How to Keep a Bad Outcome from Becoming a Lawsuit

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ABSTRACT

Objective. The incidence of medical mal-occurrences associated with interventional pain procedures is increasing. This has resulted in a corresponding increase in medical malpractice tort claims. Therefore, physicians involved in performing interventional pain procedures must understand the malpractice tort system in order to both practice more safely, and to decrease litigation risk. Further, physicians must be aware of specific trends in both their own behaviors as well as the behaviors of their patients that may decrease the chances of being sued.

Design. We systematically searched the Medline Database and recent electronic pain journals and websites for relevant articles on the topic of interventional pain procedures and litigation.

Results. Medical errors are largely cited in the lay and medical literature. Specific ideal physician behaviors that may decrease risks of lawsuits were identified.

Conclusions. Physicians cannot control all the potential contributors to errors. What can be controlled is our knowledge, skill, diligence and perseverance. Ultimately, when an unfortunate outcome results, being honest and admitting any real or potential errors, forging strong relationships, and being able to say “I’m sorry” may be the best way to mitigate blame.

Key Words. Malpractice; Liability; Legal; Forensic Medicine; Medical Errors; Complications

Introduction

Analysis of American Society of Anesthesiologists closed claims suggests that litigation is increasing for chronic pain procedures [1]. Most claims involving pain medicine were related to invasive procedures; fully one-third of which were associated with a disabling injury. This was an increase from the previous two decades of 17%. Volumes of spinal injections during the related period from 1993 to 1999 increased by 123% [2]. During the same 7-year period, the actual number of cervical epidural injections performed increased by 377% [2]. Trends in specific procedural complications relative to the recent increase in cervical epidural injections can illustrate several important points. For example, in 2001, a series of reported and unreported occurrences of catastrophic injuries after cervical epidural injections began [3–7]. The previous closed claims studies predated these occurrences [1]. Lamenting this increase in procedural complications, Carette and Fehlings [8] called for a critical appraisal of the indications for cervical epidural steroid injections noting: 1) that the epidemiology of cervical radicular pain is often favorable to spontaneous improvement over time; 2) that the pathology of cervical radicular pain more often involves a mixed discogenic and degenerative vs purely discogenic cause (potentially less amenable to treatment with steroids); and 3) that procedural validation with category one evidence was lacking. Thus, Carrette and Fehlings ponder the whole issue of medical necessity. Is there conclusive evidence of malpractice in these cases? Post hoc analysis of these adverse...
Physicians worry to a variable extent about malpractice, differentiated from maloccurrence by an obvious violation of the standard of care, although it has been noted that most patients who are injured do not sue [12]. Most physicians believe the preponderance of lawsuits is frivolous, but a recent study of 1,452 closed malpractice claims where trained physicians analyzed the merit of these cases, contradicts this view. Eighty percent of the claims in this study were for injury involving disability or death. Unfortunately, in nearly 40% of claims, there was no demonstration that medical care was responsible for the injury. Of the discordant outcomes (27% of all claims), 10% involved a payment when no error had been made [13].

Most physicians truly want to improve their patients’ well-being, but both personal and system errors confound our ability to provide consistently optimal results. The complex interaction of system processes and multiple dynamic interactions with personnel and technology may produce a statistical inevitability for errors [14]. The publishing of “To Err is Human” by the Institute of Medicine [15] led to a great discussion and implementation of several safety themes, after the report detailed the occurrence of nearly 100,000 mortalities per year caused by medical errors. Many authors ask, however, what physicians can really do to improve patient safety and limit malpractice claims. Those factors that are under our control include our intellectual pursuit of the physician ideal: being well-informed on the latest literature, mastering complex technology to perform procedures and surgeries expertly and safely, being able to synthesize information about complex topics and mitigate risk in complicated situations, all the while factoring in the interaction of external psychosocial stressors. Those issues that physicians often cannot personally control include poor or outdated technology available to us from the clinic or health system we practice in, the demanding hours that we work and the resulting fatigue that results from overwork, requirements to see certain numbers of patients to meet financial or productivity goals, the competence and social skills of our health care colleagues (including nurses, other physicians, allied health personnel, and administrators), and other system-related problems. Further, a patient culture of “blaming someone” and seeking retribution or compensation for errors or injuries seems to be operative in health care [14]. Indeed, in a survey of patients in a large health plan, 39% of respondents felt that the physician should be punished when their care led to a medical error [16].

Standard of Care

In the event of a malpractice claim, it is necessary that physicians understand the requirements for a physician–patient relationship. While legal definitions of Standard of Care may differ from state to state, most include physician activity that “a reasonably prudent and competent physician with the same or similar training would do in the same or similar circumstances” [17]. Formerly, regional or local standards of care have become nationalized due to national graduate medical education standards and board certification requirements. Medical malpractice is a type of tort claim, where the physician as the defendant has allegedly breached his duty to the patient or their representative, the plaintiff. Technically, for a successful legal outcome, the plaintiff and their expert testimony must demonstrate the following four elements: 1) that a physician–patient relationship existed, defining the “existence of duty”; 2) that a breach of duty occurred, which is established by greater evidentiary “proof” that the care was not consistent with the standard of care; 3) that harm, either physical or mental morbidity or mortality, occurred to the patient; and 4) that the harm to the patient was directly and causatively related to the negligent action or inaction of the defendant [17].

As a discipline, Pain Medicine has not established guidelines for expert witnesses, but other related specialties are attempting to improve expert testimony. The American Academy of Neurology, for example, has established what the key elements of expert testimony should be, what qualifications the expert should possess, and the guidelines by which they should perform their duties [18]. Similarly, the American Association of Neurological Surgeons has recently established clear guidelines for expert neurosurgical testimony [19]. Many states are adopting expert witness regulations as a part of the Medical Practice Act.
For example, in the state of Illinois, for a radiologist to provide expert testimony on a particular procedure, they would have to be not only Board certified in the specialty, but actively involved in the practice of the particular procedure in question [20].

**Physician Ideal Behaviors**

Patients have specific expectations for their physicians. In a recent study, seven ideal behaviors that patients desire of their physicians were identified. These attributes included: 1) being confident; 2) empathetic; 3) humane; 4) personal; 5) forthright; 6) respectful; and 7) thorough. Of these seven, the physician’s thoroughness was the most often mentioned attribute [21]. While achieving and maintaining professional competence is critical to provide high-quality patient care and to avoid malpractice claims, aspiring to these ideal behaviors can significantly mitigate against poor outcomes leading to malpractice suits. Physicians who exhibit caring behaviors to their patients are likely to enjoy mutually respectful and healing relationships [22].

**Relationships**

Developing warm and respectful relationships with your patients is extremely important, and physicians should get to know each one as more than a specific procedure for that day. One should endeavor to remember details about each patient, and potentially, their family or friends as well. Specific details about such topics as children, hobbies, or personal anecdotes provide for deeper relationships. Demonstrating such a level of interest in one’s patients engenders trust and goodwill. Sending brief cards or comments may be useful as well if they are personal in nature. Actively listening to patients’ concerns and responding to their questions will foster a spirit of shared commitment and partnership in their health care. The American Academy on Physician and Patient recommends the mnemonic PEARLS for relationship building: Partnership, Empathy, Apology, Respect, Legitimization, and Support. These further send the important message that “I will not abandon you.” They contend that the purpose of the medical interview is not only to derive medical information, but also to provide patient education and to build relationships [22]. Relationship building is often enhanced by asking “what else?” or making statements such as “you seem sad” to get at the core reasons for the visit [23]. The results of a “Trust in Physician Scale” completed at 20 community-based family practices suggested that being comforting and caring, demonstrating competence, encouraging and answering questions, and explaining were strongly predictive of patient trust [24].

**Knowledge**

To appear competent, the physician must have command of the literature including awareness of recent updates, consensus or practice guidelines, and new research findings. To appear competent, they must also be confident without projecting condescension or arrogance. One should be aware of recent media reports of advancements or complications of medical care as patients will almost certainly have been exposed to this information. Case reports about specific procedures or medications and related complications are the first inclination of potential trends in many cases. For example, the first case report of catheter tip granuloma associated with implantable intrathecal infusion pump delivery of morphine was a full decade ahead of substantial consensus guidelines and eventual animal studies to determine their cause [25].

Attendance at national meetings and reading the journals of societies with a specific focus on pain medicine and neuromodulation will provide the practitioner with state-of-the-art knowledge as well as developing trends in pain therapy.

**Informed Consent and Documentation**

In order to minimize medico-legal risk, it is paramount for the physician to document an informed consent discussion with the patient that contains the goals of the therapy, alternatives to the proposed care, probable outcomes and risks that a patient should know about, as well as a discussion of advanced directives, and the roles of other team members. If such documentation is not created, it will be difficult to defend that the details were covered or that this interaction actually occurred. The patient’s signature on an informed consent document is one method of insuring that an informed consent discussion was performed. Specific issues regarding informed consent should be decided with the legal counsel for each physician’s practice.
Comprehensive documentation in your medical record, such that care could be assumed by another physician, not only provides for high-quality patient care but will also minimize medico-legal risk [26]. If procedure templates are used, they should be modifiable to thoroughly document aberrations. Altering the medical records after they have been finalized will be seen by plaintiffs’ attorneys as fraudulent. If changes are needed, for example, if a factual error was noted in the record, a single line through the statement should be drawn and the reason for the change should be written or dictated and transcribed. Alternatively, a changed note should be dictated indicating the time, date, and nature and reason for the change.

Disclosure of Medical Errors

Factual and full disclosure of all errors should be made. For unclear reasons, this straightforward and honest approach is often most difficult for physicians. Nonetheless, patients want their physicians to make a statement that 1) an error has occurred; 2) the nature of the error; 3) why the error occurred; 4) how the recurrence of the error will or can be prevented; 5) an apology [27]. According to Berlin, the essentials for an “authentic apology” are: 1) acknowledgment that a rule was violated; 2) admission of fault for the violation; 3) genuine remorse and regret; and 4) an offer of restitution and promise of reform [28]. There is evidence that a sincere apology can reduce the incidence of litigation [28]. Unfortunately, Taft states that a botched apology may make things worse, as it may engender more anger from the patient [29]. Equally disturbing is that in many cases, a lawsuit will result regardless of the physician’s honesty and apology [28]. Notification of parents regarding errors involving children will decrease litigation for all but the most severe errors by 36%. Unfortunately, severe errors involving children are more likely to result in litigation [30]. Although several states have laws that protect physicians from apologetic statements made to patients being subject to discovery, only Colorado has a statute that covers admissions of guilt to patients [28]. Many malpractice insurers and plans may not allow apologies to be made without violating coverage issues. A recent Washington law grants immunity if the apology is given to the patient within 30 days of the incident [31]. Individual physicians should know their state statutes and insurers policies regarding medical error apology.

Immediate Actions

If one receives a letter of intent to sue, the following steps are recommended: 1) notify your malpractice carrier immediately and copy the letter to them; 2) after each mal-occurrence you are aware of, make a file separate from the medical record of additional recollections with as much detail as you can remember. If this was not done, review the medical records you do have, and try to reconstruct what happened, making copious notes about the case; 3) review the medical literature pertaining to the topic; 4) be polite to the patient and do not confront them if seen; 5) do not talk to your colleagues about the case; and 6) do talk to your spouse or partner or someone who can provide emotional support [32].

Final Recommendations

According to Rice, there are 10 ways to guarantee a lawsuit. These include 1) not keeping detailed records; 2) not documenting informed consent; 3) “fixing the record” after injury has occurred; 4) trusting the patient to follow through on testing; 5) not tracking test results; 6) not reconciling medications and allergies; 7) diagnosing over the phone; 8) not caring if your patient likes you; 9) assuming each patient needs only a few minutes; and 10) not saying anything when an error or bad outcome does occur [26]. Perhaps the best advices are:

- Develop strong relationships with your patients, be conscientious and available to them, and answer their questions.
- Develop a culture of safety in your practice to minimize risks of error, constantly looking for ways of improving systems of care.
- Full disclosure of medical errors to patients, owning up to the error, and providing excellent aftercare of the patient.

It is important to recognize that physicians can, and do, make errors while practicing within the standard of care. We are not required, nor can we practice, entirely error-free. What is required is that we do whatever we can to minimize the risk of these errors and their negative impact on our patients. This is accomplished by ensuring that we are well trained, competent, and up to date in our medical knowledge. This is not, however, enough to prevent malpractice suits should a bad outcome occur. We must also ensure that documentation exists to support our care of the patient and that we have demonstrated our competence, honesty, concern, and empathy for our patients.
References


