

# the Reporter

## State profiles make malpractice information public

By Laura Brockway

*“Settlement of any claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice occurred.”<sup>1</sup>*

### Introduction

The above disclaimer appears on the Massachusetts Board of Registration in Medicine’s web site in an attempt to put into context information that was once unavailable to the public. Fueled by reports of medical errors and a push for patient safety, all 50 states and the District of Columbia have internet-accessible, searchable databases for physician license information and disciplinary actions on state-supported web sites. And while these types of physician profiles remain relatively uncontroversial, a growing number of states have added physician malpractice information to their profiles.

“Although the reporting of disciplinary and criminal actions by courts, medical boards, and hospitals is potentially the most damaging to a physician’s reputation, the likelihood of a physician being subject to one or more of these actions is small. However, the same is not true for medical malpractice actions. It is almost inevitable that a practicing physician will, at some point, be sued by a patient.”<sup>2</sup>

Currently, 13 states make malpractice settlement information available online. Most follow the Massachusetts model, described in this article, and include only the number of settlements made with the amounts categorized as either below average, average, or above average. In addition to the malpractice information, some states also post hospital restrictions and criminal convictions. Florida makes the most information available, listing all judgment and settlement amounts. Three states make malpractice settlement information available, but not online.

This article will review the type of malpractice information available on Texas and other state profiling systems, and will discuss issues surrounding their significance to patients.



## Massachusetts

Available at [www.massmedboard.org](http://www.massmedboard.org)

Massachusetts became the first state to adopt a profiling system in 1996, allowing the public access to an unprecedented amount of information on physicians. The legislation was enacted against a backdrop of consumer frustration with the Massachusetts Board of Registration in Medicine's lack of ability to sanction physicians and the board's unwillingness to disclose disciplinary information. In 1994, this dissatisfaction was further fueled when *the Boston Globe* published a series of articles on medical malpractice and the Board's inability to discipline physicians who had been sued repeatedly for malpractice.

Facing intense public scrutiny, a special committee was convened to investigate the newspaper's charges. At the same time, the Massachusetts Medical Society, convinced some form of profiling legislation was inevitable, had its own profiling bill introduced.<sup>2</sup> "The Massachusetts law is a scaled-down version of a proposal that would have required the disclosure of all complaints and of all malpractice claims, whether they have been proven or not."<sup>3</sup>

The Massachusetts physician profiles system incorporates malpractice data into its physician profiles, but that information is put into context. Only the number of paid claims for an individual physician is listed, but it is compared to those of other physicians in that same specialty, and it is explained whether payments were average, below average or above average for the specialty. The profiles do not include specific payment amounts or the number of suits filed against a physician. Malpractice information is also accompanied by a lengthy disclaimer, intended to put the information in context.<sup>1</sup>

In its first full year of operation, the Board took approximately 30,000 phone calls, received 1.6 million hits on the web site and faxed 58,000 profiles.<sup>4</sup> Proponents of the Massachusetts profiling system predicted that the availability of "this kind of information widely and in such detail is a harbinger of what other medical boards and health care networks will do."<sup>5</sup>

## Florida

Available at [www.doh.state.fl.us/mqa/Profiling/index.html](http://www.doh.state.fl.us/mqa/Profiling/index.html)

In the two years that followed the implementation of the Massachusetts system, five states passed similar legislation incorporating malpractice information into the physician profiles.<sup>6</sup> One of those states, Florida, "departed from the standard set by Massachusetts in an important, and perhaps, troubling way."<sup>1</sup>

Florida profiles are available through the Florida Department of Health. In addition to including basic background information, Florida physician profiles incorporate criminal offenses, final disciplinary information from licensing agencies, specialty societies, health maintenance organizations, hospitals, and a description of the level of malpractice coverage for each physician. Malpractice information is made available by the Florida Department of Financial Services, and includes the actual dollar amounts of settlements and judgments. Florida also makes information on pending malpractice claims available to the public.<sup>7</sup>

## California

Available at [www.medbd.ca.gov/](http://www.medbd.ca.gov/)

Like Massachusetts, California's most recent profiling legislation came about after a series of newspaper articles attacked the California Medical Board's function as a public watchdog group. The newspaper filed an open records request for all malpractice settlements reported to the California Medical Board. (California law requires the board to collect reports from insurers on mal-

practice indemnity payments of \$30,000 or more.) An injunction was eventually issued to keep the records from the public, but legislation was introduced to make those reports public. A compromise bill, ushering in the "three strikes" rule, was passed and became effective January 1, 2003.<sup>8</sup>

The law requires the board to make public records of malpractice settlements when a physician has three settlements in excess of \$30,000 in a 10-year period. High risk specialties are subject to a four-strike standard. Only settlement reports submitted to the board after January 1, 2003, count toward the total three strikes against a physician. Settlement amounts are identified as below average, average and above average for the medical specialty.<sup>8</sup>

## Texas

Available at [www.tsbme.state.tx.us/](http://www.tsbme.state.tx.us/)

Physician profiling legislation was passed in Texas in 1999, and was revised in 2003. Texas physician profiles, which are available on the web site of the Texas State Board of Medical Examiners, include the following:

- information about education and training;
- patient services such as Medicaid acceptance;
- accessibility for persons with disabilities;
- hospital privileges;
- any language translation services offered;
- a description of any criminal charges, disciplinary actions taken by the TSBME or another state licensing board;
- the results of any investigations the Board conducted as a result of malpractice claims (the board investigates when 3 malpractice claims are reported within a five-year period); and
- a description of any medical malpractice claim against the physician for which the physician was found liable, a jury awarded monetary damages to the claimant, and the award has been determined to be final and not subject to further appeal.<sup>9</sup>

## Is malpractice data predictive of quality care?

*"Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence."*<sup>1</sup>

One of the main arguments against public dissemination of malpractice information is that reporting such data will not reliably allow consumers to choose better physicians. ". . . it is not known whether, and to what extent, there is a link between a physician's malpractice history and his or her level of expertise. There has been much research to suggest that whatever link is present may be weak at best."<sup>2</sup> The research includes the following studies.

- A study published in the *New England Journal of Medicine* determined it was the severity of a patient's injury that was predictive of a malpractice payment, not the occurrence of an adverse event or the occurrence of an adverse event due to negligence.<sup>10</sup>

- In a study from *JAMA*, researchers reviewed the relationship between a physician's malpractice history and later claims, and concluded that "claims history is not a measure of technical medical competence and is certainly no measure of value of a physician to society."<sup>11</sup>

- If quality of care is not a major determinant of malpractice litigation, what is? A study published in *JAMA* found that a history of malpractice claims is indicative of a physician's interpersonal skills. "Physicians who have been sued frequently are more often the objects of complaints about the interpersonal care they provide even by their patients who do not sue."<sup>12</sup>

"So given the weak link between malpractice and expertise, what of states such as Florida that report malpractice information in the actual dollar amount, but at the same time, fail to provide

any contextual information save for a brief warning regarding settlements.”<sup>2</sup> What is a patient to conclude when he reviews the profile of a physician with no disciplinary actions, exceptional credentials (education, hospital privileges, awards, publications), but who also has a one million dollar paid claim?

“If advocates cannot set forth a more direct relationship between malpractice and physicians’ behavior, however, the publication of malpractice information will provide only a confusing message to the public . . .”<sup>13</sup>

### How do patients use the information?

“To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality health care by selecting a doctor based solely on malpractice history.”<sup>2</sup>

The question remains, do patients use the profile information to choose physicians? Recent evidence suggests that only a small proportion of patients rely on profiles. “Recommendations of family, friends and physicians are the consumers most trusted sources of information in selecting health plans and providers.”<sup>14</sup>

*Health Marketing Quarterly* published an article examining the way patients assess the quality of health services. Researchers polled 2,006 adults about their health care decisions. The patients were asked to rate the amount of influence a selected group would have when it came to choosing a new physician. The top three categories were: “your regular doctor or other individual doctors”; “friend or family members”; and “patients who are surveyed about their satisfaction with quality of care.” Less than 20 percent of patients rated institutional sources (such as medical societies, media, consumer groups, employers and government agencies) as having “a lot of influence” on their choice of a new doctor.<sup>15</sup>

In another study published in *Quality Health Care*, Marshall et al concluded from their literature review that consumers rarely searched for information on the performance of hospitals and providers, and that when such information was available, they did not understand or trust it.<sup>16</sup> The Kaiser Family Foundation came to similar conclusions based on a national survey of health care consumers. They found that only one out of 10 Americans has used quality information for comparing health plans, hospitals and providers.<sup>17</sup>

“Although more and more consumers are using the internet to access health information, there is no evidence suggesting a major change in how they select, use or evaluate health care.”<sup>18</sup>

### Future directions

“You may wish to discuss information provided in this report, and malpractice generally, with your doctor.”<sup>1</sup>

Since the Massachusetts database began operation in November 1996, consumer groups and the media have continued their attempts to expand the availability of malpractice data to the public. New Jersey’s new physician profiling law takes effect in June and those profiles will include “any malpractice settlement that has been paid out.”<sup>19</sup> However, patients will not have to wait until June, thanks to a New Jersey newspaper. In January 2004, the New Jersey Superior Court ruled that the state must release notices of medical malpractice settlements it has received from the past five years to the public. The case was brought against the state by *the Record*, which requested all notices submitted within the last 10 years to the state Medical Practitioner Review Panel. The paper had recently published a series of articles critical of the review panel.<sup>19</sup>

Despite the weak correlation between malpractice history and physician competence and the evidence suggesting that few patients use the profiles, why is there such a demand for access

to malpractice data? Greenwood, writing in the *Journal of Legal Medicine*, offers a plausible explanation. “By the media’s reporting so prominently examples of misconduct by physicians with a history of disciplinary problems . . . many consumers may get the impression, perhaps correctly, that medical boards lack the desire or ability to prevent these physicians from practicing medicine. And by reporting so prominently other incidents of bizarre or tragic medical events . . . many consumers may get the impression that such misconduct occurs with much greater frequency than is actually the case. Nevertheless, consumers may value access to licensing and disciplinary information more highly than is warranted.”<sup>2</sup>

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# *Treating difficult patients*

## techniques and strategies to reduce risk



### **Objectives**

At the conclusion of this activity, the physician will be able to:

1. Identify methods to maximize patient satisfaction.
2. Recognize warning signs that may indicate difficult patients.
3. Describe six different types of difficult patients that physicians may encounter.
4. Utilize strategies for dealing with difficult patients.
5. Identify appropriate steps to take when terminating the physician/patient relationship.

### **Course author**

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### **Disclosure**

Tanya Babitch has no commercial affiliations/interests to disclose related to this activity.

### **Target audience**

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

### **CME credit statement**

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

TMLT designates this educational activity for a maximum of 1 category 1 credit

toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

### **Ethics statement**

This course has been designated by TMLT for one hour of education in medical ethics and/or professional responsibility.

### **Directions**

Please read the entire article and answer the CME test questions. In order to receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Allow four to six weeks from receipt of test and evaluation forms for delivery of certificate.

### **Estimated time to complete activity**

It should take approximately one hour to read this article and complete the questions.

### **Release/review date**

This activity is released on April 1, 2004, and expires on April 1, 2006. Please note this CME activity does **not** meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

### **Introduction**

At some point, almost all physicians have come across patients they wish they could avoid. Although difficult patients may make physicians and their staffs feel like giving up, there are ways to deal with the many types of difficult patients through a variety of communication strategies and other techniques. Patients can be difficult for many reasons, some of which the physician and staff may be able to influence. In this article, we will discuss methods that may help prevent

patients from becoming difficult, identify warning signs of difficult patients, describe different types of difficult patients, suggest a variety of methods for dealing with difficult patients, and discuss what to do when you are unable to reach a resolution with a difficult patient.

### An ounce of prevention

Practices can use a variety of strategies to help prevent the potentially difficult patient from “blossoming.” Although these strategies may not always prevent problems with patients, there are certain courtesies you may be able to extend to your patients that will make their experience with your practice more pleasant. Increased patient satisfaction can lead to increased patient loyalty.

A patient’s first impression of your practice can be something that lingers through the entire experience with you. Examine your waiting room with an objective eye. Is your waiting room equipped with comfortable chairs that suit your patients, i.e. elderly patients versus pediatric patients? Are there enough chairs? Is there a noisy television blaring the latest shock-talk show? Are your magazines relatively current, or were they published in 1989? Do you offer coffee or water in the waiting area? Be sure that your waiting area is both comfortable and pleasant for your specific patient population.

Long waiting times are one of the greatest sources of patient dissatisfaction. Recently in a Las Vegas small claims court, a patient won a lawsuit filed against a doctor who kept him waiting for four hours. Do whatever you can to decrease patient waiting times. You may need to adjust your schedule to accommodate several acutely ill patient visits per day or change your scheduling methods to avoid routinely over-scheduling yourself. If there is no way to avoid delays, ask staff to inform patients of the reason for the delay, how long the delay may be, and offer to either re-schedule, or see another physician in the practice (if available).

Make sure the forms you are giving patients to fill out while they wait are easy to understand and to complete. Try filling out a set of forms yourself to ensure they make sense.<sup>1</sup>

Taking steps to ensure that your patients are comfortable and relaxed before they see you may avert an encounter with an already annoyed and dissatisfied patient.

Good staff interactions with patients are vital. Research from the Physician Insurers Association of America indicates that 28 percent of malpractice claims involve a staff member.<sup>2</sup> Training sessions on how to deal with patients courteously can help staff to understand your high expectations of their customer service skills.

Staff interactions with patients will likely begin on the telephone, so do not neglect this part of your practice. Written guidelines for staff telephone interactions may be helpful. Call, or ask a friend to call your practice to make sure your staff answers the phone promptly and courteously. If possible, avoid automated voice mail systems. If you must use an automated system, test it yourself to be sure that it is easy to quickly reach a person if necessary. Verify that your system does not hang up on patients as they try to navigate through it. Patients will appreciate a prompt, courteous, and efficient phone system, whether it is a person or an automated system.

A practice brochure can be helpful in setting up realistic expectations. A brochure can be used to let patients know what to expect from you and what you will expect from them. Your prescription refill policy, after-hours communications, and fee schedule are suitable things to include in a brochure.

Utilize patient satisfaction surveys to measure how happy your patients are with their experiences at your practice. Include categories such as comfort, staff courtesy, and telephone interactions. Patient feedback can help you to be aware of areas that may be lacking in your practice and identify areas in which you are doing well.

Unfortunately, making your waiting room into a haven for patients, hiring the most courteous and saintly staff, and consistently getting patients into their appointments on time may not always prevent a patient from becoming “difficult.” At some point, most physicians will meet a patient that they do not know how to effectively communicate with. These challenging patients come with many different personality types, demands, and issues.

### Warning signs

When physicians suspect that they have a patient who will be difficult or challenging, there are warning signs to help identify problem patients. In his book *Preventing Medical Malpractice Suits*, James Schutte, PhD, lists these warning signs:

- listing multiple complaints about previous doctors;
- soliciting critical comments about previous doctors;
- making cynical jokes or comments aimed at doctors;
- consistent rudeness toward the physician or office staff;
- excessive flattery or expectations of the doctor;
- self-professed expertise about the real or imagined health problem;
- any unusual way of relating to the doctor, whether manifested as sexual remarks or attempts to form a surrogate parent-child

relationship;

- doctor shopping;
- repeated and persistent signs of non-compliance, including skipped appointments, ignored medical advice, and failure to take medication appropriately; and
- failure to pay medical bills.

Paying attention to these warning signs may save you a good deal of grief. Patients who are full of complaints about the medical profession may never be happy with any physician’s care, and may be more likely to sue you. Caution must be used when dealing with patients who have moved from practice to practice and criticize each of the physicians they have dealt with in the past. Rudeness may be overcome through the use of communication strategies, but abusiveness towards you or your staff should not be tolerated.<sup>3</sup>

High expectations are not unusual in today’s increasingly media-reliant and internet-savvy patients. Be watchful for patients who have unrealistic expectations or who believe that they have more medical knowledge or expertise than you do. These patients may wish to follow their own treatment plan, and may be angry or noncompliant if you do not order the tests or prescribe the medications that they think you should. Noncompliant patients can be a constant source of difficulty in your practice, so it is important to recognize and deal with these patients effectively from the start. Document your recommendations and the patient’s noncompliance. Most importantly, physicians’ instincts should dictate their actions. If you are uncomfortable or have a “bad feeling” about treating a patient, do not ignore it.

### Patient types and strategies

Difficult patients come in many different guises. The most important technique to remember when dealing with any type of difficult patient is to try to communicate as effectively as possible. Remember that communication styles will differ from patient to patient. It is important that you get to the patients’ underlying issues when you are having trouble communicating with them. The patient may not be truly difficult, but may have family issues, economic circumstances that make it burdensome or impossible to pay for medications, illiteracy, or other problems that you may not be aware of. All of these factors may influence how compliant your patient is able to be. Taking time to ask a few probing questions can help explain patients’ seemingly irrational behavior.<sup>4</sup> At times, however, you will have patients who do not respond to your efforts, and with whom communication is more challenging. You may recognize one of your own patients in the types that follow.

### The angry and aggressive patient

This patient may start exhibiting aggressive or rude behavior before reaching the exam room. They may mistreat your receptionist, blow up if they are forced to wait for their appointment, and generally get angry if anything is not as they wish.

#### *Defuse their anger*

Defusing these patients as quickly as possible should be the goal of the staff and the physicians. As difficult as it may seem, maintain your composure, and do not lose your temper. If the patient's wait is long, or there is an appointment mix-up, apologizing to the patient instead of arguing will help to reduce the anger. Even if you suspect the mix-up is the patient's fault, it may be more helpful to apologize than argue about who made the mistake.

#### *Ask and listen*

Ask what patients are dissatisfied about; you may be surprised to learn that they feel genuinely wronged. They may have a valid complaint that has not been addressed. Acknowledge their feelings and look for a way to correct the situation.

#### *Use the "three-step assertive response"*

In *Rx for Success: Communicating to Reduce Risk*, Barbara Pickelman suggests that the staff use the "three-step assertive response" to deal with angry patients. This strategy entails showing empathy for the patient's situation, stating how you can help them resolve the problem, and describing the benefit to patients if they take your suggestion. Using statements like, "I can see that you're upset," and "I understand your concern" can help to show that you care about your patient's feelings. She also suggests you use direct eye contact and a firm but controlled voice with these patients.<sup>5</sup>

#### *Remove the patient from public areas*

If the patient is still angry and ranting in your waiting room, move the patient to a more private area to discuss concerns. Even an empty exam room is preferable to the waiting area full of patients.<sup>5</sup> Staff should feel that they are able to ask the office manager to step in when necessary.

#### *Use a "favorite" staff member*

If you have a patient who is consistently cranky, dissatisfied, or rude, it may be helpful for you to find their preferred or favorite staff member and ask them to handle this patient during phone calls or appointments. The patient may have asked to speak to a certain person in the past, or you can ask your staff who might be best at dealing with this specific patient. You may have a staff member

who is skillful at defusing patients; use this person to handle problem patients, and always express appreciation for performing this service.<sup>6</sup>

If none of these techniques are effective, and a patient's behavior escalates to abusive, threatening, or violent in nature, it is time to end your relationship. If a patient's behavior in the office becomes dangerous, do not hesitate to call security guards or the police. At the end of the article, appropriate methods for terminating the physician/patient relationship are discussed.

### The anxious, needy patient

These patients may present to your practice with multiple complaints, call your office frequently, and request numerous appointments. Their complaints may be chronic and vague, but potentially worrisome to the physician.

#### *Focus attention and listen*

These patients may respond well to very focused attention. Allow them to list all of their complaints before you interrupt them, and let them see that you are listening and acknowledging their complaints. These patients tend to feel that they are not being listened to, or that they are being rushed.<sup>6</sup>

#### *Schedule short, regular appointments*

You may find it helpful to schedule regular appointments with these patients in order to give them ample time to talk with you. By scheduling short, focused appointments regularly, you may reduce the number of phone calls and unscheduled visits you receive.<sup>6</sup>

#### *Ask for a list of health issues*

Ask these patients to bring in lists of their health issues to their regularly scheduled appointments. A list may help you to focus on what needs to be addressed immediately and what can wait until the next scheduled appointment.<sup>7</sup>

#### *Establish boundaries and guidelines*

Needy or anxious patients may require some gentle but firm guidance. Let them know that you expect to see them at their next scheduled appointment to discuss some of the less urgent health issues. Try not to let these patients become too dependent on you, and set limits on their demands.

#### *Give them something to do*

Anxious and needy patients may also benefit from being given something to do, even if it is not a specific prescription for medication. Exercise, dietary changes, hobbies, group activities, and getting a pet can help needy patients to feel that they have a purpose.<sup>7</sup>

#### *Look for underlying issues*

Look for underlying issues when dealing with patients who appear to have multiple, non-organic complaints. These patients may have issues such as depression, anxiety, history of physical or sexual abuse, or substance abuse. Be sure to approach these topics with care. Reassure the patient that these circumstances are not uncommon, and that you ask all of your patients the same set of questions.<sup>4</sup> Delving a little more deeply into these issues may give you insight into the patient's behavior.

### The noncompliant patient

The noncompliant patient can present in a variety of ways. Patients may be noncompliant with their treatment plan, medication plan, dietary recommendations, or they may not show up for their appointments. Noncompliant patients can be cause for concern because they may have bad outcomes, and then blame or sue their physician. The physician should strongly and repeatedly encourage patient compliance with treatment plans.

#### *Delve into reasons for noncompliance*

Look for underlying factors in noncompliant patients. They may be taking care of a sick relative at home who demands all of their time and attention. They may be embarrassed to tell you that they do not understand parts of your treatment plan. Illiteracy or language barriers can be an issue. It may be difficult for a patient to be compliant when they cannot read the instructions on their medications and are ashamed to admit it. Cultural and religious beliefs may also be a factor in patient compliance. Try to understand the patient's beliefs and develop a plan that is acceptable to both of you.

#### *Compromise*

A patient may be willing to compromise and follow some of your treatment plan, but document your recommendations and the patient's comments and choices. Work in stages or steps, guiding the patient to do the important things first. Introduce one thing at a time to the patient.

#### *Develop a written plan*

A written treatment plan signed by patients may help them to understand the seriousness of their condition and the importance of their compliance.<sup>3</sup> Write down the patient's condition, what it means, what your treatment plan is, and the risks of not following your plan. Use straightforward and simple language. Review it with the patient to be sure they understand all the elements, and ask them to sign it. Give the patient a copy and keep the original in the medical record.

*Track no-shows and cancellations*

If a patient fails to show for an appointment, the physician should generally be informed. When possible, ask your staff to tell you at the end of the day who has failed to show. When indicated, ask staff to contact patients who need to come in. Some physicians have their staff contact all patients who fail to show. Document these efforts to contact the patient and re-schedule. This allows you to be aware of patterns of noncompliance and act accordingly. If a patient has failed to show several times, it can be helpful to send a letter that expresses your concern and notifies them of the potential risks of not following your treatment plan and coming to scheduled appointments. Keep a copy of this letter in the patient's chart.

**The know-it-all**

These patients may come to you with a treatment plan already in mind. They have preconceived notions about what their condition is and how you should treat it. When you disagree with the tests they feel should be ordered, or the medications they should receive, they become angry or doubt your skill as a physician. In today's media-dominated world, they may have received incomplete or incorrect information from the internet, television, or radio. They may also have received incorrect information from a relative, neighbor, or friend.

*Remind them that you are the physician*

Remind patients that your role as a physician is to give them what they need, not what they want. Listen to what they want and acknowledge it, but do not acquiesce to patients' wishes for a treatment or plan that you feel is useless, risky or inappropriate. Some patients may want to "delay" treatment which can be risky in and of itself. Delaying treatment also increases the chances that some aspect of patient care will fall through the cracks.

*Explain*

Instead of being insulted or irritated, try to spend a few extra minutes explaining why you are recommending or not recommending certain tests, medications, or treatments. Once they understand your treatment rationale, patients may be more willing to trust you. If you explain your recommendations to patients, and they feel you are not meeting their needs, you can ask them if they would like to choose another physician.<sup>6</sup>

**The drug-seeking patient**

The drug-seeking patient presents a particularly difficult dilemma for the conscientious physician. The physician must make efforts to determine which patients have real

medical complaints and which are "prescription-shopping." The physician should watch for clues while keeping in mind that there are many legitimate requests from patients who suffer from pain.

*Look for red flags*

Drug-seeking patients may present with certain "red flags" that can help the physician to identify them. They may express symptoms of pain for vague or unspecified medical problems that cannot be verified on examination or testing. They may make repeated requests for more prescriptions than are appropriate, and have excuses for "lost" prescriptions. They may ask for a specific drug, and believe that only this drug will cure their symptoms. They may call at the last minute for refills, and state that the situation is an emergency. They may be hesitant or unwilling to supply you with any prior medical records. They may make multiple visits to ERs for pain medications.

*Identify the patient and obtain information*

Document patients' identities by requesting a picture ID, making a copy, and keeping it in the medical record. When you suspect a patient of drug seeking, try to confirm their statements about their medical condition by contacting prior physicians and pharmacists. Obtaining past medical records can be of great assistance.

*Limit prescriptions*

Write prescriptions for very limited quantities, and be wary of requests for early refills.

*Ask the patient to sign an agreement or contract*

If you are concerned a patient may be drug seeking or overusing a prescribed controlled substance, but you feel the medications are necessary, develop an agreement. In this contract, specify what your prescription policies are, what your expectations are, and what behaviors can result in the patient being terminated from your practice. Go through the agreement with your patients to be sure they understand all the elements, and then ask them to sign it. This contract can help to make it clear that you will not accept "drug shoppers," and it can sometimes deter patients who might not have legitimate medical needs.

*Send them to a specialist*

Do not hesitate to refer patients with chronic pain for a second opinion, or to a reputable pain management specialist. Do some research to find a pain management specialist in your community who you are comfortable sending your patients to.<sup>8</sup>

**The patient who will not pay**

Patients who do not pay may have a variety of reasons for their behavior, and it is worth the time of physician or staff to determine these reasons before proceeding.

*Explain your fees*

Patients may not fully understand your fee structure. Discussions regarding fees should take place in a private area at their initial visit. Avoid embarrassing or humiliating the patient by discussing payment issues in front of other patients in the waiting room.

*Examine the reasons for nonpayment*

Patients may be experiencing a financial hardship, and may be eager to discuss alternate payment methods with you. If patients refuse to pay because they are dissatisfied with their care, the physician should be made aware of the situation. If you are dealing with a dissatisfied patient who is considering a lawsuit, you may wish to examine the medical record and decide whether to pursue payment. Also, consider whether your billing procedures are causing nonpayment problems (confusing statements, nonitemized bills, etc).

*Offer alternative payment plans*

Offer patients who are experiencing financial difficulty different payment options. Patients who will not send any money at all when presented with a \$500 bill may be willing to send \$50 a month.

*Send a warning letter*

If none of your collection attempts are effective, and the patient has ignored the option of payment plans, it may be necessary to send them a warning letter. The letter should inform the patient that if they are unwilling to pay, they could be dismissed from the practice. Discharging a patient should be a last resort, only after repeated attempts have been made to contact and work with the patient on a payment plan.<sup>8</sup>

**Case study**

In *Preventing Medical Malpractice Suits*, James Schutte discusses the anguish caused by a difficult patient.

Jack, a 62-year-old, disabled former steelworker saw an internist for intermittent chest pains, dizzy spells, and a recurrent cough. The doctor did a full work-up, which revealed a resting blood pressure of 190/115, serum cholesterol of 360 mg/dL with a high density lipoprotein fraction of 40, an ischemic heart, fasting blood glucose of 236, chronic bronchitis, and obesity. Both of Jack's parents died of heart disease in their 50s. Jack was bitter and angry about the doctor's advice to quit smoking and lose weight, and insisted that he was "big boned." He also insisted "all

that stuff” about smoking was untrue, and that his childhood family doctor smoked. The physician prescribed a blood pressure-lowering medication, but Jack quit taking it within a week. He stated that he had been told by “some of the guys” that the pills could make him impotent. The doctor tried to get Jack on a low-fat and low-sodium diet, and Jack argued that he did not believe foods like steak and eggs could be bad for him. Jack had a negative response to all of the doctor’s treatment suggestions and refused to follow any of her recommendations.

Jack returned for follow up with the doctor in two weeks, and, not surprisingly, had not improved. Jack complained about the doctor “harping” about his smoking and diet. The doctor referred Jack to a cardiologist who recommended cardiac catheterization. Jack refused the catheterization, calling the cardiologists “butchers,” and claiming they did not know what they were doing. Jack saw the internist seven times in the following five months, continued to refuse to follow her recommendations, and continued to openly blame her for his failure to improve. Eventually Jack suffered a myocardial infarction and proceeded to sue the internist and cardiologist.

The suit went on for years before the internist, who had two small children at home, finally was worn down and agreed to settle for \$9,000. Although the claims representative was confident the case could be defended successfully (due to the internist’s excellent documentation in the medical record), the internist was not willing to fight it anymore. The cardiologist was not willing to settle, and the suit against him was eventually dropped.

Schutte evaluates this case as a mistaken decision on the part of the internist to keep seeing a hostile and noncompliant patient. Fortunately, she documented all the interactions with the patient extensively, so this case would have been easy to defend had the internist decided to persist. The patient had nothing but insults and complaints about all of his past and present doctors, and made it clear that he was completely unwilling to follow any of the physician’s recommendations. It may have saved the doctor months of heartache if she had terminated the physician/patient relationship when it became obvious that the patient refused to be helped.<sup>3</sup>

### Risk management considerations

#### Documentation

Documentation of your interactions with difficult patients may be your best protection if the patient later decides to sue you. All telephone calls, office interactions, and written correspondence should be documented in the medical record in detail. Do not be afraid to include quotes from the patient in your doc-

umentation. Documenting patient noncompliance and all your efforts to make the patient compliant can be your proof that you were conscientious. Be sure that staff is also aware of the importance of documenting their interactions with “problem patients.”

#### When you cannot work it out: termination of the relationship

There may come a time when, as a last resort, you feel you must end the physician/patient relationship. This should only happen when all attempts to treat the patient effectively have failed. If a patient is repeatedly abusive or threatening, it is appropriate to dismiss the patient from your practice. If a patient is belligerent and noncompliant, you may want to consider whether you can help them, and whether you want to continue to try.

Repeated nonpayment can be a reason for firing a patient from your practice if a patient’s condition allows, but use caution if you are going to dismiss a patient for this reason. Repeated efforts should be made to work out a payment agreement, and a warning of dismissal should be given in writing.

Check your managed care contracts so that you are aware of the plan’s requirements for dealing with patient termination. Some physicians also make it a policy to dismiss patients who have repeatedly missed appointments. If this is the case, it is a good idea to have a written policy in your patient brochure and to give patients ample warning orally and in writing. It would be difficult to find fault with a physician who dismissed “drug shoppers” or patients who have altered or forged prescriptions.<sup>9</sup>

There are times when it is not in the physician’s best interest to terminate the relationship. Any patient who presents with an emergency condition should be treated immediately. If providing prenatal care to a woman in the third trimester of pregnancy, it may be difficult or impossible for the patient to find another physician. It is advisable to get a surgery patient through the postop course before dismissal. Minors should be considered very seriously before they are terminated from your practice, since it could appear callous to dismiss them because of their parents’ actions. Patients with critical health issues may be more difficult to dismiss from your practice.

Physicians should take care to follow appropriate steps to dismiss a patient in order to avoid being accused of abandonment. The physician must provide adequate notice by sending a letter to the patient by both first class mail and certified mail, return receipt requested. Keep a copy of the letter and the return receipt in the chart to document your appropriate notification to the patient. The

physician must give the patient adequate time to find another physician and should be willing to see the patient in case of emergencies. Stress the importance of the patient finding another physician. You are not required to state a reason for terminating the relationship, and it may be in your best interest not to be too specific.

### Conclusion

Although dealing with difficult patients may fill physicians and staff with dread, using communication strategies tailored to each specific patient type can help improve your relationship with these patients. Try to communicate clearly with patients about what your expectations are, and what they can expect from you. Although you may occasionally encounter patients whose behavior makes them impossible to treat, most patients want to have their health needs met and to have a good relationship with their physician. By improving communication with patients and looking for underlying causes for problem behavior, you may find that your “difficult” patients become manageable.

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# risk management consult

**Q: I read somewhere that the TSBME changed the recommended guidelines for what I can charge for copies of medical records. Is this true, and if so, what is the new recommended charge?**

**Answer:** Effective March 4, 2004, the TSBME guideline continues to recommend a \$25 charge for the first 20 pages and 50 cents per page (previously 15 cents) thereafter.

**Q: My practice includes obstetrics. Recently, the mother of a pregnant minor was verbally abusive and threatening to a member of my staff. Can I terminate the physician/patient relationship?**

**Answer:** What a conundrum this question poses! The answer is yes but with many caveats. Your physician/patient relationship is with the minor who is pregnant. Because she is pregnant the minor may seek and consent to prenatal care. However, with parental involvement and the incumbent stress-filled nature of this situation that may include a wide range of emotions from anger to blame, the physician and staff are trying to balance all of these challenges and provide quality care for this patient and her unborn child. If the patient is compliant and your relationship with her is one of cooperation and open communication, ask her if she wants her mother involved. If she does, advise the mother that her behavior may be damaging to the well-being of the patient and unborn child and is unacceptable. Try to discover the real cause of her behavior and seek resolution. Your interpersonal skills and those of your staff in dealing with difficult situations may be put to the test.

If the challenges with the parent appear insurmountable and you decide to end your relationship with the patient, you may do so. However, it may not be easy. Verification of the transfer of care to a new physician is recommended under these circumstances. If the pregnancy is high-risk, terminating the relationship may be inadvisable as it may be difficult for the patient to find another specialist. If the pregnancy is normal, advise the

patient to select another physician without delay and to notify the office of the date of her first appointment. Have an authorization signed to release a copy of the medical record and arrange for delivery of the record before that first appointment if possible. Continue routine prenatal appointments if scheduled during this process. Be available for any obstetric emergency situations.

If the patient does not select a new physician, continue her care on schedule. If care is discontinued at this point, it could lead to an allegation of patient abandonment. Be firm with the mother. Designate a mature staff member as her contact. Establish an agreement that unacceptable behavior will not be tolerated and she will be asked to leave the premises if she is abusive or threatening.

Document actions in the medical record keeping comments factual, objective and nonjudgmental.

**Q: I am a surgeon and while on emergency department call rotation performed surgery on a patient with**

**multiple fractures sustained in a motor vehicle accident. Upon presenting to the office for the first postoperative appointment, this patient refused to pay anything toward his bill. Can I terminate my relationship with the patient?**

**Answer:** The short answer is no. Your relationship with the patient cannot be terminated at this time. As long as the patient requires postoperative management reflecting the standard of care dictated by his condition, he cannot be dismissed from your care. Doing this will be viewed as abandoning the patient. Continue to try to establish a payment plan with the patient and document his response. Upon completion of his medical care, send written notice requesting payment of his account. Indicate if there is no response, the account will be forwarded to collections. Place a copy of the letter in the medical record.

*Please email your risk management consult questions to [barbara-rose@tmlt.org](mailto:barbara-rose@tmlt.org).*

## Risk Management Times

### Breaking news for the medical practice

2004 Spring Seminar Series  
Registration — 1 p.m.  
Program — 1:30-4:30 p.m.

#### Who Should Attend?

This seminar is intended for nurses, office managers, front office staff, and medical records personnel.

Tuesday, April 13  
Houston, TX

Wednesday, April 14  
Houston, TX

Tuesday, April 20  
Fort Worth, TX

Thursday, April 22  
Lubbock, TX

Tuesday, April 27  
Rancho Viejo, TX

Thursday, April 29  
Tyler, TX



To register or for more information, contact:  
Natalie Gilmore,  
800-580-8658, ext. 5911  
[natalie-gilmore@tmlt.org](mailto:natalie-gilmore@tmlt.org)

# closed claim study

## Negligence in performing cataract surgery

by Barbara Rose and Laura Brockway

*The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.*

### Presentation

A 54-year-old man presented to an ophthalmologist with complaints of difficulty reading. The physician examined the patient and noted a dense, white cortical cataract in the right eye. Visual acuity was noted to be 20/200 in the right eye and 20/40 in the left. The ophthalmologist planned to perform a cataract extraction with lens implant in the right eye.

### Physician action

During the procedure, which was performed approximately two weeks later, the nucleus dislocated and a vitreous prolapse occurred. The ophthalmologist performed a vitrectomy and placed an anterior chamber lens. After the surgery, the patient's visual acuity in the eye was 20/80, and the retina was intact.

At an office visit one week after the procedure, the retina was attached and the patient was noted to have 20/80 visual acuity in the eye. The ophthalmologist removed the suture and noted reduction in the corneal edema. During another office visit seven days later, the patient reported his vision was improving every day. The visual acuity at this visit was 20/40 and the retina was flat and attached.

Six days later, the patient presented to the ophthalmologist's office complaining of decreased vision in the right eye. The patient first noticed this loss of vision four days earlier, but did not contact the ophthalmologist because he hoped his eyesight would return. The physician diagnosed a detached retina.

He scheduled the patient an appointment with a retinal specialist the next morning at 8 a.m. The patient was advised as to the urgency and emergent need for surgical repair of the retina, and was given explicit directions and a map on how to get to the specialist's office.

The patient did not show for his scheduled appointment. The specialist's office contacted the patient who told them he had changed his mind and was not keeping the appointment. At his deposition, the patient testified he was afraid and did not have the money to pay for the surgery. He further testified that the ophthalmologist told him that he would lose sight in the right eye if he did not keep the appointment with the specialist.

Five weeks later, the patient was seen by another ophthalmologist in a neighboring city on the referral of his attorney. (The attorney apparently found this ophthalmologist through an expert witness service.) The ophthalmologist examined the patient, whose vision in the right eye was hand motion only. The retina was detached and the ophthalmologist referred the patient to a retinal specialist in Houston for emergency surgical repair. The patient claimed he could not get approval from his insurance company for surgery in Houston. The ophthalmologist then referred the patient back to the retinal specialist in his hometown. (This was the same physician the patient was scheduled to see five weeks earlier.)

The patient was seen by the retinal specialist eight days later. He found a total retinal detachment with the macula off. The scarring indicated the retina had been detached for six to eight weeks, dating back to the time when the ophthalmologist first noted it. The retinal specialist surgically repaired the patient's detached retina approximately four weeks later (this delay was due to the patient's insurance). The patient recovered and has 20/200 vision in the right eye and 20/40 vision in the left eye.

### Allegations

The allegations in this case included:

- negligence in failing to obtain a B-scan

of the retina prior to surgery;

- negligence in not making an earlier conversion to an extracapsular cataract procedure (This would have prevented vitreous loss and the need for the vitrectomy, which led to the retinal detachment.);
- failure to become aware of complications after the suture removal; and
- untimely referral to a retinal specialist.

The plaintiff claimed to have lost significant past/future wages as a result of the incident, even though he had not filed a federal income tax return in five years (three years before the incident and two following).

### Legal implications

Defense experts were supportive of the defendant's care in this case. The retinal detachment was not the result of substandard care by the defendant, as evidenced by the fact that the patient's vision improved dramatically after the surgery. The defendant made the conversion to an open procedure at the proper time and the decision to operate without a B-scan ultrasound was reasonable. The defendant followed the patient closely, including examining the retina at every post-operative visit, and immediately took action once the detachment was discovered.

The defense also argued that it was the patient's own negligence that reduced his chances for recovery of vision. According to testimony given by the retinal specialist, if the repair surgery had been done within five to six days of the detachment, there was a 25 percent chance that most or all of his central vision could have been restored. When the patient presented for surgery, five to six weeks after the detachment, his chances for restoring central vision were nil. Further, the patient admitted he was told by the defendant ophthalmologist that his eyesight was at risk if he delayed seeing the specialist.

Interestingly, the plaintiff's expert in this case was the same ophthalmologist who examined the patient five weeks after he

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# the Reporter



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failed to show for the appointment with the retinal specialist. This expert denied under oath that he had a physician/patient relationship with the plaintiff, even though he examined the patient, created a chart and billed the patient's insurance company for the visit.

A possible weakness identified in this case involved late additions to the medical record. The plaintiff's attorney was in possession of two versions of the patient's medical record. One version of the record had been given to the patient to take with him to the retinal specialist. (Ultimately, the patient did not keep that appointment.) The second version of the chart was requested by the patient a month after the referral to the retinal specialist and two weeks before he presented to the out-of-town ophthalmologist. The second version of the chart included several additions in which the physician elaborated on his prior assessments.

Regarding the discrepancies between the records, the defendant ophthalmologist explained that when he examined the patient,

he took notes on self-stick notes, which were then attached to the patient's chart. When the original records request was received, the staff member removed the notes to allow the pages to run through the copy machine. When the second records request was received, the defendant thought the records were for the retinal specialist, and he transcribed the notes into the chart for clarification purposes. And while the plaintiff was not disputing anything in the modified version of the chart, their expert stated it was inappropriate to add this information weeks after the fact.

### Disposition

This case was taken to trial and the jury rendered a unanimous defense verdict. During post-trial interviews, the jury members stated they did not have a favorable opinion of the plaintiff or the fact that the plaintiff's expert was retained through an expert witness service.

### Risk management considerations

This defendant physician prevailed at a trial before a jury. What, if anything, needed to be done differently? Use of sticky notes to record the findings in a patient exam is to be

avoided under any circumstances. No recognized style or format in designing a comprehensive medical record includes the use of sticky notes. Even when a record may not be available, it behooves physicians and staff to use a form designated for the chart. The patient name and date of entry are elements to be included. Avoid the use of self-stick notes as a permanent part of the medical record. As reflected in this claim, removing them to copy a record resulted in an incomplete record.

Physicians who may be perceived as altering a record can compromise their defense. Avoid the opportunity for this to occur with notes entered in the medical record contemporaneously. If a note pad is the only paper available when information is recorded, request the record and transpose the notes in the patient's medical record in a timely manner.

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