How to Get Sued for Malpractice: Four Studies In Self-Destruction

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In the past, I have written about how to *avoid* getting named in a medical malpractice action. But it can often be instructive to view things from the opposite perspective. So this time, let's turn it around and actually try to get named in a malpractice suit. It usually only takes one of the following misadventures:

- Practice bad medicine and have a bad outcome
- Practice good medicine, communicate/document poorly, and have a bad outcome
- Upset the patient or his family, or equally badly, have a staff member who upsets them, and *then* have a bad outcome
- Falsify or attempt to change the record no matter what the outcome

Here are four cases from my files that illustrate how easy it is to get yourself sued.

Bad Medicine and Bad Outcome

A 34-year-old female accountant presented at an urgent care center with a low-grade temperature, and she was feeling weak. The tech pushed her in a wheelchair to an exam room and took her vital signs, which were abnormal (pulse 120, respiratory rate 36, BP 100/42). The patient, however, was not thoroughly examined, no tests were ordered, and she was discharged with an anti-anxiety medication and told to rest.

The chart was poorly documented and not completed until the end of the day—after the clinic staff had learned of the patient's death from the medical examiner.

A chart review was performed after the center and provider were named in a malpractice suit. Based on vicarious liability, negligent supervision, and poor credentialing. The provider was named for his care, which was believed to be subpar. The defense could not find an expert who could support the care the patient received. Ultimately, both the center and provider agreed to pay the financial limits on their malpractice policy.

Poor care and poor documentation are the most common causes of malpractice suits. In this case, the young woman died of overwhelming sepsis secondary to pneumococcal sepsis. Had this happened after proper treatment and charting, the plaintiff's attorney would have had a hurdle to overcome to make the case on the basis of causation; if the diagnosis had been made correctly and the patient aggressively treated, the defense could then have argued that no matter what had happened, the patient's fate would have been sealed.

However, the case never made it that far. The care was so bad and the chart so poorly documented that the defense team offered the $2 million policy limit.

Lesson: use care paths, force yourself to document the pertinent negatives, and remember that as a provider, you may be the last person to have an impact on a patient with a life-threatening problem.

Good Medicine, Poor Documentation and Communication

A 47-year-old female presented to an urgent care with intermittent, right-sided chest pain that worsened with exertion, mild shortness of breath, and fatigue. She had a family history

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of coronary artery disease and was a smoker. Her exam and chest x-ray were normal. Her ECG showed non-specific changes only. No cardiac enzymes or other lab tests were drawn.

According to the patient's deposition, the physician verbally advised her to go to the emergency department for further evaluation. The note on her chart read: "Advised patient to go to the ED for further work up." The diagnosis in her chart was: "Chest pain, etiology to be determined."

The patient elected not to go to the ED that day for further workup. Three days later, she suffered an MI and underwent emergency angioplasty and stent placement; she was on a balloon pump for cardiogenic shock for about 16 hours. She ultimately survived, but her ejection fraction was only about 35%. The patient sued the provider for negligence on the theory that her care was below the standard.

A review of the care found the history, physical, and evaluation to be adequate, save that cardiac enzymes were not drawn in the urgent care center, as they should have been. The legal issue ultimately centered on appropriate informed consent. Was the patient advised of the risks of not going to the ED to complete treatment?

The plaintiff argued that although she may have been told verbally to go to the ED (which she denied), and although this advice was in her discharge instructions, the significance of abandoning her workup while still in progress had not been made clear to her. Had she known how bad the outcome could have been (and was) of not completing her workup, she certainly would have proceeded directly to the ED. The provider ultimately consented to a settlement and the plaintiff was paid an amount slightly below policy limits.

Lesson: when the patient has a condition that is causing or could cause serious morbidity or mortality, document the instructions thoroughly.

Staff or Provider Upsets Patient or Family

A 32-year-old male with a history of intravenous drug use presented at an urgent care for the fourth time in six days for low back pain. He stated that his pain was not improving and demanded more pain medication. Documentation on the triage note stated that the patient was rude and argumentative to the front office staff. His vitals at the time of treatment were: pulse 104, respiratory rate 18, BP 158/92, and temperature 39.0° C. Since it was the patient's fourth visit in less than a week and his complaints were generally unchanged, the provider performed a very cursory exam.

In addition, the provider confronted the patient about his previous IV and now prescription narcotic addiction, essentially accusing him of trying to feed a drug habit. The diagnosis on the chart read: "Back pain, narcotic abuse, and drug-seeking behavior." The patient was not given more pain medication. Instead, he was escorted in a wheelchair to the door and made to walk to his car.

Three days later, the patient was unable to ambulate, incontinent of urine, and in severe pain. An ambulance rushed him to the ED where he was found to have acute cauda equina syndrome from an epidural abscess. Ultimately, the patient underwent emergent surgery to drain his abscess. Despite aggressive treatment, he remained wheelchair-dependent and had to self-cath. He died 18 months later of complications from urosepsis, skin ulcers, and narcotic abuse.

The family sued the center and the provider, who both agreed to settle the case for policy limits after the care and documentation were reviewed and could not be supported by their expert.

Lesson: be nice. Life is too short—and the risks too high—to treat a patient (or anyone) disrespectfully; it always comes back to haunt you.

Falsify or Inappropriately Alter the Patient Record

This is a no-brainer way to get sued big time. No matter how good your care was or how much the patient was responsible for his outcome, if you alter or falsify the chart, you are going to get nailed.

A 14-year-old presented to an urgent care with abdominal pain. His vital signs were normal; a brief history was ascertained and documented. The physical exam was described in the chart as: "No tenderness to the mid-abdomen"; the rest was reportedly normal. The patient was discharged after a urinalysis was obtained and was "dipstick normal." His discharge instructions were: "Go to the ED for further tests. You may have appendicitis."

Two days later, the patient reappeared at the urgent care with a high fever, rigid abdomen, and peritonitis. He was seen by the same provider as before and immediately sent to the ED, where he underwent surgery for his ruptured appendix. After a rocky post-op course, the patient recovered completely.

The family sued the provider for failure to diagnose appendicitis on the first visit. A review of the care and the electronic record did not initially raise any red flags—until the plaintiff's attorney noticed a discrepancy in the discharge instructions and subpoenaed the actual electronic log of the medical record. This log revealed the time and date of all keystrokes entered into the chart, as well as who was logged into the record at the time.

Right after the patient was sent to the ED on the second visit, the provider went back into the electronic record of the patient's first encounter, which had not been closed out, and typed the word "No" before "tenderness to the mid-abdomen." He then deleted "F/U with PCP in a week," instead adding: "Go to the ED for further tests. You may have appendicitis."

Despite the patient's complete recovery, the insurance company agreed to pay policy limits and dropped the provider and center as clients.

Lesson: I can almost always find some redeeming aspects of a patient's care and treatment—until, that is, it is found that the chart has been altered. Then all bets are off. ■