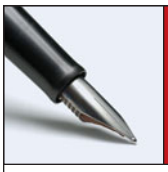

Once You're in Court, Your Documentation May Be All That Can Save You

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"It's lonely being the defendant in a medical malpractice case."

Truer words were never spoken. At some point in our careers, the majority of us will be named in a medical negligence case. The unfortunate reality is that medicolegal issues will arise as a part of our professional lives along with a multitude of negative emotions (which inevitably spill over into our *personal* lives) when we stand accused. These negative feelings, thankfully, can be avoided altogether with a proper understanding of how best to avoid—or at least prepare for—a malpractice case before it even occurs.

The lessons I've learned have come from both personal experience as a defendant in two malpractice cases very early in my career (both of which were dismissed during discovery), as well as subsequently providing expert review of numerous cases for attorneys. Through this I've realized the most important factor for a viable defense is clear documentation of your thoughts, especially in the medical decision-making (MDM) component of the medical record.

Now, you may be thinking: *We've heard this before. – If it's not written, it wasn't done.* However, I cannot state emphatically enough how often poor documentation has led to settlements that could have been avoided had the provider's thought process been explicitly charted and not assumed.

The sad reality is that once you are put in the position of having to defend your medical decisions in court, you will realize just how much weight is placed on your documentation. The process of having to defend your medical decisions is a somber one. You will feel isolated. It will be difficult to ever feel at ease while you replay the case over and over in your mind. You won't be allowed to talk to your own experts, and you'll be left with nobody to speak to about any of it except for your attorney.

What are some of the toughest times as a defendant? Certainly, while having to defend your care, the plaintiff will make terrible allegations against you. You'll be called a liar and a falsifier of records, and incompetent. You won't be permitted to tell your story as you would to a colleague; the plaintiff will question you and try to get you to tell the story the way they want. They'll purposely make statements and ask questions they know will be stricken from the record, just so the jury will hear them anyway.

You may begin to have doubts about yourself and your capabilities as a clinician, as well as about the fairness of the legal process all together. Through all this, the only thing you can rely on and that is under your control—long before you're in court—is your own documentation.

This is the major difference for clinicians who are able to go

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through the process with confidence when named in lawsuits and those left wrecked with stress.

The article *See You in Court: Practice and Documentation Change from a Mock Trial* (*JUCM*, January 2022), dealt with a mock trial involving an emergency department case with many clinical issues which would have made the medicolegal defense troublesome.[1]

To recap, the patient described presented with symptoms consistent with an acute MI, confirmed by ECG; 49 minutes after presentation and consultation with both an interventional cardiologist and the on-call hospitalist, the patient was admitted to the ICU. During the night, he continued to have chest pain and another ECG was indicative of an anterior STEMI. Subsequently, the patient was finally taken to the cath lab and the culprit left anterior descending (LAD) lesion was stented.

Despite the intervention, the patient progressed to cardiogenic shock.

The simulated trial was viewed by participants ranging from medical students to attending physicians. The attendees heard allegations of "failure to diagnose" and "delay in diagnosis" presented by the plaintiff. Although the vast majority of participants maintained that the defendant in the mock trial met the standard of care, a large percentage also stated that they planned to change both their future medical practice and documentation practices as a result of having viewed the simulation.

What I can say from experience reviewing similar cases is that the plaintiff's legal team would have many questions regarding the time that elapsed from initial presentation to definitive cardiac intervention, stating emphatically that the delay led to the level of harm that reached the patient. While I did not have the privilege of reviewing the medical record, clearly the outcome of the case would hinge on the clarity of documentation from the interventional cardiologist as to why the patient was not taken to the catheterization lab initially upon presentation.

Questions we could expect to be raised would include:

- Why did almost 6 hours of time lapse from the initial presentation to deterioration before cardiac intervention ensued when the diagnosis was never in question?
- What did the hospitalist do to monitor the patient's clinical status?
- What did the emergency physician discuss with the cardiologist when he initially spoke to him?

I can also say from experience that the defendant's legal team will have a much easier case to defend if there are clear answers to these questions contained within their client's own documentation.

The immediate management of acute coronary syndrome is relatively well established. To briefly review, patients with suspected ACS should be *promptly* evaluated and treated because the benefits of reperfusion therapy are greatest when initiated quickly. The diagnosis is made based on patient history, ECG, and cardiac biomarkers, which delineate between STEMI and non–STEMI. Rapid reperfusion with primary percutaneous coronary intervention (PCI) is the goal when coronary occlusion is suspected.

"If your care in these high-risk scenarios is clearly documented, your case will hold less appeal to would-be plaintiff's attorneys and you may just save yourself from being named in the lawsuit in the first place."

If PCI cannot be performed rapidly, patients with STEMI can be treated with fibrinolytic therapy. Coupled with appropriate medical management, PCI can improve short- and long-term outcomes following acute MI. Post myocardial infarction care should be closely coordinated with a cardiologist to ensure appropriate secondary prevention strategies to prevent recurrence, morbidity, and mortality.[2]

If you have a modicum of acute care experience, this is likely obvious to you. However, if this is not how the patient's care proceeds and a lawsuit ensues, the explanation for the deviation better be clear in your documentation. It might even be clear to the attorneys who are doing their best to convince the jurors that a poor outcome was all your fault. As far as the jury is concerned though, outside of what was written, it's just your word against the patient's (who is someone they can identify with, mind you). Anything you say on the stand often comes off as revisionist rationalization to save your own skin—unless there's a written, real-time document illustrating that you did everything you were supposed to do at the time, according to your training and the standard of care.

Based on my experience and what I've learned about how malpractice attorneys think, I believe this case would have been difficult to defend and likely would have been settled. Certainly without thorough documentation to explain the delays in care the defendants would have little hope. What we all know to be obvious, but which time and time again is deficient in medical records, is clear documentation as to why you are, and why you are not, performing a medical intervention for a patient. As a matter of fact, if your care in these high-risk scenarios is clearly documented, your case will hold less appeal to would-be plaintiff's attorneys and you may just save yourself from being named in the lawsuit in the first place. ■

References

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