Protect Yourself From Malpractice Suits

Mary Jane Minkin, M.D.

Clinical Professor, Department of Obstetrics and Gynecology,
Yale University School of Medicine

There are many areas in the practice of gynecology that can lead to malpractice lawsuits for a practitioner who is not careful, even if he or she practices good medicine. Potential risks include failure to diagnose cancer, not following up with patients, failure to thoroughly check test results, and not keeping proper documentation. The cautious physician will attend to every problem that a patient presents, make sure that patients follow instructions, keep meticulous documentation, and always follow up to make sure his or her patient is progressing well.

- **Sensible everyday practices keep the lawyers away**

Although most people assume that liability issues in our business focus only on "bad baby" cases, the practice of gynecology has many areas of inherent risks. Of course cases stemming from surgical complications are well recognized, but office practice carries its own significant risks. Unfortunately, these issues are not conveyed routinely in residency training programs. Many physicians go through programs believing that as long as they practice medicine as well as they can, they will never be sued. As someone who has looked at several hundred cases over the past 12 years, I would like to point out common potential risks and suggest ways to avoid them. All of the examples are from real cases.

Evaluating Breast Masses

The most common single medical malpractice lawsuit in the United States currently is failure to diagnose breast cancer. The typical scenario is that a woman presents to her gynecologist with a lump of some sort, no follow-up is done, and the patient is later diagnosed with breast cancer. There are often questions as to whether the cancer indeed arose from the previous site, and whether earlier intervention would have altered the ultimate outcome.

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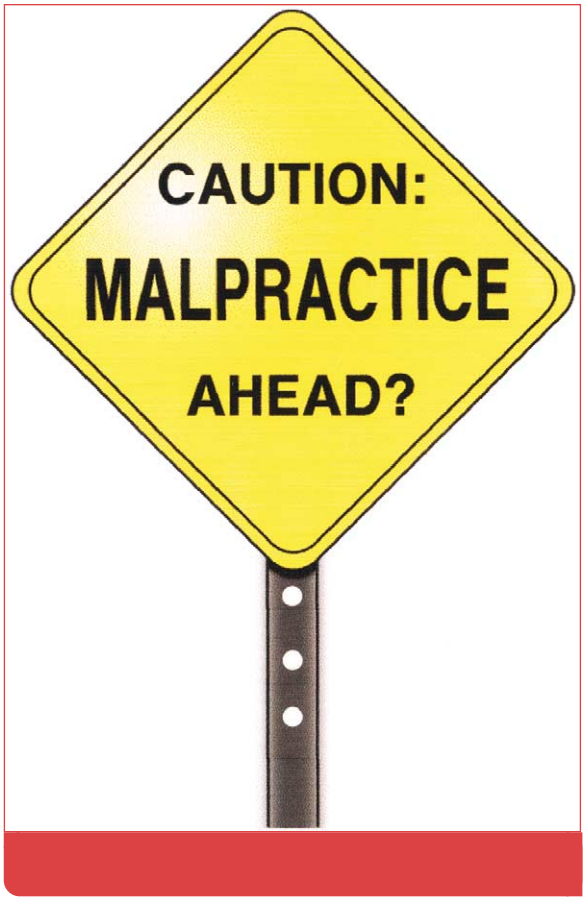
To limit your liability in situations like this, make sure that the discovery of any palpable lump is followed up by a medical person (which can be a nurse practitioner) —but you cannot rely on the patient to let you know the lump is gone. If the patient is premenopausal, and you feel that the lump is fibrocystic, you can instruct the patient in measures to minimize it (decrease caffeine intake, recommend vitamin therapies if you are so inclined), and reevaluate it after two or three menstrual cycles. You should also have the patient get a mammogram and ultrasound—if the area is clearly cystic, it does not require surgical intervention; if solid, it will require surgical evaluation.



Using a Tickler File

Put the patient's name in an office tickler file. That way, if she does not keep her follow-up appointment, your secretary or nurse will call her and remind her to come in. Your office staff can then write a note in her chart, to show that you did due diligence to have her return.

If the mass is still present after two or three menstrual cycles, you should refer the patient to a general surgeon, unless you have been well trained in breast biopsies. If a mass initially feels at all suspicious, or if the patient is postmenopausal, refer to a general surgeon right away. Use a tickler file for this patient also to make sure she sees the general surgeon within a month.

In this very busy era, mammograms are often put with a patient's chart for the gynecologist to sign off on, and many practitioners automatically just initial any mammogram as long as it says "no mass" or "normal." However, if this is from a patient whom you have sent to evaluate a palpable mass, a "negative" mammogram is not definitive, and the patient still may require referral to a surgeon. Always look at your office notes regarding the findings of the latest breast exam before signing off on the mammogram.

Tickler files are also useful for other follow-up areas. For instance, we automatically assume that patients listen to and hear everything we tell them, which unfortunately is not the case. I put all Pap smear follow-ups in my office tickler—either for follow-up of an abnormal result, or for a repeat Pap after therapy. If I have a menorrhagia patient with a low hematocrit, I will also put that in a tickler for 2 months, to make sure that the patient is reminded to repeat it. (Yes, we also seem to have responsibility for women taking the iron tablets we instructed them to take. If you schedule a hysterectomy for a menorrhagia patient who does not take her iron replacement and requires a blood transfusion preoperatively to have the case performed, the patient may add that to her list of complaints if there is a postoperative complication.)

Signing Off on Laboratory Tests

You should always look at the results of all lab tests—not only mammograms—that are placed on the front of a chart. Your signature on the result slip means that you have seen the result. The worst example of negligence in this area that I have seen actually occurred in an obstetrical case, where a patient had a grossly abnormal 3-hour glucose tolerance test (all four values), and

the physician just initialed it and did nothing further; the results were routinely filed in the chart. The baby ended up with a shoulder dystocia during delivery, and the events were clearly indefensible—this was an obvious case of unmanaged diabetes. Another example would be a Pap smear in which no endocervical cells were obtained—if that were a follow-up to a previous Pap that had atypical endocervical cells, you would certainly want that patient back to repeat the Pap right away—but if you just filed the report, you might not see that patient for a routine visit for a year. If the Pap has no endocervical cells, check the results of the previous Pap smear.

Keeping Proper Documentation

Improper documentation can adversely affect patient care and may be just what the patient needs to prove a negligence case. Whatever you are discussing with your patient, write it down. If you are discussing management options for her fibroids, for example, write down that you discussed options, and state why you recommended what you did (unfortunately, in some states—most notably, New Jersey—you have to discuss with the patient even measures that you would not medically recommend). Of course, you need to discuss with the patient the risks and benefits of whatever choice you and she make. I do not require patients to sign a consent form for hormone therapy (although I know that some physicians do); however, I dictate into every note in my charts, after a thorough discussion of the WHI, "WHI results discussed," or "hormone therapy discussed."

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Surgical Care: Pre- and Postoperative Concerns

Although surgical complications are not traditionally thought of in an outpatient setting, they really need to be discussed in this context. We have patients sign elaborate operative permits, because we all know that even the best gynecologist can cut a ureter or penetrate the bowel in any pelvic operation. But an informed consent must be thought of as a double-edged sword—we have patients sign these permits because these complications can happen; but when patients have atypical complaints postoperatively, we need to remember that these mishaps can occur, and can be discovered after the patient has gone home. This is particularly true for laparoscopy when done in a totally outpatient setting.

For example, say you operate on a patient for pelvic pain (at which time you find significant endometriosis), but that pain has been managed preoperatively by NSAIDs. Postoperatively the patient keeps calling for more narcotics to manage her pain, but you cannot write off her pain management requirements to "chronic pelvic pain." The patient needs an office visit for evaluation, as she might have suffered a perforated bowel. Or if a 30-year-old patient complains postoperatively that she cannot go to the bathroom without being short of breath, has an O_2 saturation of 88, and on the chest x-ray you order shows more that a liter of fluid in her chest, you cannot write that off has a normal postoperative laparoscopy course.

However, if such a patient is brought in (or kept in the hospital), evaluated promptly, and cured surgically, the case is very straightforward to defend successfully—an operative mishap occurred, but it was promptly recognized and promptly repaired. It is in general only when the complication goes undiagnosed that these cases are difficult to defend.

Your office must run well to make sure that all phone calls are attended to by the appropriate triage individual, and they need to be documented. When a patient can produce a copy of a long distance phone bill documenting a call to your office and you have no record of receiving that call and having dealt with it appropriately, it is difficult to defend lack of proper advice to her. And of course with the new HIPAA rules in effect, all of these conversations must be conducted in strictest privacy.

If you are using a new piece of equipment in the operating room and a representative of the company is to be present, you must make sure that that individual is approved by the operating room to be in attendance. That individual cannot operate, but can assist in the use of the equipment.

It is also much easier to defend a complication in a case in which surgery is clearly indicated, and that indication needs to be clearly documented. When a hysterectomy is performed for "menorrhagia," and the preoperative hematocrit is 38, or when the indication is "fibroid uterus," and the final pathology shows a 120-g uterus without any fibroids, it is difficult to defend the complications of cuff abscess or pulmonary embolus. Good preoperative work-ups will also keep you out of trouble. When a patient weighs 200 pounds, has facial hair, and both parents have diabetes, it is prudent to at least obtain a preoperative blood sugar reading. When that patient calls complaining that her wound looks red, you will be quicker to invite her in for a checkup if you know she has diabetes—but it would also have been more prudent to have her diabetes under control before you operated on her.

Residents: Who Is Responsible for What?

Working with residents and fellows presents some different issues. Lawyers are always eager to sue residents and any other hospital employee they can, because the hospital usually has more money in reserve for malpractice cases ("deeper pockets") than do individual physicians. Most physicians feel that they are the "captain of the ship" when it comes to their patient's care, and are responsible for any problem that occurs during their patient's hospitalization. This is, according to most attorneys, currently not the case, and individual residents are responsible for their own actions. So if your resident sees a patient for evaluation of a fever of 103°F, evaluates the patient, and doesn't call you, the resident is responsible for his or her own actions (or inactions) and their consequences. However, if the resident draws blood cultures at your request, and you are the private attending discharging the patient, it is incumbent on you to check on the blood culture results before discharging that patient. When that patient shows up in a neighboring emergency room and where it is discovered that the patient is growing out *Enterococcus* and the result was available prior to discharge, there is no good defense.

All readers of this article are well familiar with these issues. But given the fast-paced practice lives we lead, we all can easily have some of these mishaps occur. Good medicine takes time—and it is hoped that some day, even the HMOs will realize this. Defending a malpractice suit, however, takes even more time. But preventing a suit from happening in the first place takes relatively little of your time.

Mary Jane Minkin, Clinical Professor
40 Temple Street
New Haven, CT 06510
maryjanem@cshore.com