

The 10 Commandments of Risk Management **By David S. Rubsamen, M.D., LLB***

The great majority of medical malpractice cases reflect fact situations that are repetitive. The restlessness of the anesthetized patient is interpreted as a reaction to light anesthesia rather than a response to hypoxemia; the feverish and listless infant with a poor suck is treated in a routine manner and the diagnosis of meningitis is not considered; the 32-year-old male with chest pain that is typical for an impending infarction is treated for muscle strain because he is “too young” to have a heart attack, etc., etc. Just as these specific errors keep turning up, there are broad generalizations which encompass a large fraction of the settlements or adverse verdicts which physicians experience each year.

1. Don't alter records. Altered records constitute such a vexatious problem for defense attorneys, it would be appropriate to make this the first **five** commandments. Consider the case of a family physician that saw a 3-year-old child at 5:00 p.m. on a Friday. The child had a low-grade fever and had been fussy all day. According to the mother, the doctor's examination was cursory. The patient was sent home. The mother was told to telephone if the child got worse. At 2:00 a.m., the patient could not be roused, and the mother rushed her to the hospital where a pneumococcal meningitis was identified. There was severe residual brain damage. The doctor learned of the patient's hospitalization the following morning. He immediately went to his office and obtained the child's chart.

In the record he wrote just eight words, filling in three lines which had not gone to the edge of the page. He indicated, “retinas OK, neck supple, child is quite alert.” These emendations were so obvious, it is difficult to think the doctor was trying to fool anyone. But the mere fact of the changes raised the question of deceit motivated by a guilty conscience. This was enough to dictate a million-dollar settlement. This occurred in a conservative venue, and it is quite likely the doctor would have prevailed if he had gone to trial, but for the record alteration.

Sometimes the record alteration consists of a lost page. This is about as bad as a written alteration, because it implies the page contained something adverse to the defense.

2. Keep good records. Every mistake is not actionable. The standard of care is not perfection, it is merely living up to a quality of practice which is represented by other competent physicians. With this in mind, consider the value of an excellent record by a caring doctor.

The patient was a 16-year-old high school girl whose family had been going to the same internist for 20 years. The mother brought her daughter to the doctor at 1:00 p.m. on a Tuesday afternoon. The girl had been sick since the previous day with fever and malaise. The internist's history and physical examination were

detailed. The patient's temperature was 102. The doctor specifically noted the neck was supple and Kernig's sign was negative. A white blood cell count was 9000, with 76 percent PMNs and four percent band forms. He sent the patient home with a diagnosis of viral infection. At 5:00 p.m. he phoned the mother to ask how her daughter was. He was told she was about the same and was resting.

At 10 p.m. she fell out of bed, and the family found her unconscious. She was immediately taken to a local community hospital, where the emergency medicine physician made the diagnosis of meningococcal meningitis, but delayed two hours before treatment was initiated. Disseminated intravascular coagulation was a complication. The outcome was amputation of both feet and the tips of several fingers. The lawsuit proceeded **only** against the hospital, and the case was settled for \$1 million.

Why wasn't the internist sued? I asked this question of the plaintiff's attorney, and he told me his medical reviewers were somewhat critical of the failure to investigate further after identifying the granulocytosis, but the detailed examination, and the fact the doctor called later that day, caused the attorney to omit him from the lawsuit.

3. When a complication occurs, don't continue in a routine manner. The classical situation concerns the anesthetized patient who experiences a cardiac arrest during anesthesia induction. Resuscitation is successful, then the anesthesiologist and surgeon decide there was no significant injury and the procedure continues as though nothing adverse had happened. There is no consultation with a neurologist, so the hypoxic brain damage experienced by the patient is not identified until he fails to awaken postoperatively. Thus, the opportunity for immediate treatment of the brain injury is lost. I have seen this reluctance to recognize possible error replicated in a variety of fact situations.

4. The inexperienced nurse must not be given an isolated post. When the recent nursing graduate is given the graveyard shift, because this is the least desirable duty, the stage is set for a disaster. A particularly poignant example concerns a nurse who had received her RN two months earlier. At 3 a.m. on her first night of duty on the pediatric ward, she was the only RN. She sought to suction the tracheostomy tube of an unconscious 5-year-old who was on a respirator. It was unclear just how the problem developed, but there was little doubt that the nurse's unfamiliarity with the equipment resulted in a cardiac arrest and death of the patient. Subsequently, the nurse abandoned her career.

5. Establish a rigid protocol for processing laboratory results. For example, when a PSA value of 8 is lost to follow-up because a laboratory slip is placed in a patient's chart without the doctor reviewing it, the defense will be at a loss. Or perhaps the laboratory does not telephone the emergency medicine physician about a panic value, and critical treatment of the patient is delayed for

a couple of hours. It is essential that every hospital and medical office establish an inflexible routine for communicating and reviewing all laboratory results.

6. Look at the record of the prior visit. This is especially critical where another physician has previously evaluated the patient. For example, there was the patient with retrocecal appendicitis who saw five different physicians at an HMO in the course of four visits on successive days. Each visit was at night, and no physician had the record of the previous visits to review. This was the reason for the failure in diagnosis and the patient's death.

7. Don't hesitate to refer a difficult case. My greatest concern about the managed care trend is that the specialist will not be consulted in a timely manner. Every plaintiff's malpractice attorney who has commented on the issue emphasizes that capitation plus a delay in referral equals an excellent malpractice case from the plaintiff's standpoint.

Whether or not the doctor's motive was an economic one, the plaintiff's attorney will probably be able to make it seem that way. Thus, from a strictly legal point of view, when managed care is combined with capitation there should be a heightened awareness of the need for timely referral.

8. The house staff requires appropriate supervision. This is particularly true for the intern or first-year resident. When a jury is convinced that an unsupervised trainee has exceeded the scope of his skills, an adverse treatment outcome will almost certainly be blamed on the failure of supervision.

9. Record your telephone conversations. Once the lawsuit is filed, the patient's memory can become highly selective. Even a brief notation about what the patient said and what the doctor advised can be of great help to the defense. When the doctor expands on his note, telling the jury in greater detail what was said on the telephone, his testimony will then be much more believable compared to a recollection unsupported by any note.

10. Carry adequate malpractice insurance. This admonition requires some emphasis. It is true that occasionally the plaintiff's attorney will not sue the uninsured doctor, because his case against insured co-defendants is fairly strong. Therefore, even though the uninsured physician might normally be the target defendant, the attorney may choose not to run the risk that this doctor might be hit with 100 percent of the verdict. But where the doctor is the only prospective defendant, he will very likely be sued if he has any assets.

For example, there was the case of an obstetrician who hospitalized a 21-year-old primipara at 35 weeks of gestation. She had moderate toxemia, and shortly after hospitalization the fetal heart rate dropped to 80. The doctor delayed an hour and a half before accomplishing a Cesarean section, and the outcome was marked brain damage. While the doctor had considerable assets, he refused

to settle the case. The jury's verdict was \$3.9 million. The doctor had been uninsured for the previous 20 years, and he explained that he didn't choose to obtain insurance because his hospital did not require this of the medical staff.

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