Protecting Yourself Against Medical Malpractice Claims, Part 2

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In the December issue of JUCM, *Dr. Shufeldt introduced a discussion on how to not be named in a malpractice suit by suggesting that providing excellent customer service, never saying "no" to a patient, and thorough documentation of the pertinent positives and negatives are viable techniques to reduce your malpractice exposure. Here, he continues the discussion with other precautions you can take.*

Failure to make an appropriate referral is a reason commonly cited when providers are sued. This broad category includes failure to suggest hospitalization, failure to call for a consult, and failure to prescribe a specific plan or treatment. For example, if a patient admits to being a smoker and you diagnose bronchitis or some other respiratory condition exacerbated by smoking, your chart or aftercare instructions would be incomplete if you did not discuss—and document—smoking cessation as part of the treatment plan.

This may sound painfully obvious, but I assure you that cases have been lost for even more trivial reasons than that. You don't want to be the defendant when the patient is on the witness stand testifying that, "If the physician had only told me to (lose weight, quit shooting heroin, quit smoking meth, wear a helmet, etc.) I would certainly have followed his advice and altered my behavior. I had no idea that was dangerous!"

If you are treating a patient whose symptoms, exam, and lab findings are not adding up, or if your gut is telling you something is wrong with the patient despite your objective findings, trust your gut! I cannot tell you how many *horrendomas* I have found purely through dumb luck and listening to my gut.

The "out" we have in urgent care medicine is simply to tell the patient that their symptoms, exam, findings, etc. warrant further evaluation in the hospital. Document your discussion, copy your notes for the patient to give to the emergency physician, and send them off to the ED.

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Err on the Side of Caution

Since we do not typically have an ongoing relationship with the patient or the patient's family, it is much better to err on the side of caution. That includes treating the patient even if only "soft" evidence is available.

For example, I would manage patients who present with a sore throat and have a negative rapid strep and no evidence of mono by writing scripts for pain medicine and an appropriate antibiotic with the admonition to not fill the antibiotic prescription unless the symptoms worsen or are no better after two more days.

Before the evidence-based crowd calls for my head on a platter, consider this: Rapid streps are notoriously unreliable, patients with a viral sore throat will usually be better in two days, and very often patients who do not "get a prescription like my regular doctor gives me" simply go to their PCP to get the script you refused to give them and incur the cost of two visits. Again, I know this is not evidence based; however, it is practicality based and much more patient friendly.

You may have heard the statement, "every patient is a potential plaintiff." Unfortunately, this blatantly pessimistic statement is true. As providers, we must evaluate every patient as if we will be sitting across the mediator's table—or worse, the courtroom—from them.

In emergency medicine, we are obligated to take all comers; we do not have the luxury of dismissing patients from our practice. This is not true in urgent care medicine, however. If you are faced with a patient who is unruly or rude or repeatedly noncompliant or abusive, you do not need to continue to provide care for them. In fact, if it is their first visit and they are abusive in the waiting room, take this an omen that you will ultimately not want them in your practice and ask them to seek care elsewhere.

Call for Articles

The *Journal of Urgent Care Medicine* (*JUCM*), the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

Physicians, physician assistants, and nurse practitioners, whether practicing in an urgent care, primary care, hospital, or office environment, are invited to submit a review article or original research for publication in a forthcoming issue.

Submissions on clinical or practice management topics, ranging in length from 2,500 to 3,500 words are welcome. The key requirement is that the article address a topic relevant to the real-world practice of medicine in the urgent care setting.

Please e-mail your idea to
JUCM Editor-in-Chief
Lee Resnick, MD at
editor@jucm.com.

He will be happy to discuss it with you.

Once you start treatment, however, you are obligated to complete it for the particular episode of illness. If it is a recurrent patient, send a certified letter advising them that they should seek care elsewhere and provide a list of other urgent care centers. Also, tell them you will continue to see them over the next 30 days but after that you will no longer provide any services. A certified letter in the urgent care environment is probably overly cautious, but it covers the bases for a claim of patient abandonment.

Beware the Minimizer!

Minimizers are patients who are often "forced" to seek care by loved ones who may have been clued in to some change in behavior or condition that has them concerned. One common chief complaint that I have heard countless times when asking males why they are here today is, "I don't know; my wife made me come in."

These patients should set off alarms. This is the 55-year-old, out-of-shape guy who complains of intermittent, reproducible shoulder pain aggravated by the "honey dos" that his significant other has him performing. He's the same guy who walks you down the path of a repetitive trauma condition or muscle strain and is discharged after a negative shoulder x-ray and no EKG, then drops dead of a myocardial infarction.

When you sense you have a patient who is "dismissive" of his own complaints, be aware that the non-issues may be a harbinger for serious illness.

You may have also heard this before: "I would like to have that test, but I just can't afford it," or, "Can't you just treat me, I am sure I am fine." Basing prescribed treatment on the patient's financial status is wrought with danger. Clearly, some patients cannot afford the "correct way" to work up an issue. However, this should not stop you from ordering the test, medications, etc., and allowing the patient to decide whether or not to spend the money.

This is the basis of informed consent: giving patients enough information to decide for themselves after weighing everything. Remember, "cost effectiveness" does not carry weight in a standard-of-care determination. The take-home point here is to practice good medicine, foster informed consent, and document everything.

Ultimately, not being named in a malpractice suit requires a good deal of luck. However, avoiding issues commonly cited as reasons that providers are named in suits will also lower your chances for ending up at the defendant's table.

In summary, being kind and respectful to patients and families, thoroughly documenting the treatment and the plan, facilitating informed consent, identifying the patient who is noncompliant, abusive or minimizing, and not letting patient's finances dictate your prescribed treatment will significantly reduce your risk of being named in a malpractice suit. ■