

## Digging Deep for the Roots of Risk

By Judith H. Fine, RN, MSN, TMLT Risk Management Representative

**M**ost physicians agree with most risk managers on at least one point: insofar as possible, a medical liability claim is something to be avoided. In recent years, medical liability claims have been filed in the United States with such a high frequency that it is difficult to imagine that any physician who practices medicine in this country today might be unaware of this significant potential threat to his or her professional life.

In spite of keen awareness and even with the best of precautions, no physician can avoid all risks related to medical malpractice claims. A certain amount of risk "comes with the territory" of medical practice, for example, the risk of a patient experiencing an allergic reaction to a drug the first time it is prescribed or the risk of a surgical complication that could not have been foreseen. Traumatic and severe patient injury may, in itself, be a factor that precipitates a claim. Patients sometimes file frivolous claims in the absence of any possible medical negligence. Sometimes a physician trapped in an ethical dilemma may knowingly take risks in order to act in the best interest of the patient. The list of unavoidable and nearly unavoidable risks goes on and on.

There are many risks, however, that physicians *can* avoid. Progress notes and other documentation in the medical record are a case in point. Every medical school student is instructed regarding the documentation of a physical examination, but not every

practicing physician actually documents what is seen, heard or otherwise observed. Little or no documentation of physical examination findings may make it difficult to successfully defend a medical malpractice claim, even if the claim is unfounded. Less than adequate documentation of any aspect of medical care may raise questions about the actual circumstances and events that occurred.

**M**edical documentation, although extremely important, is only one of many areas in which risks might be avoided. Front office processes, including billing and collection procedures, handling of telephone calls, appointment scheduling and the release of medical information, comprise fertile ground for risk. So are back office procedures. A few of the back office activities where risk can hide are sterilization of instruments, preparation for a potential medical emergency and disposal of hazardous waste. Avoidable risks respond to changes and improvements. Modifying an office process, formulating office policies, and launching a quality assurance program can all make a positive difference.

If, then, physicians and their employees might be able to do some things differently and thereby reduce their risk of professional liability, why does the more risky way of doing things sometimes persist, even when avoiding a medical malpractice claim is a recognized goal? Human behavior

is complex, and many factors converge to influence it, including the physical environment, social issues and psychological factors. Health care delivery structures have created new relationships and new patterns of interaction that may effectively impose some limitations on how things are done, and change, even positive change, is not easy. Notwithstanding the huge range of possible reasons for risky behaviors, the following factors stand out as recurring themes that form the root causes of risk.

### Understanding of liability and risk management

Almost all physicians have knowledge regarding the causes of potential liability in their specialty, but that knowledge is not always focused in a way that suggests positive changes. Risk management seminars and home-study programs may help clarify the concepts and encourage physicians to put risk management to work in their practices. TMLT insured physicians also have an opportunity to increase their understanding of their potential liability issues and related risk management techniques by requesting a Risk Management Practice Review, offered as a free service by the TMLT Risk Management Department. Is proactive risk management a priority in your practice?

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# Roots of Risk (continued)



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## **Contentedness, complacency and control**

A physician who has never been sued may not see a reason to strive to reduce liability risk. If a specific risky behavior has not precipitated a problem, changing that behavior may not seem warranted. By the same token, a physician who sees risk as a phenomenon that cannot be controlled may also lack motivation to make changes. Phrases like, “we have always done it that way,” and “what difference does it make?” and “things are okay the way they are,” are clues that change-resistant risk may prevail.

## **Financial issues**

New business arrangements may increase profit (or decrease loss), but at the same time may generate new risks. While managed care organizations may offer advantages to employers and to patients, physicians have begun to see that managed care also brings with it new liability risks. Whether it relates to staffing or infection control or billing, any time a corner is cut to save a dollar, a quality issue surfaces and begs to be examined. Quality is peculiarly related to risk, in that the two tend to increase and decrease inversely. To ignore one is to ignore the other.

## **Communication**

These days, especially, time is money. Seeing more patients in less time may be considered desirable, but both the quality and quantity of communication may suffer. Communication with other physicians and with office and hospital staff is sometimes taken for granted. Some patients seem to make communication a struggle, and they are labeled as “problem patients.” Both written and oral communications are critical to potential liability risk.

## **Delegation**

Under the Texas Medical Practice Act, physicians can delegate almost anything to almost anyone. Increasingly, physicians are delegating tasks that they once performed themselves, but often they lack ironclad assurance of staff competency. In some Texas locations it is difficult to find knowledgeable, competent employees. In others it is difficult to find any employees at all. Are you sure that everything you delegate is done as you want it to be done?

## **Procedural systems**

Whenever people and paper are the means for getting tasks done, sooner or later something is likely to fall into a “black hole.” The lab report that was never read, the consult report that was never received and the little health problem that was never treated because it was only mentioned to the receptionist — improved procedures could have prevented these risky errors. Patients can get lost in a physician’s office in ways that an exit sign would not help. Could that happen in your office?

## **Stress and coping**

Physicians, like all humans, experience stress from time to time, and some of that stress is related to the demands of medical practice. Recent changes in the structure of health care delivery are a major contributor to physician stress, regardless of the details of the changes. Generally speaking, physicians cope very effectively with the stresses of medical practice, employing coping techniques that enable them to control and manage their emotions as well as enabling them to continue to practice. The possible downside of this successful coping, however, may be that the very activities that are helpful toward coping are often ones that

increase liability risk. For example, a physician who experiences a series of stressful practice events might cope by attempting to distance himself from his patients by decreasing conversations to a minimum and avoiding any discussion of patients’ emotional concerns. Might a physician who is uneasy with day-to-day medical practice decisions perhaps minimize documentation of patient encounters to avoid reconsidering those decisions? Might he or she act in a highly directive manner, putting little emphasis on patient education and informed consent? Given what is known about stress and coping, these seem to be valid questions.

Physicians might do well to dig up these roots and scrutinize them in the context of their own lives and medical practices. Once the roots of risk have been located and recognized, reducing professional liability risk is no longer just a matter of saying, “I’ll document better” or “I’ll ask my staff to be nicer to patients.” Weeding out risk means attending to the roots. Any gardener knows that this is much more difficult, but it is also much more effective and the only way to achieve a permanent result.

# UP CLOSE AND PERSONAL:

## One Physician's Claim Experience

by Matthew E. Masters, Jr., MD

The career of a physician is inherently stressful, but for me the greatest stress, and my morbid fear, was that of being sued for malpractice. When it happened I was shocked, stunned and thoroughly frightened. My pre-conceived notions about lawyers and insurance companies did nothing to quell my fears. Faced with this “worst case scenario” and projecting far into the future, I was a nervous wreck. On top of all this I was told, “Do not discuss your case with anyone.” I felt isolated, alone and threatened. Needless to say this was unrealistic, but at 3 a.m. this kind of eerie, obsessional thinking takes on a life of its own and becomes a huge vortex that sucks in its sleepless victim.

In the clear light of day, I knew that I was in a situation that had taken over my life and that I had to take steps to deal with this problem in a constructive way. Although I had attended some seminars about medical malpractice, I had believed that malpractice claims happened to other people (usually “bad” doctors) and that they would not happen to me if I practiced good medicine. In addition to being set straight on that issue, I realized that I was suffering from an acute lack of knowledge about the litigation process. My first stop was the TMA Library. A literature search yielded a review in the *New England Journal of Medicine* that was complimentary of a book by Zobel and Rous entitled, *Doctors and the Law*. I skimmed the book on the spot, and found it to be both well written and humorous. At that point, I was definitely in need of a good laugh, and I appreciated the authors' explication of the prevailing stereotypes that physicians hold. I used the weekend to read the book and found that it served the dual purpose of outlining the litigation process and placing it in a cultural

perspective that made it understandable to me.

I found the admonition not to discuss my case with anyone to be really problematic. I was walking around with the “world on my shoulders” and trying to carry out my daily duties without any support. My lawyer clarified that I could speak with my wife, my physician, my minister, and a counselor. If I chose to I could also mention to others that I was going through this process, but I could not discuss specifics with them. I was firmly admonished not to discuss the case in any form or fashion with any of the other treating physicians. Once I had an idea of the boundaries involved, I set about getting some help. At the time, I was working for a progressive multi-specialty clinic, which had retained the services of an academic psychologist experienced in counseling physicians facing a malpractice claim. I found it a great relief to unburden myself of my numerous fears and concerns within a confidential setting. I also spoke to my minister and my physician. I found that I had numerous sources of support, and that I did not have to carry this load all on my own.

My other form of consistent support was my legal counsel. TMLT had retained two attorneys to help with my defense. They both had considerable expertise in defending medical malpractice cases, and their track record was excellent. I began to take a very active role in my defense, reviewing the chart, related medical literature, the CV and previous publications of the plaintiff's expert, and attending all of the depositions in the case. As I acquired more information I began to relax more as the case developed. It turned out that my case was extremely

defensible, but it would hinge on the quality of my deposition testimony. I began to prepare for deposition by returning to the TMA Library to review literature and to watch videotapes on how to give a deposition. I then went through a mock deposition with my attorneys. When deposition day arrived, I was nervous, but I had done my homework. I had faith in God and trust in my legal counsel. The three and a half-hour deposition went well.

Two and a half years after the initiation of the suit, the case against me was dropped. During that time I learned a lot about the process of malpractice litigation and about myself. I realized that I was highly invested in control — I wanted to control my patients' outcomes, my medical practice, my lawsuit, my health and my family. As time went on I came to believe that my control was limited to myself, and that I had no control over the plaintiff, their expert or their tactics. I also learned that the ultimate outcome was out of my hands. I learned to live in the present, directing my focus toward what little I could control and letting God control the rest. Paradoxically, only when I surrendered control of the outcome did I experience peace of mind.

Personal growth and career opportunities grew out of the lawsuit. Following the lawsuit, I changed my style of practice for the better. I also reorganized my life to include what I truly enjoy doing — teaching residents, seeing patients, writing and consulting. I make half the money that I used to make, but I have a better quality of life and more time to devote to my family, students and residents. I have also become aware of the wealth of support I have available to me if I am willing to access it.

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## Deposition Pointers



- Wear clothing appropriate to an important business meeting.
- Treat all persons in the deposition room with respect.
- Speak slowly and clearly.
- Tell the truth.
- Do not argue or be defensive.
- Testify only as to what you remember clearly.
- Do not be concerned with the appropriateness of a particular question.
- Do not speculate or state anything as a fact that you do not know.
- Give accurate estimates.
- Do not volunteer any facts not specifically requested.
- Beware of a question that assumes a fact.
- Be alert to paraphrases.
- Answer all questions asked unless your lawyer instructs you not to answer.
- If asked, "Is that all?" respond with "That is all I can recall at this time."
- Do not try to memorize your testimony.
- Do not answer a question unless you have heard it accurately and clearly understand it.
- If you do not understand a question, say so and request clarification.
- If you are asked about a document, ask to see and review the document before answering.
- If any attorney begins to speak, stop your response and allow him or her to make the statement.
- Do not lose your temper, get angry or get excited.
- Do not give your professional opinion outside your area of expertise.
- Do not give your professional opinion about another health care professional unless you are thoroughly familiar with the facts of the case.
- Do not explain your professional opinion unless asked.
- If you wish to take a break at any time in the deposition, ask for one.

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