Top Liability Complaints Include Diagnostic, Medication Errors

Major Categories of Health Care Professional Liability Issues.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

In the field of health care professional liability, the newest area on which lawyers are focusing is under-anticoagulation and over-anticoagulation for atrial fibrillation.

Liability issues are of concern to all health care professionals. To impact liability issues, we must first identify the major categories of existing clinical risks. Some important situations that can result in adverse outcomes include mammogram misses, failure to diagnose cancer, and heparin-induced thrombocytopenia. The newest area on which lawyers are focusing is under-anticoagulation and over-anticoagulation for atrial fibrillation. Other big problems include bad outcomes for spine procedures, bad baby cases, chest pain, acute myocardial ischemia (MI), and failure to identify coronary events. A new liability frontier in Pittsburgh, where I practice, is failure to screen for colon cancer. Failure to diagnose pulmonary emboli and aortic aneurysm rupture are both on our 'hit list' for reducing adverse outcomes. A local insurance company published its own 'hit list' of the top 5 conditions that they have seen with the greatest frequency during the past 15 years. These conditions include coronary disease, acute MI, breast neoplasms, displacement of discs for back patients, and neurologically impaired newborns. In terms of expenses, a top issue on the 'hit list' includes newborn neurologic impairment, for which we have had some multimillion-dollar awards in Pennsylvania. Malignant neoplasms of the breast, acute MI, disc disease, and aortic aneurysms are also included in the top 5 most expensive conditions because of the significant amount of morbidity and mortality associated with these conditions. In Pennsylvania, the top 5 specialties with the most claims filed include internal medicine, general and family medicine, obstetrics and gynecology, general surgery, and orthopedic surgery. For internal medicine specialists, the most frequent liability situations include (1) a lack of diagnosis that comes from waiting too long and results in a bad patient outcome; (2) failing to refer patients to a specialist; (3) an excessive delay in diagnosis; and (4) a misdiagnosis. Indemnity is defined as the money that is paid by the defendant or the defendant's insurance company to the patient, the plaintiff, and the plaintiff lawyer. The specialty with the most indemnity paid is obstetrics and gynecology. Other specialties at the top of the 'indemnity paid' list include general surgery, internal medicine, family medicine, and orthopedics. The top 3 complaint issues are errors in diagnosis, medication errors, and improper performance. Basically, the definition of medical malpractice is failing to do what an ordinarily prudent physician would do under similar circumstances. Therefore, if your peer group would do something and you did not do it, then that is evidence of malpractice. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Medical Records Should Be Clear, Unaltered

Consent and Documentation Issues Top Professional Liability Concerns.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Good documentation is 1 of the keys to success in many liability cases. Be clear in your documentation, and write out your thought processes and differential diagnoses. Remember, you do not have to be right 100% of the time.

In the field of health care professional liability, consent and documentation are 2 important issues. The topic of consent involves more than signing a piece of paper before surgery. It also involves the issue of consent to treat people in a medical office. It is important to have discussions in the office with the patient about medications and/or course of treatments being prescribed so that patients have a chance to gather this information, process it, and ask questions. These discussions help establish a rapport between patient and physician, which is going to be very important if there is a bad outcome later. We want that patient to be comfortable enough to return to you and discuss the outcome instead of picking up the phone and calling a lawyer. Good documentation is 1 of the keys to success in many liability cases. Many physicians recall having a conversation with the patient and the statements they made, but if they do not write this information down, then they lose their credibility at trial. Therefore, being clear in your documentation is critical. Be sure to write out your thought processes and differential diagnoses. You do not have to be right 100% of the time - you can make an error in judgment that does not equate to malpractice. If you are pursuing various differentials and it happens to be incorrect and if you have made a reasoned decision, then that is not malpractice. This does not mean you will not get sued for the mistake, but you can defend your position if you have the documentation to provide that defense. The first thing a plaintiff lawyer does after listening to the patient's story is get the records and review them. They are going to take cases with poor documentation for which they can say that something is missing or something was not done. However, if the doctor provides good documentation, then the lawyer will likely pass on the case because they get paid only if they win. Never "doctor" your records - do not change or alter records after you complete them. Do not try to cross out anything, and do not try to add things. If you are going to write an addendum, write it as an addendum. If you need to make a correction, then do it the right way. Do not obliterate it with a felt-tip pen or correction fluid to white it out. Just draw a single line through the materials you are correcting, make the correction, and then date and initial it. Improperly altering your records is a criminal act in most states, can jeopardize your insurance coverage, and can subject you to punitive damages in the right case. The plaintiff lawyers love to see altered records because it does not matter what the medicine is, they just tell the jury what a bad doctor you are and that you are trying to cover something up. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Handoff, Discharge Communications Critically Important

Patient and Peer Communications Important Issue in Professional Liability.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

An important topic of concern for professional liability is careful communication with patients, families, and physician peer groups. For physicians, communication with their peers via charts only is an area for disaster.

In the field of health care professional liability, communication is a very important topic. Physicians must communicate with their patients by having an open discussion about treatment plans in such a manner that patients become involved in those plans. In this era of HIPAA (Health Insurance Portability and Accountability Act), we must first get the patient's permission to have a discussion with family members when we believe that they, too, should be involved in the care plan. In addition to patient communications, physicians must communicate with their peer groups. Communication via charts only, without actually talking to another doctor, is an area for disaster. We cannot stress strongly enough how careful communication with patients, families, and physician peer groups is important. When communicating with patients, patients must be made part of their own health care team - they should be an active participant in what is being done. The physician must have an honest and open relationship in which the patient can disclose important information needed to help generate the best care plan. When a primary care physician refers a patient to a specialist, the physician must stay current with the patient's condition and treatment. When the patient returns to the primary care provider, the physician and the specialist must then determine who will do which portion of the care plan, requiring good communications between individuals. For instance, they must determine who will order follow-up testing and monitor different parts of the patient's care. Handoffs are a critical communications issue. The Centers for Medicare and Medicaid Services and other payers are focusing on discharge planning and necessary communications associated with planning and relaying the course of care. Presently, much focus is placed on the timing of discharge. Patients perceive that hospitals want to run them out of the hospital as soon as possible because of various pressures from insurers. At the University of Pittsburgh Medical Center, a rapid response program called Condition Help (Condition H) has been developed to give patients a resource to call when they believe something is being overlooked or ignored by the care team. With Condition H, an administrative person and a nurse or physician who is not connected with the patient's care come to the room, listen to complaints or concerns, and deal with them in real time. Because these calls get an immediate response, something gets done right away, and the hospital and patients avoid adverse outcomes. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Residents Must Be Encouraged to Ask for Help

Adequate Supervision of Resident Staff Is Area of Risk for Professional Liability.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Attending physicians and surgeons are responsible for supervising their residents and ensuring that patients get adequate care. Attendings are ultimately responsible when a resident makes a mistake.

A major area of risk for health care professional liability issues is supervision of the resident staff at a health care facility. This is a big problem, especially for teaching hospitals. Remember, attending physicians and surgeons are responsible for supervising and ensuring that patients get adequate care. Often, residents have varying degrees of autonomy, and attendings need to make sure that residents receive adequate supervision. Attendings are ultimately responsible when a resident makes a mistake. With residents' 80-hour workweeks, more handoffs will be occurring in the facility, so it is very important that the people caring for each patient communicate clearly. Attendings must always encourage residents to ask questions or to seek assistance. Do not let residents think that asking questions or seeking assistance from an attending is a sign of weakness. Attendings must be available to respond to needs of their residents. If these needs are not communicated directly, the information should at least get pushed up the chain from the resident to the chief resident to the fellow and ultimately to the attending. The important idea is that the attending physician encourages a resident to ask for help whenever it is needed. Remember, residents are the best and brightest people and are accustomed to handling things on their own. Some residents may want to take care of something on their own because it is a macho thing and they feel that they should not need help at this stage in their careers. Attendings must ensure that all residents understand that asking for help is not only okay but is also a sign of maturity. What's more, it is actually a sign of maturity for attendings to ask for help. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Failure to Offer Screening Exams New Malpractice Target

Failure to Screen for Colon Cancer and Other Conditions as a Liability Issue - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Many patients have refused screening for colon cancer, but because there is often no documentation of their refusal, primary care physicians may face malpractice claims for failure to screen.

(Card 1 of 2) Providing screening for conditions such as breast cancer and colorectal cancer are new areas of focus for professional liability cases.

Case Report: This is the case report of a man who was diagnosed with metastatic colon cancer at age 53 years. Before diagnosis, he had presented to his primary care physician on multiple occasions for acute episodic care starting at age 49 years. He had at least 15 visits during a 3-year period. During that time, despite having reminders on the chart, the patient was never offered an option for colorectal cancer screening. At age 52 years, he presented with some rectal bleeding, and this too was ignored. About 6 months later, he presented and was diagnosed with Dukes' stage D carcinoma, a fairly advanced carcinoma. Before the resulting liability trial, I (Dr Solano) reviewed this case with the defense lawyer, and we agreed that we should settle. We had some issues with Pennsylvania's Medical Professional Liability Catastrophe Loss (CAT) Fund (renamed the Medical Care Availability and Reduction of Error [MCARE] Fund in 2002). Nonetheless, we reached a pretrial settlement for $1.3 million, but we were unable to get our CAT Fund to cooperate with these settlement plans. At the time of this case, Pennsylvania's CAT Fund provided some level of malpractice insurance above the primary insurance carrier. When this particular case went to trial, the physician was fairly arrogant and did not make a good impression on the jury. The jury verdict was for $5.8 million for failure to screen. One of the important problems with this case was that the guidelines for colorectal cancer screening were prominently displayed on the chart by the physician's employer. As a result, the plaintiff lawyer went to trial but did not base the case on the failure to diagnose colon cancer with the rectal bleeding. Instead, the plaintiff lawyer based the case on failure to screen for colon cancer. This very interesting tactic is very concerning, considering that probably 40% of people in the United States now have had a colonoscopy and maybe 60% have had some other kind of screening. Considering these facts, there is a large gap of patients who have not been offered any screening for colon cancer. Because there is often no documentation of offering the screening exam that is declined by the patient, this could be a huge frontier for malpractice cases. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Refusal of Screening Exam Must Be Documented

Failure to Screen for Colon Cancer and Other Conditions as a Liability Issue - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Primary care physicians must document when they offer screening exams to a patient and the patient's decision regarding the exam. If the patient refuses the exam, the refusal needs careful documentation.

(Card 2 of 2) Primary care physicians (PCPs) must document when they offer screening exams to a patient and the patient's decision regarding the exam. Often, there is no documentation of offering a screening exam that is declined by the patient. As a result, this "failure to screen for disease" is becoming the next frontier of malpractice cases. Physicians must discuss and document screening tests, and they need to clearly have documentation of a patient's refusal. Therefore, make sure you use chart tools or, if you have an electronic record, use health preventative reminders, make sure you go to that section, fill it out, and document (1) if a patient refused and (2) the risk of not screening. In malpractice cases, you must provide adequate documentation that appropriate care was offered and it was the patient's decision to not undergo the procedure.

Case Report: A 50-year-old woman discussed with her primary care physician (PCP) her desire to undergo a colonoscopy. However, she never underwent the procedure, had colon cancer, and died. Her estate sued the PCP. The PCP's defense was that the woman had said she was going to have the screening procedure done through her obstetrician gynecologist (OBGYN), yet there was no documentation in the PCP's chart about the patient's statement. Her husband specifically denied that testimony at depositions. Because of the lack of documentation regarding the patient's statement, the responsibility for performing the procedure fell back on the PCP, especially since the patient had indicated that she wanted the test. The OBGYN in this case also testified that he did not discuss the screening exam with the woman and that he did not order it nor did he routinely order these exams. Instead, he expected the PCP to take care of colorectal screening. The OBGYN's documentation was consistent with those statements and helped sink the PCP in this case. This is a tricky arena because, in the area of mammography and gynecological surveys, we often have shared responsibilities with our gynecological colleagues. As PCPs, we must pursue breast exams, mammograms, and Pap smears. When I (Dr Solano) practiced in a women's hospital during the first part of my career, I would offer gynecological surveys and mammograms to women who had not received them. Then, I would document that I offered these exams and the patient's refusal. Remember, if you do not have documentation of these events, then they did not happen from a legal perspective. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Overdosing, Underdosing Big Problems With Coumadin Therapy

Professional Liability Issues for Managing Anticoagulation With Coumadin.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Coumadin management is becoming an increasingly problematic area in professional liability. Both overdosing and underdosing are problems, and physicians must provide meticulous tracking of patients.

Case Report: A 45-year-old man had an aortic valve replacement and was started on anticoagulation therapy with Coumadin (warfarin). For years, his cardiologist regularly monitored his prothrombin time (PT) and International Normalized Ratio (INR), which had been stable for some time. Then, at some point, the cardiologist had some issues in his office, and this patient went 4 months without PT or INR being assessed. The patient then presented to his primary care physician (PCP) with a severe headache. The PCP thought the patient most likely had a sinus headache. Within 24 hours, the patient was admitted with a central nervous system bleed, and his INR was 5.5 (INR goal for anticoagulation: 2 to 3). This malpractice case was settled for 7 figures. Coumadin management is becoming an increasingly problematic area. Both overdosing and underdosing are problems, particularly in patients with atrial fibrillation. Our organization has mandated meticulous systems in all of our primary care offices to track when patients are due for their PT assays, document adjustments made in their Coumadin dose, document drug interactions, and verify that emergency contacts are available. Some good software programs are available to help track patients and calculate the Coumadin dose. Another problematic area is communication between PCPs and cardiologists or hematologists. The responsibility of managing Coumadin for a patient must be clearly defined and must consistently be with 1 provider. For instance, if a patient must have Coumadin stopped before undergoing a procedure, then who will be responsible for restarting and managing the Coumadin going forward must be clearly defined. Communication is key among providers. Communication between the physician and the pharmacist is another area of concern. In one case, a verbal order was called in for Coumadin, and the pharmacist thought he heard 7.5 mg, but the true dose needed was 2.5 mg. In this case, the patient overdosed and had a major catastrophic bleed. The lesson is that, if you are going to call in an order for Coumadin, then spell out the dose to avoid confusion. It is easy to say "five" and spell it out. Getting patients involved in self-managing their Coumadin is critical. They need to understand the monitoring process, dose adjustments, and the potential for drug interaction. The physician must strongly reinforce how many drug interactions there are with Coumadin. Our office gives a pamphlet to patients at least once a year to remind them to call their physician any time they are going to take another medication so that dosing and drug interactions can be discussed. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Altering Records Can Make Malpractice Cases Indefensible

Defensible Liability Cases Can Be Made Indefensible If Records Are Altered.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Addendums to medical records can be made safely when done correctly. However, tampering with a record is never appropriate and can turn defensible malpractice cases into indefensible cases.

Case Report: A 32-year-old woman presented to her primary care physician (PCP) with a 3-month history of heartburn. She had many risk factors for coronary disease including a family history, cigarette abuse, and a cholesterol level >250 mg/dL. She reported pain that occurred on bending and lying down. She was treated for reflux esophagitis and was found dead the following day. Autopsy showed significant 3-vessel disease. Based on the patient's history, this case was very defensible because she was young and had typical reflux symptoms that worsened with bending over. The PCP handwrote a note on the day of seeing the patient, making the diagnosis of gastroesophageal reflux disease (GERD) or reflux esophagitis and outlined a treatment plan. However, the day he found out about the death, he added a note suggesting that the patient could get a cardiac evaluation but that the patient refused. Unfortunately, the lawyer's handwriting experts looked at this record and confirmed that it was altered. We could have defended his case just based on symptoms. However, altering the record like this physician did was like handing the lawyer a birthday cake. When a lawyer finds altered records, he or she does not want to settle the case. Instead, the lawyer wants the jury to hear about the events so that they will give the plaintiff a big verdict. Even though this case was defensible on the basis of reasonable choice in treatment, it was settled for 7 figures because the case became indefensible when the record was altered. One of the lessons in this case is that uncommon presentations of typical diseases are defensible if they are statistically likely. The other lesson learned in this case is that tampering with the record is indefensible. If you want to make an addendum, it is safe to do so, but it must be appropriately dated and documented. Make sure that people see that you are adding to your original note or supplementing it so that it is dated and timed as to when you are adding it. When correcting a record, cross out the material using a single line, then date and initial the change. Remember, reconstruction of a record is never appropriate, and removing documents is unacceptable. Handwriting technology is at an incredible level. Experts can track differences in ink pens, pencils, etc. So, do not mess with a record. In addition, you never know if a clean version of that record has already been copied for insurance or billing purposes. If it is floating around, then the plaintiff lawyer will find it and will crucify you if you have tried to change that record. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Negligence, Injury Required to Win Malpractice Case

Physical Harm Must Be Proved by Plaintiff Lawyer to Win Malpractice Claim.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

In malpractice cases, it is not just enough to show that there was a breach in the standard of care. The plaintiff lawyer also must have expert testimony proving that the negligence caused some harm or injury to the patient.

Case Report: A 38-year-old woman presented with scapular pain in late August. She was a friend of a friend, and the primary care physician (PCP) said, "Let me see your friend." He focused on the evaluation, and the individual never really was a patient of this PCP. In any event, the PCP thought the scapular pain was musculoskeletal in origin, placed the patient on anti-inflammatory medication, and recommended physical therapy. The patient presented about 2 months later for a physical exam. No breast mass was found at that time, but a mammogram was ordered. In November, the patient presented with hypercalcemia and worsening diffuse bone pain. She was found to have metastatic breast cancer. This case went to trial based on failure to make a timely diagnosis. The good news is this was a defense verdict. The plaintiff lawyer pursued the strategy that there was a delay in diagnosis and, if the tumor was diagnosed 3 months earlier in August, the patient would have survived. In this case, we were very fortunate that the lawyer was totally unprepared. He actually irritated the jury by attacking all the defense witnesses. He had a scheme that the 3 defense witnesses belonged to the same country club and were in cahoots to basically get the PCP off. So, the lawyer spent a great deal of time attacking the 3 defense experts. We were very fortunate that this plaintiff lawyer was not properly prepared. Usually, plaintiff lawyers are over-prepared because their incentive is to get paid. To do so, they must win the case or get it settled. If they lose, they are out all the money they have advanced for expert witness fees, court fees, etc. In this case, the patient had breast cancer at the initial presentation. Therefore, there was really no delay in diagnosis, and there was no change in the outcome as a result of a 3-month delay. In malpractice cases, it is not just enough to show that there was a breach of the standard of care, the plaintiff lawyer also has to have expert testimony that that breach caused some harm or injury to the patient. In this case, whether it was or was not a breach did not really matter because there was no harm caused - this patient had a bad prognosis from day 1. There are some sophisticated juries that listen to the medical testimony and make this distinction. They have answered questions on jury verdict sheets saying that the doctor was negligent but the negligence did not cause any damage. Then, when the verdict comes back, it is a defense verdict. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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PCPs Not Required to Question Specialists' Conclusions

Primary Care Physicians Can Legally Rely on Expertise and Evaluation of Specialists.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Primary care physicians (PCPs) are not required to independently evaluate data received from a specialist to whom they have referred a patient. Instead, from a legal perspective, PCPs can rely on the expertise of the specialist.

Case Report: A 69-year-old woman noted reddening and soreness in her left breast. Her mammogram was negative, but out of an abundance of caution, she was sent to the surgeon who did a skin biopsy and a fine-needle aspiration biopsy (FNAB). The FNAB results showed atypical nuclei. The skin biopsy showed inflammation in the upper dermis and focal hemorrhage in the lower dermis. The pathologist report did not rule out cancer and stated that an excisional biopsy may be indicated. After receiving this pathology report, the surgeon wrote a letter to the primary care physician (PCP) and stated that the patient did not have cancer - instead the patient had an inflammatory process. However, the surgeon enclosed a copy of the pathology report along with the letter to the PCP. The patient continues to see the surgeon about other issues and never contacts her PCP about any breast symptoms during this time. Six months later, the surgeon does an open biopsy and finds cancer. The family sued the surgeon, who settled the case. The family also sued the PCP, alleging that this doctor should not have accepted the surgeon's conclusions and should have independently evaluated the biopsy report. When the case went to trial, a hung jury resulted, meaning that the jury could not come to a decision unanimously or in a number sufficient to let one side or the other win. After the case was over and after hearing all the evidence and hearing the jury verdict, the judge entered a judgment for the PCP, saying that the doctor had a right to rely on the surgeon who said no cancer was present. The PCP was not required to independently evaluate that pathology report and was allowed to rely on the expertise of the specialist to whom the PCP had referred the patient. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Documentation May Prove Appropriate Care to Jury

Documentation Is Bedrock of Physicians Defense in Malpractice Cases.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Even if a physician has excellent documentation of a case, this does not prevent a malpractice claim from being pursued. Nonetheless, this documentation will be the bedrock of a physician's defense in such situations.

Case Report: A 42-year-old woman presented to the emergency department (ED) with acute radicular pain. The ED physician noted that there were no red-flag symptoms associated with back pain and the radicular pain. The following day, an MRI was ordered by the ED doctor and a large herniated disc was found without spinal cord compression. The next day, the patient follows up with the primary care physician (PCP) and is appropriately treated. On day 5, the patient starts complaining of some numbness in the groin area ('saddle anesthesia'). She was seen immediately by the PCP, and within 30 minutes of presentation, she was airlifted to a tertiary care center with a possible diagnosis of cauda equina syndrome. She was operated on 36 hours later. The patient claimed to have persistent pain and was unable to enjoy sex because of her numbness. She sued the PCP for failure to offer an operation because of a huge bulging disc. The case went to trial and the verdict went to the physician. This case demonstrates the value of meticulous documentation. The PCP had impeccable documentation of symptoms, the neurologic exam, and his thought processes. He followed all guidelines established at a national level for acute back pain. Even the radicular symptoms and the fact that the ED doctor did not follow the guidelines by ordering an MRI did not overwhelm the evidence that this PCP did the right thing. We fortunately had a spine physician say that the size of the disc was not a prognostic matter for outcome. All this information added to the prompt attention to detail and prompt service helped convince the jury that this patient got appropriate care. The disposition was that the PCP was a caring physician and not negligent. Therefore, extraordinary care and documentation saved this PCP from a horrific outcome. Even if documentation is very good, it does not prevent the claim from being pursued or a lawsuit from being filed. Nonetheless, documentation will be the bedrock of your defense. Your experts are going to need the documentation to review the case and prepare the reports and testimony needed to defend your actions. When you are sitting on a witness stand 5 years after seeing a patient (some cases take forever to go to trial), you will need that documentation to refresh your recollection and explain to the jury what you were doing, why you were doing it, what course you were following, and why. Your memory alone usually is not sufficient to convince a jury, especially when you get cross-examined. Therefore, meticulous documentation is critical to prevent a claim or to defend you if a claim is filed. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Care of Headaches, Migraines Major Liability Risk

Care of Migraines and Headaches Puts Physicians at Risk for Liability Claims - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Headache is an important area for malpractice claims, especially at the emergency department level. Physicians must closely monitor headache symptoms and any change in those symptoms.

(Card 1 of 2)

Case Report: A 52-year-old woman with a history of migraine presented with a headache. She was admitted for observation. She had had an MRI and a CT scan in the past year, and both were normal. No imaging was done on admission or during the day because of this reassuring past MRI and CT scan. During the course of the day, the headache changed character. She developed slurred speech and an unrelenting headache that was unresponsive to Dilaudid. At about 5:00 pm, the patient was handed off to a covering physician, but the change in symptoms was not communicated to the doctor. The woman ultimately had a bleed in her central nervous system (CNS bleed). Her primary care physician (PCP) arrived at about 9:00 pm, and by then the patient had been having symptoms for at least 9 hours as documented by nursing notes. The patient was transferred to a tertiary care facility, and she had a completed stroke with residual sequelae. In cases such as this, we see that handoffs can be a big problem and that communication is a huge problem. This case was settled. Headache remains a huge area in which physicians continue to be at risk for malpractice claims, especially at the emergency department level. If someone has a history of classic migraines, presents with typical migraine symptoms, and reports that the headache has not changed in character, then we must consider the possibility that the presenting headache is a migraine. However, when people have migraine headaches that change in character, we cannot ignore the possibility that a CNS bleed may be causing the headache. In the case report above, the meticulous nursing documentation was actually a coup for the plaintiff expert because the nurses had documented every change in their notes. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patient Statements Help Distinguish CNS Bleed From Migraine

Care of Migraines and Headaches Puts Physicians at Risk for Liability Claims - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

When a patient presents with severe headache to the emergency department, a normal-appearing CT scan can lull the physician into a false sense that a central nervous system bleed can be ruled out.

(Card 2 of 2) Headache and migraine remain an important area where physicians continue to be at risk for professional liability claims. During a bleed in the central nervous system (CNS bleed), the typical catchphrase reported by the patient is, "This is the worst headache in my life." In medical school, we are taught to immediately think "CNS bleed" when we hear a patient saying this to the health care team. Therefore, this information must be communicated clearly - talk with your nursing staff and other physicians. When a patient presents with severe headache to the emergency department, a normal-appearing CT scan can lull the physician into a false sense that a CNS bleed can be ruled out. However, listen to the history and listen to the patient. If the patient has a good story and the CT appears normal, still do a spinal tap to look for blood. Remember, the physician is going to be charged with whatever is in that chart, including nursing notes. Anytime you hear a patient say that this is the worst headache in his or her life, all the bells and whistles should go off. At the University of Pittsburgh Medical Center, we advocate use of something called 'SBAR' to facilitate communications between nurses and physicians. In this acronym, S stands for situation, B stands for background, A stands for assessment, and R stands for recommendation. By using the SBAR approach, we have a uniform way for the nursing staff to communicate with physicians, allowing doctors to quickly grasp what is going on with the patient, hear the nurse's report, and understand their recommendations. The doctor can then move forward with the appropriate order. The more physicians communicate with each other and the nursing staff, the less likely it is that they are going to have to communicate with lawyers. By talking to each other and taking care of problems as they arise, physicians can avoid the need to take time for preparing for a deposition or sitting in a courthouse to go through a trial. The best strategy is to talk to each other, not to lawyers. Nonetheless, lawyers are there to help when you need them—at least this is true for the good guys. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Disparaging Comments Can Lead to Malpractice Claims

Disparaging Remarks by Colleague Can Result in Malpractice Claims - Part 1.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Frequently, malpractice defense cases get started because of a comment made by a subsequent treating physician - some other health care provider who criticized the previous care that was rendered.

(Card 1 of 2) When discussing topics in health care liability issues, one important issue is that of malpractice claims being made against one physician based on disparaging remarks made by a second physician. Frequently, when lawyers are doing discovery in a malpractice defense case, they find out that the whole case started because of a comment made by a subsequent treating physician - some other health care provider who criticized the previous care that was rendered. After thinking about these disparaging remarks, the patient gets a lawyer to file a claim. Often, remarks made by the second physician are just gratuitous or even sarcastic or facetious. Nonetheless, the remarks upset the patient and serve as the genesis for some medical malpractice cases.

Case Report: A 62-year-old woman had a total hip replacement done. Six months later, she had recurrent dislocation of the hip. She became upset with her orthopedic physician and consulted a new doctor. The new doctor said very clearly that the wrong cup component was inserted and that he could fix her problem. She had a good outcome and promptly filed a malpractice case. The second physician's note is very derogatory and inflammatory of the initial orthopedic care. This suit was settled for $150,000 despite the fact that the defense was able to produce experts who suggested that the appropriate components were inserted during the initial surgery. In liability cases such as this, one physician basically gives a patient and a plaintiff lawyer ammunition to sue a colleague, and this almost falls into the category of nuisance. This case, like others, probably could have resulted in just a change in doctor rather than in a lawsuit if the second physician had kept his comments to a minimum. Particularly if the area of care provided by the first physician is gray, please keep the comments out of the medical record. If you want to document some constructive criticism, then be factual and not emotional. If you have a problem with what another physician did and you know that individual, speak directly to them. Remember, if some error is egregious enough, protocols are in place to address it through a peer-review process. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Patients Should Take Complaints About Care to Original Provider

Disparaging Remarks by Colleague Can Result in Malpractice Claims - Part 2.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

Patients with complaints about previous care should address their complaint directly with the doctor who provided that care. The subsequent physician should not make comments about the care that could engender a lawsuit.

(Card 2 of 2) Malpractice claims against one physician are sometimes based on disparaging remarks made by a second physician.

Case Report: A pregnant woman presented with headache and hypertension. Her physician ordered a couple of urine collections on her to rule out a pheochromocytoma. All urine tests were normal. The woman eventually had her baby, and everything was fine. About 6 or 7 years later, she presented with headache and palpitations and was found to have a pheochromocytoma. The woman was prepared to bring a malpractice claim against the physician, but her endocrinologist told her, "Your physician did the appropriate workup at the time and the results were negative. You really don't have a case." The endocrinologist called the physician and said, "Just in case you get sued, I want you to know what happened and what I communicated with this patient." Therefore, as physicians, we can help prevent malpractice cases when our colleagues do the right thing, and we can hurt our peer group with our comments as well. If the patient complains about previous care, then the subsequent physician should always tell the patient to address their complaint directly with the doctor with whom they take issue. As the subsequent doctor, do not give legal opinions about malpractice or make comments about the care that could engender a lawsuit. If you see a situation that truly needs to be addressed and you cannot do it directly with the previous provider, put it into the peer-review process and/or discuss it at a morbidity and mortality conference. Or, if the situation is especially serious, ask the state board to investigate this physician's care and practice. Take some proactive steps if you really have a doctor who ought not be practicing. Often, it is very difficult to report a peer, but in the long run you are protecting your community and you are protecting that doctor from making a big error if they are having some problems. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Diligently Track Tests That Have Been Ordered

Follow-Up and Documentation of Follow-Up Important Considerations in Liability Issues.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

If you order a test, you must make sure that the test is performed. If the test is not performed, you must contact the patient, ask why the test was not performed, and document this in the patient's record.

Case Report: A 45-year-old man went to the emergency department (ED) with atypical chest pain and had risk factors for coronary disease. He went to see his primary care physician (PCP) within 1 week, and the PCP ordered a stress test. The stress test was never done. The patient came in for follow-up on 2 other occasions for non-related symptoms. Within 3 months of the chest pain, he underwent spine surgery for spinal stenosis, and he died 2 weeks postoperatively. He was found to have severe coronary disease with acute infarct in the left anterior descending coronary artery distribution. This case was settled out of court. The important lesson in this case is that, if you order a test, you need to make sure that the test is performed. If the test is not performed, you must contact the patient, ask why the test was not performed, and document this in the patient's record. This case demonstrates that you must be diligent, particularly in the area of high-risk tests. Prostate-specific antigen (PSA) tests must be monitored carefully, especially to watch for a change in PSA for patients who have had normal PSAs in the past. Other areas that are difficult to defend without documentation of follow-up include diagnostic tests, (particularly mammograms), mammogram follow-up, and CT scans of the head where something is done or not. In an office or hospital setting, patients come in and then leave quickly. As a result, one of the problems we see is test results that come back after the patient is discharged. You must follow-up on those results that come back once the patient is gone. At the University of Pittsburgh Medical Center, we have a system by which post-discharge results are automatically sent out to the ordering physician and/or the PCP, assuming we have that information on record. This system ensures that those results are forwarded to the people who need this information. However, with any test that is ordered, you must follow-up on it. You must make sure that you have seen the results and have done whatever needs to be done to follow-up with the patient. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Carefully Document Patient Compliance Issues

Documenting Care and Reminders Given to Noncompliant Patients Helpful for Malpractice Defense.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

For patients who repeatedly miss follow-up visits to monitor an existing condition, make repeated phone calls to the patient to encourage a follow-up visit, and then document noncompliance issues carefully in the patient's record.

Case Report: A 46-year-old man had a history of alcohol and cigarette abuse. He was followed up for typical symptoms of gastroesophageal reflux disease for at least 5 years in a primary care clinic. His symptoms responded to therapy with proton pump inhibitors, but at times, the patient was not very compliant with his medications and follow-up visits. At that time, he never had any red-flag signs in terms of pain with swallowing or food sticking. After missing 6 months of follow-up visits, he presented with severe anemia. He was then diagnosed with a metastatic gastric carcinoma. Interestingly enough, this case was dismissed because of meticulous documentation of missed appointments. The physician's staff had made repeated phone calls to the patient for outreach to get him to come in for follow-up visits, and this was well documented in the patient's record. Factors critical to the successful defense of this case included the meticulous documentation of noncompliance issues by the primary care physician, the lack of red-flag symptoms, and the absence of any reflux symptoms at each encounter. The lesson to be learned from this case is that you must carefully document compliance issues when you have noncompliant patients. In a case we saw several years ago, a patient presented during the evening hours with crushing substernal chest pain. The internist made the patient handwrite a note that he was refusing to be hospitalized against medical advice. Unfortunately, the patient went home and died. The family sued, and the case went to trial. The defense won, partly because this physician went to extremes to document the patient's refusal for care in the medical record using a note written in the patient's handwriting. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Records, Caring Demeanor Help Avoid Trials

Secrets of Preventing Malpractice Claims: Lessons Taught by Plaintiff Lawyers.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

If the care provided by a physician is deemed to be appropriate and compassionate and if a physician looks kind, caring, and not arrogant in the deposition, then the plaintiff lawyer will be more likely to settle a malpractice claim.

Plaintiff lawyers have taught defense attorneys some very important lessons regarding malpractice cases. For example, if the care provided by a physician is deemed to be appropriate and compassionate and if a physician makes a good appearance in the depositions (looks kind, caring, and not arrogant), then the plaintiff lawyer knows he has a difficult issue and will be more likely to settle. Plaintiff lawyers also tell us that they will not fight the medical record. In other words, the plaintiff lawyer does not want to take a chance on a patient who tells a completely different story than what is documented in the medical record. Instead, these lawyers want those cases for which documentation is either lacking or poor. Therefore, for cases with meticulous documentation, plaintiff lawyers are not going to fight the documentation, and they are not going to take the patient's word that something completely different happened or was not done for them. A critical preventive measure that all physicians can take against malpractice claims is to meticulously document all cases. In Allegheny County in southwestern Pennsylvania, about 75% of malpractice cases that go to trial are settled on behalf of the defense. This is not true in Philadelphia County, but Allegheny County is very friendly to doctors probably because both our plaintiff and our defense lawyers know that, if we have a good case, we are going to try it and we are probably going to win based on these statistics. In western Pennsylvania, of cases that are not settled and go to trial, doctors and hospitals win >80% of their cases. Nonetheless, even when you get a defense verdict, you have spent probably hundreds of thousands of dollars, the doctor was tied up in court for a week or more, a great deal of money went into preparing the case, and all cases come with some emotional cost. In malpractice cases, the plaintiff is not the only so-called victim. Physicians who are caught up in litigation are victims as well. At the University of Pittsburgh Medical Center, we have a program where we can refer physicians, who are involved in serious events or litigation, to counselors, who are able to help physicians through the litigation phase. No mental health file is created for these circumstances, and there is no charge to the physician's health insurance company. We provide this service to physicians and other health care providers to get them through these trying times. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Documentation of Evening, Weekend Calls Often Overlooked

Conversations and Care Delivered During Off-Hours Need Careful Documentation.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-*Special Presentation;* ():

A lot of phone conversations with patients and care administered during off-hours do not get documented properly because the physician is not in the office or hospital setting.

After years of managing malpractice cases, we have seen several preventative strategies that help health care professionals avoid litigation. One important area that puts physicians at risk for liability issues is weekend and night coverage. Many phone calls are received, and a lot of care is delivered during off-hours. All of these care events need documentation. We suggest you set up a phone line in your office on which you can dictate into the phone to document the call or the actual care delivered. Remember to include what you did and what you did not do during this off-hours situation. Make sure that the physician for whom you are covering gets a record of what happened. We have found that when patients call a physician's office during off-hours, they tell us that they remember everything that was said in that conversation very clearly because calling a doctor's office after hours is something they never or almost never do. However, the physician will tell us that they get after-hours calls all the time. Therefore, the physician must document the call in some way, shape, or form. Remember, the patient is going to have a clear memory of the conversation, and after talking to a lawyer, they will have an exact memory of the conversation. The physician must have documentation to defend what was or was not discussed and the advice and/or care that was given. The documentation does not need to be extensive, but it is nonetheless as important as the documentation of advice and care administered during normal office hours. A lot of care administered during off-hours does not get documented because the physician is not in the office or hospital setting. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Several Areas Continue as Common Liability Pitfalls

'Click Errors' for Computerized Orders, Incomplete Medication Discussions, and Patient Referral Issues Can Increase Liability Risks.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-Special Presentation; ():

Several areas of health care continue to be liability issues for the physician, including errors in ordering medication, incomplete discussions about drug side effects, and patient referrals to specialists.

Several areas of health care continue to put the physician at risk for malpractice claims. These include medication errors, treatment plans, and discussions about drug side effects with patients. Many of our medication errors in the past were due to handwriting errors. Even with electronic prescribing, there are still errors, especially 'click errors' in which a physician selects (or clicks on) the wrong dose or the wrong instructions. The avoidance of 'click errors' is becoming extremely important as our world becomes more computerized. Solid treatment plans in which the physician gets the patient involved in self-management are very important. The physician must be sure to talk about indications for medications and side effects for medications, especially dangerous side effects. Often, physicians breeze through side effects in discussions with patients and do not tell them all the other things that can happen. Renewed efforts to be more complete in these discussions are necessary. Once the discussion is complete, it must be documented in the patient's medical record. The physician need not write every side effect that is in the Physician's Desk Reference, but they should note that the major side effects were discussed. For example, if you have a routine with your patients in which you discuss a standard litany of side effects, then you can note on the record that these were discussed. Then, years later, you can credibly testify that you told the patient about side effects 1, 2, 3, 4, and 5 because you tell every patient receiving this medication about points 1, 2, 3, 4, and 5. Another area that may put physicians at risk is appropriate referral. If you are not sure whether a referral is needed, bring other people into the mix. In one recent case, a man presented with some visual disturbances to his primary care physician (PCP). The PCP ordered a sedimentation rate on the patient, which was very low. Accordingly, the PCP referred the patient to an ophthalmologist. The patient continued to have problems and the ophthalmologist continued seeing the patient. The patient ended up having temporal arteritis and went blind because the ophthalmologist missed the diagnosis. From a professional liability perspective, the PCP was not held responsible because he made the appropriate referral. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Honest Conversations About Physician Errors Essential

Expert Tips on Managing Medical Errors by the Physician.

Francis X. Solano Jr, MD, and Richard P. Kidwell, JD

-Special Presentation; ():

Patients want these 3 things when their physician has made an error: an apology, a clear explanation of what happened, and an assurance that changes will be made so the same mistake does not happen to someone else.

When a physician has made a mistake, the best policy is to disclose the error and to be candid, forthright, and honest with the patient. Do not make a second mistake by ignoring or covering up the first one. Talk to risk management personnel or your legal advisor about the best course of action. Then, sit down with the patient, explain what occurred, and apologize. Patients want these 3 things when their physician has made an error: an apology, a clear explanation of what happened, and an assurance that changes will be made so the same mistake does not happen to someone else. Many states have 'apology laws' so that physicians can have this conversation with their patients and not worry about it coming back to be used as evidence against them. In addition, explanations about what the physician plans to do differently to avoid this mistake again are called 'subsequent remedial measures,' which are not admissible in court. In any event, do not be afraid to have the discussion with the patient. Even if the mistake is associated with a bad outcome, you want to continue that dialogue with the patient, and you want that relationship to be close enough that you can take care of the patient. After talking with either risk management or your legal advisor about the situation, you may find that something as simple as writing off some bills or providing some follow-up therapy or home care may be sufficient to get the patient past the event. After you tell the patient about the mistake, focus on what you are going to do to get them past it and how you are going to help get them better, including bills that will be written off. This may be enough to prevent them from contacting a lawyer. On rare occasions, patients who sue their physician still follow up for further care with them. These patients should not be fired by the physician because, in court, the case will look ridiculous if the plaintiff is still coming to the physician for further care. Keeping a good, open, and honest relationship with the patient is important, even if you might have to bite your tongue a few times. Another important point is doctor accessibility - before something happens, you want to be accessible to the patient, to respond to phone calls, inquiries, and questions or concerns. Even after something happens, you want to remain accessible. Finally, if you must appear for depositions or trial, remember to be humble and not arrogant. Arrogance is the worst thing that our lawyers see when they have a physician in the courtroom. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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Good Documentation May Sway Lawyer to Drop Case

Risk Management Fundamentals.

Kidwell RP:
Postgrad Obstet Gynecol; 24 (October 15): 1-3

Good documentation contains the following essential elements: each entry made with the date and time recorded, legible writing, entries that are consistent with one another, and all corrections made properly.

Objective: To review the use of documentation and communications as a means to help physicians prevent or help defend themselves against malpractice claims.

Results: When a plaintiff's attorney accepts a case, the attorney will acquire copies of all the physician's documents about the case and will have them reviewed by experienced staff members and expert witnesses. The plaintiff's attorney wants the records to be incomplete, with gaps in the documentation regarding actions taken by the physician. However, thorough documentation of the physician's actions and judgments may sway the attorney to drop the case. Good documentation contains the following essential elements: each entry made with the date and time recorded, legible writing, entries that are consistent with one another, and any corrections to an entry made according to professional and state standards. The date and time noted for each entry helps establish the chronology of events and helps demonstrate the physician's level of responsiveness to various situations encountered with the patient. Clinical judgment is important to document when multiple reasonable diagnoses or treatment plans exist. An adverse patient outcome does not mean that the physician provided substandard care, but the plaintiff's lawyer will comb through the documentation trying to prove that different diagnoses and treatment options were not considered. Good notes are made as soon as possible after an event, as demonstrated by the time/date notation, proving good recall of both the events and decisions made. In addition to good documentation, solid communication skills can also help a physician prevent a malpractice claim. The physician must use good verbal and written communications to convey important information to and from other care providers. Encouraging a sense of teamwork with other doctors and care providers on a case can help keep the lines of communication open. A physician must also have good rapport with his patients, allowing adequate time for discussions about their condition and treatment options. The comfort level of each patient with his or her physician depends largely on the level of open communications between these individuals.

Conclusions: Both good documentation and good communications with the patient and other health care team members can help prevent a malpractice claim.

Reviewer's Comments: How many times have we been told this? And yet because of carelessness, time constraints, inaccuracies both corrected and uncorrected, and/or illegible penmanship, we continue to fall into the traps of the plaintiffs' attorneys. This article should be read by all physicians who see patients and keep records.

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Knowing Patient's Health Literacy Can Improve Communications

Seven Strategies to Improve Communication With Patients.

Staff Writers:

Inside the Joint Commission; 12 (July 30): 1-8

The language of the medical world can be confusing to patients. Good physician communication skills can help the patient more fully understand their condition and the directions they have been given.

Objective: To review 7 different approaches to help improve the effectiveness and character of communications between physicians and their patients.

Results: During the initial exam of a patient, the physician needs to take time to determine the health literacy level of that patient. An assessment tool called the *Newest Vital Sign* has been created by a team of researchers to help health care providers determine if the patient can read and understand health information. Understanding the health literacy level can help the physician and other staff members know when additional time may be required to assist the patient in understanding new information and new orders. In addition, the physician should encourage patients to ask questions and to admit when the medical terminology is over their head. Perhaps the 3 most important questions a patient can ask are as follows: "What is my main problem?" "What do I need to do?" "Why is it important for me to do this?" When speaking with patients and writing instructions, the language used by physicians and staff members should be simple, easy to understand, and free of technical terms that are often confusing. When helping patients select options in their care, physicians can help by giving patients simple options and clear facts, which should simplify the decision-making process and make final directions easier to remember. Although physicians are often in a hurry to move on to the next patient, they should be reminded to speak slowly to patients so that their words do not become garbled and misunderstood. Finally, asking patients to repeat the directions they have been given can help the physician determine if they understood what they were told.

Conclusions: The language and terminology of the medical world can be confusing to patients. Communication between the physician and patient can forge a trusting bond and can help the patient more fully understand about their condition and the directions they have been given. Therefore, physicians must be aware of each patient's medical literacy level and strive to speak with them using clear, easy to comprehend language.

Reviewer's Comments: How true, this article. As lawyers quite often use "legalese", we physicians too often use "medicalese" and also quite often the patient is reluctant to confess his failure to understand our communications. I doubt if this article contains much information we don't already know, but it certainly points out a rather uniform deficiency in our medical-to-layman communication skills, suggestions for correction, and a brief lexicon of synonyms more easily understood.

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