MALPRACTICE: EXPOSING WEAK LINKS THAT CAN PUT YOU AT RISK

A LITTLE CAUTION AND A LOT OF GOOD COMMUNICATION CAN PROTECT YOURSELF AND OPTIMIZE TREATMENT. USE THESE 30 TIPS TO HELP MALPRACTICE-PROOF YOUR PRACTICE.
It goes without saying that defensive medicine has become a new practice paradigm. Some neurologists find themselves thinking about ordering tests for very rare possibilities just to protect themselves from the one case in a hundred that could prompt a lawsuit later. Others find themselves more inclined to refer out tricky cases than they were in the past, or even exclude a certain type of patient or high-risk procedure altogether.

But for all the advanced testing technologies and clinical caution, little problems in the course of daily practice can also lead to malpractice suits. Sometimes a patient may not understand your instructions but will not ask for clarification. Or if you uncover a condition outside of your expertise, a patient may not follow your advice to see another specialist and will subsequently blame you when he or she develops complications later. Even a careless conversation by your staffers can cause trouble if the patient is concerned about his or her privacy.

In these days when the medical profession is mired in an intractable liability crisis and “jackpot justice” that pays exorbitant settlements even to frivolous claims, following the best clinical guidelines for treatment and follow-up is the bare min-
Weak Links in Malpractice Protection

imum physicians should do. The current reality calls for a proactive approach to troubleshooting the imperfections at each level of a patient’s experience at your practice, from the way you conduct yourself during the examination to what happens after the patient leaves your office. But just as it is true that an ounce of prevention is worth a pound of cure, a few simple steps taken now can go a long way towards protecting you in the future.

In this article, we’ll look at how to apply advice from experts such as Lee J. Johnson, Esq. of the risk management firm Johnson & Associates in Mount Kisco, NY, along with tips submitted to the American Academy of Neurology’s patient safety committee by practitioners throughout the nation and other sources to “malpractice-proof” your practice.

EXAM ROOM MANNER
According to *Neurology* 2005;65:1284-1286, a review on the few available studies on malpractice claims, an accurate and timely diagnosis in all its forms represents the single largest category for error. Most neurologists have the first contact with the patient and caregivers at the time of a critical illness, so communication is vital. From your point of view, it’s easy to think about what questions to ask, but unless the patient and the caregivers trust you they may be less than forthcoming.

Hospital patients and staff often base their opinions about physicians on their bedside manner. An exam room in an outpatient setting may be very different, but a physician’s manners are still very important. Clear, uncomplicated and compassionate communication is still highly valued, although the increasing time pressure to see the next appointment may make it less common in many clinics.

The way you talk to a patient can go a long way towards earning their understanding, and if a mistake or a misdiagnosis does occur they will be more sympathetic to you and less likely to call a lawyer. Here are a few pointers that can improve your patients’ perception of you without wrecking your schedule:

1. Sit down when you talk. This will make the visit feel longer to the patient by making you seem less rushed. Stand up when asking for questions at the end of the appointment, because although you have given them permission to ask, your body language will show them the time allotted is brief.
2. Keep the discussion on topic. Listen carefully to the patient but cut off any digressions, as this can take time away from a productive dialogue.
3. Gentle, warm humor can help develop rapport that is vital to the patient-physician relationship.
4. If a patient asks a complex question, quickly rephrase it to make sure you understood it correctly. This gives them a chance to clarify if necessary and acknowledge your understanding of their concern.
5. After giving the patient complicated instructions, ask him or her to repeat what you told them. If they have trouble remembering, or could potentially have cognitive impairment, write instructions on a prescription pad or other piece of paper. Make sure the writing is legible and include a copy with the patient’s chart.
6. While talking to patients, try to assess their health literacy—specifically, their ability to read, understand and act on health information. If they appear to be somewhat unfamiliar with medical terms, be sure to explain any acronyms or abbreviations and give examples.
7. Avoid unrealistic expectations about outcomes, but try to impart hope when giving information. Patients who feel at least some optimism will be more compliant with their medication regimen and more receptive to any other instructions or guidance you offer.

Although practitioners may groan when they see a patient come in with a stack of papers printed from the internet, Ms. Johnson says this is actually a good thing because it often shows that patients are interested in learning more about their condition. “The more educated patients are, the less likely they are to sue,” she says. “The educated patient is the best patient.”

A physician can take advantage of patients’ curiosity by pointing them toward sources to get reliable, accurate information, such as association web sites and their pamphlets. Document the information that you provide because this counts as part of the discussion, even if the patient reads it after the visit. If the patient doesn’t have a computer or internet access, you can have a staffer print up the relevant information. “Educating by talking to patients takes a lot of time, but educating them by giving them papers and referring them to web sites takes very little time,” Ms. Johnson says. Naturally, you have to find the right balance between personal communication and reference materials, and it will differ from patient to patient.

Improving health literacy has been a focus of medical societies for some time. In 2003 the AAN reported that as many as 50 percent of adult patients with neurologic disorders can have trouble understanding the information their physicians provide. Physicians who feel they could use a little more training as teachers to their patients may want to look for some training events presented by the American Medical Association (www.ama-assn.org).

SUPPORTING STAFF
Your name may be on the shingle outside the office, but remember that you are not the only person who sees the patient. A well-trained, polite staff can help in a wide variety of
ways, Ms. Johnson says, beyond keeping the practice clean and professional looking. If they are trained and the system is efficient, everyone behind the front desk can become an effective front-line against liability risk. Writing up guidelines for conduct and procedures can expedite training your staff and remind them of the best office practices. Some methods to get the most out of your guidelines include:

8. Consider how your staff would deal with an angry or disgruntled patient. Be sure to teach them how they should handle such situations. You may want to include some model calls from patients' attorneys to decide what the best approach would be.

9. Have your staff participate in writing up the practice's guidelines. Find out the most common questions they hear and what sort of problems come up most often. Ask them to describe incidents that have occurred and what they fear could happen, then discuss the best way to handle these situations.

10. Since a common patient complaint is the amount of time they spend waiting for the doctor to see them, think about allotting longer time slots by finding ways to cut out the common reasons why appointments run long. If this is not feasible, have your staffers call patients on the particularly hectic days to reschedule their appointments. This would work best if patients would have to wait for 45 minutes or longer, because after so much time in a crowded waiting room they may not be receptive to establishing a relationship with the doctor, which may hinder proper treatment and keep him or her from truly understand your instructions.

11. Emphasize to your staff the need for privacy, particularly in light of HIPAA regulations. Be sure they know not to talk about patients or their conditions within earshot of the waiting room.

12. Establish a standardized procedure for your staff to track diagnostic test results and referrals. This can help you track down any cases where the results were never delivered or the patient didn’t do the necessary follow-up.

13. If you have a number of patients with epilepsy or neurocognitive conditions, create a standardized reporting procedure in compliance with local laws regarding reporting requirements about driving rights.

14. Create a set, standardized system to give all clinicians and staffers, instead of just one person in the office, easy access to patient records. Not being able to get the information quickly because the person in charge of record-keeping is not available could lead to medical errors and adverse effects.

Every now and then, you should apply a self-assessment tool to your office to see if there are any risks you have overlooked. Ms. Johnson particularly recommends the tools available at Medical Risk Management Services (www.mrsinc.com). Ms. Johnson's company, Johnson & Associates, also offers a number of videos and self-study courses at http://users.best-web.net/~janda/index.html.

**PROTECT YOURSELF WHEN REFERRING**

It's not uncommon to find that a patient has a condition outside of your area of expertise, but every now and then you may find a terribly urgent case that needs a specialist’s attention as soon as possible. But just giving the patient a list of specialists is practically negligent from a legal perspective, and even though it may be the patient’s fault for not booking the appointment you may share some degree of liability for not impressing the urgency upon them.

In these cases, you have to do all you can to show that you took every reasonable effort to maintain continuity of care by getting the patient to the specialist. This may mean pushing harder than usual during the referral process, through the following steps:

15. Tell the patient why you're making the referral. Have them explain back to you why you feel their condition is urgent and what their responsibilities are.

16. If a patient's condition is serious, make the referral appointment for him or her. Tell the specialist why you feel the person needs to be seen immediately. Send copies of the patient’s records when you make the referral and give the patient an appointment slip before he or she leaves your office.

17. Have a staffer check with the specialist's office to be sure the patient keeps the appointment. If not, reschedule it and tell the patient the new time. If the problem is potentially life threatening, the staffer should send the patient a certified letter notifying him or her of your concern about the missed appointment. Request a return receipt, and keep this in your records.

18. If the patient's condition improves, or new test results lead you to decide an immediate referral is no longer necessary, write down the reasons why you changed your mind.

The key is for the physician to show he or she did everything possible to encourage the patient to seek a referral. If the patient does not live up to his or her part of the deal, the doctor is off the hook for a good percentage of the liability.

Doing all you can to get a patient to follow through with a referral may not keep you from getting sued if he or she does not comply and develops complications, but it will give you a strong defense. Ideally, though, the patient will realize how important you believe the referral is during the process and comply with treatment out of their own volition.
BUILD A PAPER TRAIL
A patient’s records should not only reflect what they’ve told you and what you’ve told them, and the information should include correspondence outside of the exam room. It should also give an indication of what you were thinking about during the whole treatment process. Your records should include:

19 What you ruled out and why when making a diagnosis, along with the reasoning behind your decision. Ms. Johnson says the key is to show you did what any reasonable specialist would have done for a patient with those symptoms in that situation. “You can defend your decision, even if you were wrong, by showing what you were thinking,” she says.

20 The cautions and advice you gave to the patient after an office consultation. As noted above, this can include references and written information.

21 Any conversations you had with the patient, even those done over the phone. Some physicians use customized message forms that guide the receptionist through the process by asking for the patient’s name, the date and time of the call, the reason for the call, the chef complaint or question and the answer.

22 A brief note detailing any out-of-office encounters. Some physicians have a special notepad for recording these notes and put them with the patients’ records when possible.

23 Customized records with blanks or boxes annotated by the physician, which are considered legally acceptable. Keeling them legible will make them more credible to a jury and can prevent other health care providers from mis-interpreting your notes.

Whatever happens, it is important not to alter existing records after they are signed and initialed. Fudging the records never looks good, even if you are adding a service you actually did perform or advice you gave but forgot to note. Leaving a note after the fact may not be a strong defense either, so your best bet is to find some external documentation, such as coding for the service, that can imply you did whatever is missing.

THE CLEAR CHOICE FOR TREATMENT
Physicians stereotypically write their prescribing information on a small sheet of paper with handwriting illegible to all but the pharmacist. However, that does not mean the pharmacist likes having to decode scrawl, particularly since they too are at risk of being sued if they dispense the wrong medication or the wrong dose. So use block letters if your handwriting looks like a smear of ink, and consider taking these steps to make sure the pharmacist dispenses the right treatment and the patient takes it:

24 Because many cases of medication error are caused by mixing up drugs whose names look alike or sound alike, write down both the brand and generic names on prescriptions for drugs whose names are known to be problematic.

25 In cases where the name may be confusing, write down the intended purpose of the medication. This will give a pharmacist another clue for what prescription to fill.

26 Include simple, clearly written, specific instructions for taking medications on the prescription form. To ensure patient understanding of when and how to take medications, ask the patient to “teach back” or show you when and how the medications should be taken.

27 The wrong dosage can be fatal, so be especially careful here. Avoid using trailing zeros (write 5mg instead of 5.0mg) but always put a zero before a decimal point if there is not another number that goes there (use 0.5 instead of .5).

EXTRA MEASURES
These tips can help out in various areas of the clinic, but there are also a couple of pointers to keep in mind at each level of the clinic:

28 The situational risk factors involved with working in a clinic—being unfamiliar with a task, being perpetually short of time, etc.) create a fertile breeding ground for human error even for the best trained and most conscientious practitioner. You may want to consider adding safeguards such as oversight or a double-check system to reduce errors for more mundane tasks.

29 Trust your hunches and gut reactions. If you ever get an uneasy feeling about the patient, the caregivers or if an unpredicted complication occurs, take some time out to think. Look over the differential diagnosis and spend a little more time considering any peripheral or psychiatric issues. If you’re still unsure, order some more tests or more consultations. In confusing cases, the best course may be to refer the patient to another neurologist for a second opinion.

30 Even in the best situations, a mistake can happen. If the fault does indeed lie with you, your best defense may be a clearly spoken, personally delivered apology to the patient. It’s best to do this in a private area where no one will interrupt, ideally with a caregiver and a nurse present. Assume an open body posture when you make the admission and resist the urge to make excuses because this can weaken the apology. For more information on initiatives to encourage initiatives to protect physicians that disclose errors and samples of training videos and guidelines from major medical institutions, go to www.sorryworks.net. PN