

Trauma MedEd

10 Things That Will Get You Sued

Many trauma professionals believe that they can only be sued if they make a medical error and some harm occurs. Unfortunately, this is not entirely true. Yes, this is one obvious way to spark a suit or claim.

Unfortunately, it goes beyond that. Your patient may sue you if they even **believe** that they were harmed in some way, or think that something untoward happened while you were providing care. Here are the top 10 reasons for getting sued and my thoughts on each (in no particular order).

#1. "What we have here is a failure to communicate"

Your interpersonal skills are at least as important as your clinical skills! You may be a clinical prodigy, but if you are an asshole at the bedside, your patients will **never** appreciate your skills. You must be able to listen and empathize with your patient. Sit down, look at them eye to eye. Listen attentively. Don't appear to be in a rush to get out of the room. You'd be surprised at how much more valuable information you will get and the relationship you create.

#2. "Work not documented is work not done"

This is my quote and it's one of my favorites. **Accurate, complete, timely, and legible documentation is a**

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TRAUMA CALENDAR OF EVENTS

TRAUMA EDUCATION: THE NEXT GENERATION III

LOCATION: ST. PAUL, MINNESOTA

DATE: SEPTEMBER 17, 2015

AMERICAN ASSOCIATION FOR THE SURGERY OF TRAUMA

LOCATION: LAS VEGAS, NEVADA

DATE: SEPTEMBER 9-12, 2015

must! The legibility problem is fading with the widespread use of electronic health records (EHR, although this is creating new problems). Documentation, or lack thereof, will not get you sued. However, if you are involved in a suit or claim and your care is scrutinized, poor or missing documentation will make it impossible to plausibly contend that you did what you say you did.

It's critical that you document every encounter thoroughly enough to be able to reconstruct what you were thinking and what you did. And providing a date and time is absolutely critical. This is especially important when the EHR timestamps everything you enter. Frequently, you will be documenting something somewhat after the fact. Always make sure that it's not *too far* after the fact. Document as promptly as you can, and include the time that you were actually providing the service.

And never go back and try to "correct" your documentation, especially if the chart is being requested for inclusion in a suit or claim. If you believe there is an error, create an **addendum** and explain why the correction is necessary. If a suit or claim has been started, do not touch or open the chart without advice from your legal counsel.

#3. You are responsible for the conduct of your staff

If the people who work for you treat patients poorly, you may be responsible. It is important that your staff have bedside manner at least as good as yours.

#4. Avoiding your patients

Some of your patients may need to contact you, either while in the hospital or while at home. Don't appear to be inaccessible. This is an extension of your bedside manner. Return phone calls or messages promptly, or have one of your staff do so. Make time to meet with patient families while in the hospital. Remember, **you deal with trauma all the time; this is probably the first time they have and it is extremely stressful.**

#5. Ordering a test without checking the result

I presume that if you order a test, you are interested in the result. And hopefully it will make some difference in patient care. If not, don't order it. **But if you do order a test, always check the result.** If a critical result is found, don't assume that "someone" will tell you about it. *You* are responsible for checking it and dealing with any subsequent orders or followup that is needed.

#6. "What we have here is a failure to communicate" – part 2

Most of the time, our patients have primary care providers somewhere. Make it a point to identify them and keep them in the loop. Provide, at a minimum, a copy of the discharge summary from the hospital or emergency department. If new therapies of any kind are started, make sure they are aware. And if an "incidentaloma" is found (a new medical condition found on lab tests or imaging studies), followup with the primary care provider to make sure that they are aware of it so they can take over responsibility for further diagnosis or treatment.

#7. Inappropriate prescribing

Most trauma professionals worry about over-prescribing pain medication. But under-prescribing can create problems as well. Uncontrolled pain is a huge patient dissatisfier, and can lead to unwelcome complications as well (think pneumonia after rib fractures). Always do the math and make sure you are sending the right drug in the right amount home with your patient. If the patient's needs are outside

the usual range, work with their primary provider or a pain clinic to help optimize their care.

#8. Improper care during an emergency

This situation can occur in the emergency department when the emergency physician calls a specialist to assist with management. If the specialist insists on the emergency physician providing care because they do not want to come to the hospital, **the specialist opens themselves up to major problems if any actual or perceived problem occurs afterwards.** The emergency physician should be sure to convey their concerns very clearly, tell the specialist that the conversation will be documented carefully, and then do so. Specialists, make sure you understand the emergency physician's concerns and clearly explain why you think you don't need to see the patient in person. And if there is any doubt, always go see the patient.

#9. Failure to get informed consent

In emergency situations, this is generally not an issue. Attempts should be made to communicate with the patient or their surrogate to explain what needs to happen. However, life or limb saving procedures must not be delayed if informed consent cannot be obtained. Be sure to fill out a consent as soon as practical, and document any attempts that were made to obtain it. In urgent or elective situations, always discuss the procedure completely, and provide realistic information on expected outcomes and possible complications. Make sure all is documented well on the consent or in the EHR. And realize that if you utilize your surrogates to get the consent (midlevel providers, residents), you are increasing the likelihood that some of the information has not been conveyed as you would like.

#10. Letting noncompliant patients take charge

Some patients are noncompliant by nature, some are noncompliant because they are not competent (intoxicated, head injured). You must use your judgment to discern the difference between the two. Always try to act in the best interest of your patient. Document your decisions thoroughly, and don't hesitate to involve your legal / psych / social work teams.

Reference: 10 Things that get physicians sued. Texas Medical Liability Trust, 2011.

Why Surgeons Don't Want To Take Care Of Trauma Patients

25 years ago, an interesting study was published based on a survey sent to surgeons in Washington State. At the time, there was a perception that some surgeons were either uninterested or uncomfortable taking care of trauma patients. The survey was sent to all surgeons who were on the mailing list of the American College of Surgeons across the state. General and specialty surgeons were included.

Here are the factoids:

- 754 questionnaires were mailed, and the **response rate was 56% (!)**. This is fairly remarkable, demonstrating that the surgeons were very interested in having their opinions heard.
- Overall, about 58% preferred to treat trauma patients
- 25% believed trauma care enhanced their practice, 32% didn't see any impact, and **42% thought it was a detriment**
- Predictably, those who thought there was a positive or no impact on practice were most willing to treat trauma patients
- A third of surgeons said they would not take call if it were not mandated by their hospital
- There was no correlation with willingness to treat and degree of compensation for care
- 86% believed that malpractice risk increased when they took care of trauma patients

Bottom line: This is an old paper, and a lot has changed since it was published. Back in the day, very few hospitals were paying for call coverage. The addition of money changed the arithmetic in the heads of many surgeons, adding an economic incentive to offset the "undesirability." It did not change perceptions about the character of the patients or the possibility of malpractice. It would be very interesting to repeat this study with a broader audience now.

Reference: Why surgeons prefer not to care for trauma patients. Arch Surg 126:292-297, 1991.

Malpractice Risk By Specialty

Just how big a risk is physician malpractice (in the US)? A large database study covering nearly 41,000 physicians over a 15 year period was analyzed for claims frequency and payout information. They looked at how many physicians in each specialty faced a claim in a given year, whether a payment was made, and calculated the cumulative career malpractice risk for each specialty.

Here are the factoids:

- **The highest risk specialties were neurosurgery, CV surgery, general surgery, orthopedic surgery, and plastic surgery.** Here is the breakdown of percent claims and percent claims with payout to the plaintiff in any given year:
 - Neurosurgery 19% - 2.5%
 - CV surgery 19% - 3%
 - Gen surg 15% - 3%
 - Orthopedics – 14% - 3%
 - Plastics – 13% - 2.5%
- **The lowest risk specialties were dermatology, family practice, other, pediatrics, and psychiatry.** The breakdown of claims and claims with plaintiff payout is as follows:
 - Derm 5% - 1%
 - Family practice 5% - 1%
 - Other 4% - 1%
 - Peds 3% - 0.5%
 - Psych 2.5% - 0.5%
- The overall annual risk of being sued in a **high-risk specialty** was 16%, and of paying money to a plaintiff (*losing the case*) was 4%
- The overall annual risk of being sued in a **low-risk specialty** was 7%, and of paying money to a plaintiff was 1.5%
- **Median payouts** were as follows:
 - Neurosurgery \$215K
 - General surgery \$180K
 - Orthopedics \$100K
 - Anesthesia \$90K
 - Emergency medicine \$80K
 - Plastics \$60K
- **The cumulative career risk of a claim was 99% for high-risk specialties and 75% in low-risk**

- The cumulative career risk of having to pay a plaintiff in high-risk specialties was 33% vs 5% for low-risk

Bottom line: This data is old (10-15 years) but you get the picture. Most physicians, especially those who happen to take care of trauma patients, will definitely get sued in their lifetime. Any many will end up losing a suit. But this is not necessarily because they are taking care of trauma patients, only because of the specialty they ultimately chose.

Reference: Malpractice risk according to physician specialty. NEJM 365;7 629-636, Aug 18, 2011.

Not All Trauma Surgeons Are Created Equal

One of the problems with all the numbers presented above is that each specialty is lumped into one group. But could it be that some are more likely to be sued than other? Might it be possible to determine who they are? And to reduce their risk?

A group at Vanderbilt University speculated that a possible indicator of lawsuits to come was the **unsolicited patient complaint (UPC)**. These complaints can be subcategorized into specific issues such as communication problem, care/treatment issue, humaneness, access, environment, and billing.

On cursory exam, UPCs were not distributed evenly across all physicians. An analysis showed that physicians with UPCs were more likely to have risk management files opened and to be sued.

Data was reviewed from a 4 year period. Here are the factoids:

- About 4200 non-trauma surgeon records were compared to 55 trauma surgeons
- Non-trauma surgeons averaged 4 UPCs each, while trauma surgeons averaged 10 each
- **Care/treatment concerns were most common for trauma surgeons** (5 per surgeon), followed by communications (3), humaneness (1), and access (1)
- A risk score was calculated based on the number of UPCs per surgeon. Based on this number it was

possible to stratify them into low risk (no UPCs), moderate, and high risk categories

- **Trauma surgeons were more likely to fall into the moderate and high risk categories** than their non-trauma colleagues.

Bottom line: In most older studies, trauma surgeons were lumped in with other general surgeons, making it impossible to look at their specific risk for lawsuit. Some of these studies have suggested that trauma surgeons are at similar or lower risk than other general surgeons. This one examined the problem in a different way, and seems to indicate that they are at higher risk when patient complaints are considered.

It seems like a roundabout way of trying to answer the question. However, it does have merit. Department heads and risk managers may want to start scrutinizing complaint data. And if patterns emerge, early intervention may prevent emotionally and financial painful consequences in the future.

Reference: All trauma surgeons are not created equal: asymmetric distribution of malpractice claims risk. J Trauma 69(3):549-556, 2010.

Due to the wealth of interesting information on this topic, the July issue will continue with Medical Malpractice II.

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