Our national economy has been struggling for years, forcing more people to seek nontraditional sources of income and respond to unforeseen events in unconventional ways. As a result, the court dockets in the Commonwealth of Virginia are flooded with medical malpractice litigation. As a medical malpractice defense attorney, I have spoken with practitioners in many fields and with medical malpractice attorneys on both sides of the aisle. In every discussion, there are several common issues that appear to be catalysts for litigation. This article discusses these issues with the intent of helping medical practitioners avoid malpractice litigation, sharpen their best practices and meet their patients' needs.

Understandably, some of the practice pointers in this article may conflict with production requirements; however, the effect of malpractice litigation on a medical practice's profitability and its physicians' credentials and confidence argues for heeding these pointers.

**Practice Pointer One:**

**Know and Communicate with Your Patient AND Your Patient’s Family**

_I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick._

_I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug._

The top practice pointer from plaintiff and defense attorneys alike is found in the Hippocratic Oath. Physicians must establish a relationship with the patient and the patient’s family. Physicians who communicate well with their patients and, if authorized, with the family are usually not the targets of professional liability lawsuits. If you are a medical malpractice defendant and other treating physicians are not, the reason can often be found in the relationships established, if any. A few ways to establish physician-patient relationships include:

1. **Show your patients that you care about them.** Give your patients the care and concern you would give your mother, spouse or child. Ask yourself, “If the patient was my mother, what would I do and how would I treat her?”

2. **Answer your patients’ questions, and if they do not have any, probe.** Ask them if there is anything else they need to ask or if there is anything else on their minds about the treatment. Document your discussion about these issues or concerns. If the conversation is not documented, then it did not happen.

3. **When something goes wrong, look the patient in the eye and be honest.** If necessary, ask permission to speak with the family. Do not be evasive or coldly clinical. Initially, do not discuss medical options, unless it is a medical emergency. Let the bad news sink in first, showing your patient sympathy and kindness. When your patient seems ready to move forward, discuss options and provide a well-reasoned medical plan. If the options are outside your area of expertise, call in consultants immediately and develop a collaborative care plan for your patient. Your patient does not want to hear that something went wrong and you do not know how to fix it. (cont. page 2)
Current Trends cont.

Be there when the plan is presented, especially when another physician is implementing the plan. Show your patient and the family that you continue to be concerned; ask to be present when the provider who will possibly correct your error speaks with the patient and family. Remain focused on the patient’s care—never talk about reimbursement of medical costs or insurance coverage.

4. When communicating with a patient, refrain from letting your frustration or anger show. You are in control, and most patients lack your level of understanding of the situation. However, when a patient has made a decision regarding treatment, document the information provided and respect the patient’s choice. Do not try to force treatment upon a patient and do not treat the patient in a condescending manner.

5. If communication or relationships are difficult to establish after a good-faith effort, consider referring the patient to another provider in your practice or outside your practice. Many malpractice defendants comment that their internal voice told them they should not have taken the patient or that the patient was a potential liability from the beginning. Listen to your internal voice.

Practice Pointer Two:
Consider, Question and Answer Treatment Options

Every practitioner and attorney articulated this practice pointer in varying ways. The overriding factor noted is that practitioners must slow down, review the information available carefully and ask questions before implementing a treatment plan. They must consider the worst possible outcome if the plan is implemented and the worst possible outcome if the plan is not implemented. Taking additional time to fully consider treatment options gives practitioners an opportunity to process the textbook response to a medical condition and consider adjustments for a particular patient’s condition. Some areas of concern include:

1. Review the chart and take note of a continuation of symptoms. Go back several visits and review trends in the patient’s chart, especially when a patient is seen by several physicians in a practice. When a patient’s chart documents a medical condition over time, but the physician fails to recognize the condition, it is difficult to justify the physician’s lack of action to a jury.

2. Follow up on and review diagnostic testing and imaging studies. If you are ordering a diagnostic test, look at the results. Never leave them in a patient’s file for a future provider to identify an abnormal test finding. Cases of failure to follow up on abnormal findings are very difficult to explain to juries, for they would want their physicians to follow up on their test results.

Practice Pointer Three:
Chart Thoroughly, Accurately and Legibly

Consider the patient’s medical chart to be the most important piece of documentary evidence presented during a trial. Documentation in a medical chart wins or loses a trial. Good charting is not simply a matter of providing detail; moreover, the information contained in the details is of utmost importance. From a defense perspective, charting is a major focus of a case. Below are some guidelines on medical charting.

1. Chart in detail and legibly. Detail matters, as it is often argued that if something is not in the chart, then it did not happen. How you chart is also important. The record should be one that your attorneys and the jury can read. Do not use abbreviations or shorthand symbols. Take time to make sure the written record is correct. Failing to provide details, such as dosage amounts, in a medical chart has been the focus of board of medicine sanctions. Date and time your entries. The time an event occurred can make all the difference in defending a case.

2. Never change an entry. Follow the entry with an amendment or addendum and date and sign the amendment or addendum. To eliminate this charting risk, ensure your computer program does not allow you to change entries.

3. Read prior entries before entering a new one. If you are cutting and pasting a prior entry, always read what you intend to cut and paste first; it may not be what you want entered in the chart for the later treatment. This is a major problem because prior entries may contain information that can be harmful when carried over.

4. Write accurately, succinctly and clinically. Often physician defendants review their notes and wish they had not included certain information. Think about what you have written and make sure you want that to become part of a patient’s permanent record. Do not enter guesses or possibilities. Rather, enter findings, diagnoses and differential diagnoses. If you enter differential diagnoses, follow up on them.

5. Never open a question in a chart that you do not close. Once information is entered into a permanent record, you have an obligation. When you state that a patient may have infection, you are obligated to find out if the patient has an infection.

6. If your treatment is dependent upon consults, chart the consults and put a summary of their results in your progress notes. Doing so indicates that you are actively becoming informed as required for the treatment you are providing.

7. If a resident dictates a note or summary that you must sign off on, read it before signing.

8. Document any refusals of treatment and have the patient sign the refusal of treatment.

Practice Pointer Four:
Follow Protocol in Obtaining Consents for Treatment

Consent for medical treatment is an area of law that has grown tremendously. Lack of consent to treatment can give rise to claims of battery or malpractice. (cont. page 3)
Below are several general rules pertaining to matters of consent:

1. Signed consents should be obtained for all medical treatment to avoid battery claims. Theoretically, if a patient did not authorize the contact and injury results, then a battery claim can be made.

2. Consents should be detailed and documented. Any item not documented as covered by the consent is not considered to be included in the consent.

3. Consent should be informed. Educate your patients about the treatment to which they are giving consent. Spend time with your patients to ensure they understand the prescribed treatment. The physician should initiate a discussion about the consent, preferably with a witness present. In surgical cases, consent should be discussed before the day of surgery and not while the patient is sedated.

4. Document the consent discussion in detail.

5. If the patient is informed about the treatment and refuses treatment, then have the patient sign off on refusal of treatment.

**Practice Pointer Five:**
**Never Speak Ill of Another Provider’s Care**

Statements or chart entries by subsequent treating physicians often trigger medical malpractice litigation. With the exception of newborns, few patients come to physicians without a prior medical history. The extent or nature of prior medical history may not be known by later treating physicians. In many instances of comments about the quality of prior care, the later medical provider did not have the information necessary to justify making such a comment. These comments embolden patients to take action they would not otherwise have taken. Additionally, later providers should not attribute a poor outcome to the abilities of a prior medical provider because they do not know the circumstances confronting the prior provider. The following comments or documentation encouraged plaintiffs to litigate:

1. **Patient had a ureteral laceration.** (Incorrect statement referring to an impacted stone that was removed, causing a hole in the ureter.)

2. **Because of her ureteral injury and several failed procedures to resolve her urinoma, a left nephrostomy tube was placed.** (Incorrect statement of events prior to provider’s treatment.)

3. **His face looks like he has been through a meat grinder.** (Statement by a nursing home resident following an altercation with another resident.)

4. **Object intentionally placed in patient’s stomach during a gastric bypass was identified by a radiologist as a potential foreign object, removed by a later surgeon and identified as a foreign object because the surgeon did not know what it was.**

5. **Later dentist told patient that the prior dentist should have told him when he broke a drill off in the tooth while performing a root canal.**

6. **Teeth excessively reduced for crowns will require root canals.** (Note in subsequent provider’s record.)

7. **“Who did this to you?”**

Communicating effectively with patients, carefully considering treatment options, providing accurate and thorough chart documentation, obtaining consents for treatment and refraining from speaking ill of previous providers’ care may seem like simple bits of advice. However, these five practice pointers are among many that become obvious to attorneys when reviewing cases in litigation or board proceedings.

Medical providers merely going about their daily practices unwittingly provide evidence that either assists plaintiffs in establishing medical malpractice cases or encourages them to file lawsuits. As medical malpractice defense attorneys, we work diligently with our clients to identify, address, and correct actions or oversights that trigger litigation. Doing so preserves our clients’ medical practices by sparing their reputation and protecting their bottom lines.

The author, Nancy Fuller Reynolds, located in LeClairRyan’s Roanoke office, can be reached at 540.510.3037 or via email at nancy.reynolds@leclairryan.com.

**LeClairRyan’s Healthcare Industry and Medical Malpractice Attorneys**

**Partners**
Elizabeth K. Acee
Rodney K. Adams
Alan D. Albert
Elizabeth J. Atkinson
Todd D. Anderson
Scott W. Bermack
Ann Lisa Braun
Evan A. Burkholler
Kathryn J. Coassin
Neil H. Ekblom
Donna L. Foster
Linda B. Georgiadis
Tracy Taylor Hague
A. Neil Hartzell
Ronald P. Herbert
Patrick J. Hurd
Brian S. Inamine
John T. Jessee
Kevin G. Kenneally
Dennis R. Kiker
Powell M. “Nick” Leitch III
Bruce Leshine
Margaret P. Mason
Susan Childers North
Carlos F. Ortiz
Joseph M. Rainsbury
Shyrell A. Reed

**Counsel**
Hillary C. Agins
Kim A. Carnesi
Victoria Metaxas
Deborah I. Meyer
Donald E. Morris
Afaf S. Sulieman

**Associates**
Joseph S. Abrenio
Jennifer L. Aquino
Michael G. Caldwell
Ashley C. Dobbin
Leah S. Gissy
Michael G. Goldklang
Eleanor A. Lasky
Sharon A. Marcial
Alexander K. Page
Katherine Tanner Smith
Amy P. Wheeler

---

**LeClair Ryan**
3 Fall 2010
Who We Are

LeClairRyan is a national, full-service law firm, offering a robust Healthcare Industry team comprised of attorneys who are well-positioned to address the magnitude of issues affecting all segments of the healthcare industry, including acute care facilities, assisted living facilities, dialysis centers, health insurers, hospices, hospitals, medical device suppliers, medical laboratories, medical staffs, nursing homes, pharmacies and physician groups.

Several of our healthcare attorneys previously worked for medical organizations as in-house legal counsel, risk management and healthcare professionals. This experience gives our attorneys unique insights into and a clear understanding of the various challenges, including state and federal regulatory issues and healthcare transactional and operational matters, medical professionals face every day.

LeClairRyan’s Medical Malpractice Defense team touts a deep bench of attorneys skilled at providing invaluable representation when malpractice litigation threatens medical practitioners’ reputations and bottom lines. LeClairRyan’s Medical Malpractice Defense practice is one of the firm’s 35 practice areas recently selected for inclusion in the inaugural edition of U.S. News & World Report and Best Lawyers® listing of Best Law Firms for 2010. Indeed, in the last three years alone, our team has tried 60 medical malpractice cases to verdict.

We represent clients in matters related to an array of legal issues for a diverse group of medical specialties, including anesthesiology, dentistry, emergency medicine, family practice, gastroenterology, general surgery, internal medicine, neurosurgery, nursing, obstetrics and gynecology, oncology, ophthalmology, orthopedic surgery, pediatrics, podiatry, radiology and urology. Given these divergent areas of focus, we are able to match each case with the strength and experience of a particular lawyer.

For more information about LeClairRyan’s Healthcare Industry team, contact Patrick Hurd at patrick.hurd@leclairryan.com or 757.441.8931. To learn more about LeClairRyan’s Medical Malpractice Defense practice, contact Donna Foster at donna.foster@leclairryan.com or 804.783.7532.