chart documentation was cited most often(22%), followed by never having taken on the person as their patient in the first place(12%).

Common Misconception

- Malpractice cases emerge from severe surgical error/drastic mistake-
- Most claims arise from a **SIMPLE MISTAKE**

Poor communication with unhappy patients.

Unhappy patients are more likely to sue their physicians.

A malpractice lawsuit is not fun. Dealing with lawyers is even worse. At the end of the day, however, the lawyer is not the one suing you. Your issue isn't with the lawyer; it's with the patient.

Follow these simple tips to avoid malpractice claims:

- Communicate, communicate, communicate
- Get it in writing
- Always obtain informed consent
- Be sure to follow-up
- Manage your patient's expectation
- Put yourself in your patient's shoes
- Keep an open mind

- Great communication between physicians and patients can reduce malpractice risks.
- Great communication fosters a strong relationship with patients.
- Reduces the likelihood a patient will sue if a problem arises.

Key communication strategies

- Don't dismiss(or appear to dismiss) the patient's concerns.
- LISTEN carefully
- Set realistic expectations
- Provide clear answers

It is essential to discuss all elements of a procedure- risks, costs, etc.- *before* the procedure takes place. Communication skills are necessary to discuss the circumstances with your patient, and good documentation skills are necessary to catalog all details of the situation.

Manage your patient's expectations

Accurate and forthright as possible when discussing the available courses of action
Possible outcomes or implications that may arise from the decisions that are made

The Defensible Medical Record

- In the event of litigation, the medical record is usually the **most critical piece of evidence.**
- Reliable and credible- created in the normal course of business by the physician, hospital, or clinic at or near the time of events in question.
- There is no adequate substitute for a **DETAILED MEDICAL RECORD**

Get it in writing

- Proper documentation skills are the most important in an administrative manner
- Explicit, unambiguous documentation can come in handy should you ever need to recount a certain situation and justify what occurred in order to defend your action
- Inadequate documentation is more susceptible to a malpractice lawsuit
- Write legibly
- Date, time and sign every entry
- Specifically identify the people in your report
- Record all findings, advice, instructions, decisions, etc. on any significant issues
- If you're not sure whether or not it's important enough to be documented, **DOCUMENT IT.**
- Avoid judgmental or potentially anger-provoking descriptors
- Replace pejorative entries
- Avoid embarrassing or easily misunderstood descriptors

1. The medical record forms a clear and complete plan that legibly communicates pertinent information, credits competent care
Forms a tight defense against allegations of malpractice by aligning patient and provider expectations.
2. Physician typically approach documentation with the goal of communicating effectively with themselves. This approach creates problems when malpractice allegations are made and plaintiff attorneys, arbitrators and juries engage in what is often anger- or sympathy-driven reviews of physicians' records that assume negligently omitted or committed acts in the absence of contrary evidence.
3. The medical record should never be erased or altered, and once requested by a reviewer it cannot plausibly be amended.
Recession is impossible.
Prevention is necessary.
Thorough and thoughtful documentation provides the best supporting evidence.

Careful documentation can mean the difference between a guilty verdict in a medical malpractice case and the case being thrown out. It's worth the trouble.

Document your thought process.

How you arrived at a differential diagnosis, or a treatment plan advised. In the absence of contrary evidence, juries will assume the worst

Document shared decision making.

Shared decision making involves explaining options, risks, and benefits, and agreeing on a plan

Be sure to document your discussion and agreed plan

Share your expertise and encouragement to help guide the patient's choice

Reinforce the principle-the physician advises and the patient chooses.

Document expectations

- Explaining what will likely happen next in a patient's care
- Document any warnings or risks discussed
- Complement a concise statement of the agreed plan with a statement such as "Patient understands and agrees" which seals the patient's accepted responsibility into his medical record
- Use direct patient quotes to demonstrate your attention to patients, highlight main areas of concern
- Build credibility into the record and accurately document patient's competency, affect and attitude
- Complete the review of systems with an inquiry, "Do you have any other concerns?"
- Documenting all concerns addressed demonstrates your thoroughness in obtaining the patient's history and avoids later charges that the patient brought an important symptoms to your attention that you ignored or neglected

Unmet expectations are the emotional equivalent of broken promises.
Disappointment provokes anger.
Anger precipitates malpractice claims

A better defense

Successful clinical care is a collaborative activity with **SHARED RESPONSIBILITIES**

Patient and physician work together

Review the diagnostic and treatment options and enact a **PATIENT-CHOSEN PLAN**

Medical documentation records this **SHARED EFFORT**

Align expectations and fortify malpractice defenses

Physicians may reduce their risk for such allegations by adhering and updating to appropriate standards of care, open-mindedly approaching evaluations

Fostering and respecting patient choices

Revising the physician's view of documentation from a **NECESSARY CHORE TO AN OPPORTUNITY TO CREDIT THE EXCELLENT CARE THEY PROVIDE**