

## Six significant factors causing malpractice claims

It can -- and does -- happen and it is the number one cause of claims.

Breakdowns in this area are a leading reason why patients sue.

Patient complaint handling can be a critical component as well

Who is supposed to follow up with a patient once a specialty referral is given?

### 1. Malpractice

Even the most conscientious physician can make a mistake that might not have happened if the physician were more alert or used better judgment. Unfortunately, from a risk management standpoint, there is nothing that can be done to prevent these lapses.

### 2. Physician-Patient Communication

At MMIC we believe this so strongly that we offer several different workshops focused on changing physician communication patterns. Physicians with good patient relationships are sued less often, are better able to relate to the patient and family when there is an adverse outcome, and report generally more satisfaction in their work.

Make sure that your clinic has a procedure in place so that all patient complaints get promptly and appropriately addressed. Only treatment-related complaints should be considered for inclusion in the patient medical record. If you have doubts about what to include, contact the risk management department at your malpractice liability insurer.

### 3. Communication Among the Healthcare Team

If consulting physicians fail to clarify this up front, a patient may never hear abnormal test results and suffer an injury. Make sure all providers involved in a patient's care know who is responsible for the "big picture" -- and don't forget to tell the patient!

Poor communication among physicians and nurses involved in a patient's care can result in misunderstood orders and a patient injury. Another risky behavior is the unwarranted or off-the-cuff criticism of another provider's care, either to the patient or in the medical

record. At MMIC, we refer to this activity as “jousting,” and have seen such criticism result in malpractice claims.

#### **4. System Failures**

Use a tracking system

Tracking systems for test results, x-rays, consult reports, follow-up appointments, and appointment failures is a critical element in any physician practice. When patient test results are filed without physician review or set aside and never relayed to the patient, injuries and malpractice claims result.

A good follow-up system

Will include a log that records when samples are sent for testing, to which lab (internal and external alike), the date results are received, and when they are relayed to the patient. Clinic policy should ensure that a physician or qualified allied health staff member reviews all test results before filing in the patients’ medical records. The reviewer should initial the test results to signify they can be filed.

Another area that requires follow up is failed appointments.

When patients fail to show up for scheduled appointments, who reviews the chart to determine whether that missed appointment was for a clinically significant problem? A physician should make this determination if the appointment was for anything other than a routine checkup. If the return visit was clinically necessary (recheck of a breast lump, repeat chest x-ray for questionable area seen, redraw of a borderline protime) then staff should be assigned to reschedule the patient. Each attempt should be documented. If the patient does not reschedule, or fails the appointment again, a certified letter should be sent notifying the patient of the risks of not returning for the test.

#### **5. Documentation**

The patient's chart is a gold mine.

Frequently the key to defending against a malpractice claim, the patient’s chart can be a gold mine or a land mine. A land mine will contain entries that are cryptic, illegible, untimely, self-serving, or -- worst of all -- altered.

To prevent your patient's medical record from sinking your defense

Deficiencies in documentation can have significant consequences in three areas:

In the event of a claim, develop excellent documentation habits. Poorly worded chart notes may be enlarged by the plaintiff's attorney and mounted on five-foot-by-six-foot show card so the jury can fully appreciate every ill-conceived word. Illegible notes can be even more harmful.

The quality of medical record documentation is a critical factor in efforts to prevent and control patient injuries, malpractice claims, and malpractice claim losses.

- **Causing patient injuries:**

Many patient injuries occur because of errors, omissions, illegible entries and other medical record problems that preclude physicians and other health care providers from rendering appropriate treatment.

- **Filing of claims:**

In determining whether or not to file a malpractice claim, plaintiff attorneys scrutinize the medical records for evidence of the appropriateness, or inappropriateness, of the care rendered. If the records are incomplete, inaccurate or cannot be deciphered, attorneys may be obliged to file a claim simply to get access to better information.

- **Defense of claims:**

Medical records are one of the primary sources of evidence used by the jury in deciding whether a physician is liable for malpractice. Incomplete records can be devastating to the defense of a claim; as far as the jury is concerned, if it's not in the medical record, it simply did not happen. Sloppy or inaccurate documentation can create the impression that the medical care rendered was less than professional.

## **6. Informed Consent**

It is important to distinguish between a signed consent form and the process that you go through with a patient to obtain informed consent.

“Informed consent” is:

Something the patient gives as the result of an educational process with you, the treating physician. The law requires you to obtain the patient’s informed consent to any procedure or treatment involving significant risk to the patient. It is a physician’s non-delegable duty to provide the patient with sufficient information about proposed medical care to enable the patient to make an informed decision about whether or not to undergo the treatment. This is typically a more involved process than having the patient read a form. The patient needs to have the opportunity to engage in a discussion about the risks, benefits, and alternatives with you and have all questions answered..

MMIC recommends that you document the informed consent discussion in the progress notes at the time of the visit

A signed consent form may support the fact that appropriate and complete information was provided to the patient before treatment, and it can be additional evidence that the discussion about risks, benefits and alternatives occurred. The form does not take the place of your discussion with the patient or documentation of that discussion in the patient’s medical record.

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