



# Adverse events: Reducing the risk of litigation

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## ■ ABSTRACT

How a physician deals with an adverse event, regardless of whether negligence or error played a role, can significantly influence whether medical malpractice litigation results. Honest communication and respect for patient confidentiality are as important in avoiding litigation as the quality of care provided. Clear, careful orders, sound documentation, and greater vigilance at transition points such as hospital admission and discharge help guard against error and litigation if errors occur.

**W**HAT PROMPTS a patient to seek the advice of an attorney after an adverse event? Often it has less to do with the adverse outcome than with the patient's perception of the physician's response.

In a sample of 342 cases presented to Chicago attorneys, the vast majority of patients complained that they had never received a satisfactory explanation from the physician. In many instances calls to the physician by patients and family members went unanswered. By the time an attorney was consulted, the patient's unpleasant treatment experience was compounded by anger at what he or she perceived as being ignored.

## ■ IMPROVING THE PHYSICIAN-PATIENT RELATIONSHIP

The physician-patient relationship is the cornerstone of good medical practice and good

risk management. We have lost the bond of community we had when the physician was a trusted friend and neighbor who made house calls, and we must now find other ways to recapture that connection.

An interesting study by Levinson and colleagues compared videotapes of patient encounters by physicians who had been sued and those who had not. The no-claim physicians used more statements of orientation, such as telling patients what they could expect from their visit or treatment. They tended to use humor and laugh more often. They engaged and touched their patients. They sat down when they talked with patients. And they frequently checked patients' understanding, solicited their input, and encouraged them to talk. All of these behaviors convey a personal interest in the patient.

The length of the visit was an independent predictor of claims: no-claim physicians spent 3.5 to 4 minutes longer with patients than did their colleagues who had been sued. Understandably, this observation is distressing at a time when HMOs are mandating ever shorter patient visits.

## Danger signals

There are several danger signals that should alert you to problems with the physician-patient relationship. Patients who make you angry, are rude to you or your staff, are non-compliant, persistently present the same complaint without improvement, request specialists or special procedures, complain about billing, or insist that you are the only doctor who can help them require special vigilance. These are flags that signal discordance between the patient's expectations and his or her perceptions of the relationship, or an agenda that is not being expressed directly.

Common-sense  
measures can  
prevent  
adverse  
outcomes and  
lawsuits

## The scope and definition of malpractice

**I**n 1995 there were several dramatic cases involving malpractice that were highly publicized in the popular press. These included the death of Boston Globe health reporter Betsy Lehmann as a result of a medication dosing error at a prestigious institution, amputation of the wrong leg in a Florida hospital, and the conviction of a New York nursing home physician on charges of criminal negligence arising from malpractice.

These, and other sentinel events, were the impetus for the Institute of Medicine Report, *To Err Is Human*. Based upon data from studies of New York, Colorado, and Utah hospitals, the rates of adverse events range from 2.9% to 3.7% of hospitalizations. Of these events, 6.6% to 13.6% resulted in the death of the patient. Extrapolating those figures to more than 33.6 million hospital admissions in 1997, as many as 44,000 to 98,000 deaths may be the result of medical errors. As a basis of comparison, there are 42,000 deaths from breast cancer and 16,500 deaths due to AIDS yearly.

The financial loss due to adverse events is also considerable. The IOM report estimates that adverse events cost from \$17 billion to \$29 billion per year. Preventable adverse drug reactions occur in 2% of hospital admissions, increasing the cost of these admissions by approximately \$4,700.

### IF WE WERE AN AIRLINE, NO ONE WOULD FLY WITH US

Historically, medical institutions have used a retrospective approach to risk management. Adverse events are analyzed to determine the point of error, and a strategy is developed to avoid the error in the future. This generally involves the adoption of remedial actions, often calling for a more complex, less flexible system. This is followed by a quiescent period during which the locus of the system failure shifts, resulting in another adverse event—and the cycle repeats.

This approach was rejected by the aerospace industry more than 4 decades ago. Their approach has been to analyze each system for potential errors and develop safety redundancies. In the late 1950s the risk of an airplane crash was 1 in 2 million. Today it is 1 in 63 million. Compare this with the mortality rate due to adverse medical events. If we were an airline, no one would fly with us.

### LEGAL CRITERIA FOR MALPRACTICE

Medical malpractice is a tort—a civil wrong for which the plaintiff may seek redress through the courts. Unlike criminal proceedings, where the defendant must be guilty beyond a reasonable doubt, the burden of proof in civil litigation is by a preponderance of the evidence—more likely than not.

Although the language may vary somewhat from state to state, in order to prove medical malpractice in court, four criteria must be met:

- The physician must owe a duty to the patient. This is generally accepted to mean the existence of a physician-patient relationship.
- There must be a deviation from the “standard of care.” This is defined by statute—that which a reasonably well-qualified physician would do under the same or similar circumstances.
- The patient must sustain an injury. A drug error without an adverse action is regrettable but is not malpractice.
- The actions of the physician must be the proximate cause of the patient’s injury.

The statute of limitations is the period during which an action for medical malpractice can be initiated. It is determined by each state and there is variability between states.

However, if a physician intentionally conceals the error or injury from a patient, the statute of limitations is extended to the point at which the patient knew, or reasonably should have known, that negligence occurred.

When these signals appear on the radar screen, in addition to discussions with the patient, it is especially important to carefully

document all patient interactions—not only office visits but telephone calls, hospital encounters, and other incidents—for example,



with office or hospital staff. Notes should be factual and nonjudgmental. In these areas we would do well to follow the example of our nursing colleagues, who are expert at describing behavior in neutral language. They will chart that “the patient threw a bedpan across the room”—a simple description that conveys the flavor of the interaction. We, on the other hand, are more likely to write that the patient was “hostile” or “acting out”—which conveys our judgment or interpretation.

**Setting limits.** When caring for an overly demanding or noncompliant patient, it may be necessary to set appropriate limits. If you are able to do so, the specifics should be documented, including how and why the limitations were set and how they were communicated to the patient.

**Consultation.** If you are unable to resolve issues that interfere with the physician-patient relationship, a “consultation” may be helpful. Discussions with a colleague may provide a fresh perspective on the relationship or validate your perceptions. Hospital ombudsmen, if available, are uninvolved third parties who can do a remarkable job defusing tense situations and clarifying options. In some instances, there is a “disconnect” between physician and patient that can’t be resolved. Under these circumstances, it may be best to transfer care to another physician.

### **Maintaining patient confidentiality**

Patient confidentiality involves more than the protection of medical records. It extends to hospital cafeterias, elevators, social gatherings, and other public places. Medical misadventures should never be discussed in hospital elevators or any other public setting. The common practice of physician teams meeting in the hospital cafeteria to discuss their patients should be abandoned. Anyone observing these “card rounds” can see nearby visitors straining to hear every word as if it was the next episode of *ER*. Likewise, “amusing” patient care anecdotes are correctly viewed by patients and visitors as demeaning and disrespectful.

## **■ DOCUMENTATION**

Documentation can be tedious but is essential in both preventing and analyzing adverse

events. Should litigation be filed, your documentation is the only contemporaneous record of the events in question. The medical chart remains long after memory fades. The job isn’t finished until the paperwork is done.

### **Preventing medication errors**

Medication errors are frequent (estimated at two errors per 100 hospital admissions) and often preventable. Every order should include the date, including the year, and the time. When writing medication doses, trailing zeros should be avoided. It is all too easy to mistake 5.0 as 50. Leading zeros may prevent conversion of 0.25 to 25.

To assure that your patient is receiving what you prescribed, check the medication administration record. This assures that, for example, your order for Peri-Colace wasn’t transcribed as Percocet.

In the office, ask patients to bring their medication bottles to visits and check them against your medication list. This is particularly important if your patient is seeing more than one physician. You and your patient are at risk when you prescribe medication without identifying the other drugs the patient is taking.

Even if you think your handwriting is legible, printing is less likely to be misinterpreted by a pharmacist, secretary, or nurse. The clarity of language is as important as the legibility of handwriting. To avoid errors, complicated orders and instructions should be reviewed with the nursing staff. Whenever possible, verbal orders should be avoided.

### **Beware of transition points**

Points of transition in patient care from one setting to another and from one clinician to another present multiple opportunities for errors and omissions. Transition points include hospital admissions and discharges, emergency room visits, referrals to specialists, and transfer of care between clinicians. Whenever possible, the best communication is that which occurs directly between the physicians with the patient included in the loop.

Never assume that the absence of communication from a consultant means that there is no new information. Good consultants communicate their findings to the refer-

**Most plaintiffs sue because an unpleasant experience was never explained**



ring physician, and good primary care physicians follow up on consultations.

The transition from the inpatient admission to the primary care office is a particularly dangerous one. With increasing frequency, significant findings identified during a hospitalization are worked up in the outpatient department. To avoid having patients “fall through the cracks,” the follow-up should be organized before the patient leaves the hospital. Information regarding the abnormal finding and planned follow-up should be communicated directly to the outpatient physician by telephone, e-mail, or letter. The patient should leave the hospital with a written record of the scheduled follow-up appointments.

For less reliable patients with potentially life-threatening problems, it may be necessary to monitor follow-up and document your efforts to assure that follow-up with a registered letter. It requires less time to send a letter than it does to give a deposition.

The transition from the emergency department to the outpatient office is also potentially dangerous. Take note of patients who repeatedly present to emergency departments with the same complaint. These are patients who should be contacted regarding follow-up if they don't schedule an appointment themselves.

### **Avoid chart wars**

It doesn't help you or your patient to engage in a battle with another service or physician in the patient's chart. It just leaves a paper trail of poor communication that may affect your patient and your ability to defend yourself, should that be necessary. Documenting that you have paged a consultant or another service multiple times without response simply demonstrates that you didn't explore alternatives or find another way to meet your patient's needs. In general, it does more harm to you and to the institution than it does to the consultant.

Similarly, differences of opinion between physicians and services should be discussed and resolved. Disagreements memorialized in the hospital chart may be interpreted in a courtroom as something other than a collegial difference of opinion.

### **Always read nursing notes**

Whether in the office or in the hospital, always read the nursing notes. These are often the first documents reviewed by a legal team. Generally, they are the most legible entries in the chart and provide a chronological record of events. It would be difficult to explain why, for example, a nurse charted that the patient was in pain while the physician charted that the patient was comfortable and without complaints. When such discrepancies occur, it is important to reconcile the difference if possible. Where there is a difference of opinion it is perfectly appropriate to say in your note, “Nursing notes reviewed; at the time of my exam the patient was not in pain.”

Likewise, it is appropriate to ask nurses to corroborate your documentation if a patient refuses treatment.

## **■ WHAT TO DO AFTER AN ADVERSE EVENT**

### **Explain the event to patient or family**

Although often difficult, it is important to talk with the patient or family when an adverse event occurs. Explanations should be simple and honest even if an error was involved. Simply acknowledging that an adverse outcome has occurred may be enough to convey your continuing concern and interest in the patient. Learning about an adverse event from you is important in maintaining trust and supporting the relationship.

### **Documentation**

When an adverse event occurs, regardless of whether or not negligence or error played a role, you should notify the hospital legal department or your insurance carrier. Generally, you will be asked to write an objective description of the events surrounding the adverse outcome. Your best recollections will be those recorded immediately after the incident.

Once written, the document should be sent to your legal representative where it becomes “attorney work product,” a privileged document that is not available to the plaintiff's attorney. Above all, *never* alter a record

**It takes less  
time to send  
a letter than  
to give a  
deposition**



or destroy a document or other potential evidence.

### Do not discuss with colleagues

The temptation to decompress by discussing adverse events with colleagues should be resisted except in the context of a designated morbidity and mortality conference. Should the adverse event result in litigation, you will likely be asked to identify anyone with whom you have discussed the case. Concealing such conversations may undermine credibility and revealing them may provide information taken out of context. 

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