SEMINAR PAPER

MEDICO-LEGAL ISSUES – MINIMISING THE RISK & WHAT TO DO WHEN THEY ARISE

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By

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Introduction

1. I once sat outside a DHB CEO's office with a young doctor who was in some medico-legal strife. Trying clumsily to lighten the mood, I said that it was a bit like waiting outside the principal's office at school. She looked at me with forlorn, sleep-deprived, eyes, and said: "I never had to wait outside the principal's office".

2. This highlights a real issue for doctors in the medico-legal context. As a cohort, you are, bless you, and I mean this in the nicest possible way, nerds. You might find it ironic for a short, balding, middle-aged lawyer to be telling you this, but it's true. Most of you will never have been in any serious trouble, of any kind, with anyone.

3. But most doctors, even the very best ones, face serious complaints during their careers. Many will have their actions questioned by patients, colleagues, and/or employers. Many will have to explain their actions to the Medical Council, the Health and Disability Commissioner, the Health Practitioners Disciplinary Tribunal, and/or the Coroner's Court.

4. This is tiger country for which most doctors are ill-equipped by their life experiences, and training. The rules are different. It is not always enough to have tried your hardest or done your best. It is not always enough that you care very deeply about what has happened. You are not in charge. Your word is worth no more than anyone else's. The reference points, logic, and objectives are different to what you are used to.

5. But fear not, help is at hand. Obviously, if things get really bad, that help will come in the shape of a short balding middle-aged lawyer. But well before you get to me, or any of my fellow *nazgul* horsemen and horsewomen of the apocalypse, there is a whole lot that you can do to help yourself.

6. This seminar addresses minimising the risk of medico-legal issues arising, and what to do when they do arise.

Minimising the risk of medico-legal issues arising

The importance of listening and empathy

7. Listening and empathy skills are fundamental to good medical practice. They are also a significant prophylactic to medico-legal issues. Many complaints arise where patients have felt rushed, brushed aside, not listened to, or not cared about.

8. Patients may have been waiting some time before seeing you. Often they will have rehearsed what they want to say. It is very important for them to say it, to tell their story. It might not all actually be relevant or important to their diagnosis and treatment, but it will be relevant and important to them. When they see you, you need, within reason, to let them say what they want to say, in their words, without interruption. It usually won't take long.

9. There is a telling story about steps taken by a US medical insurer to reduce malpractice claims. The insurer is said to have studied the listening skills of its most-sued 10% of doctors (most of whom apparently were orthopods). It found that, on average, they interrupted their patients within the first 20 seconds of any consult. The same doctors were then required to ensure that they did not interrupt their patients for at least the first two minutes of any consult, using an egg timer. The

malpractice suits reduced significantly. The consultations also did not last any longer.

10. Of course, not interrupting people straight away is just the beginning of good listening. Ideally doctors should be active listeners. Active listening is a specific communication skill, analysed in the work of psychologist Carl Rogers. In 1980, Rogers said:

> "*Attentive listening means giving one's total and undivided attention to the other person and tells the other person that we are interested and concerned. Listening is difficult work that we will not undertake unless we have deep respect and care for the other.."*

11. Listening and empathy go hand in hand. Empathy is a hard concept to pin down, and some people are better at it than others. But sick and injured people want to know that their doctor cares about them. This does not mean that you have to buy every patient an "*I wuv you*" balloon, or like them on facebook. But be polite and friendly, maintain good eye contact, don't cross your arms or lean back in your chair, and show natural emotional responses to what you are being told, be it funny or sad. Empathy is obviously important in itself, but people are also much less likely to complain about someone who they think cares about them.

Document, document, document

12. Doctors have a professional obligation to maintain adequate notes and documentation. The Medical Council Good Medical Practice Guide states:

> ***Keeping records***
>
> *5. You must keep clear and accurate patient records that report:*
>
> *relevant clinical information*
> *options discussed*
> *decisions made and the reasons for them*
> *information given to patients*
> *the proposed management plan*
> *any drugs or other treatment prescribed.*
>
> *6. Make these records at the same time as the events you are recording or as soon as possible afterwards.*

13. A failure to maintain adequate notes/documentation can have serious medico-legal consequences in and of itself. From 2004-2013, the HPDT heard 15 cases on inadequate note-taking/documentation. In all of them it was found that the doctor had failed to maintain notes/documentation to a proper professional standard.

14. A failure to maintain adequate notes/documentation can also have wider implications. If a complaint arises, the notes are the best evidence of the care provided to a patient. If notes are deficient, a complaint is made by a patient, and it becomes the patient's word against the doctor's, then there is every prospect that the patient will be believed ahead of the doctor.

15. Document communication touch points with patients as well. A very sad recent case involving a still birth highlights the importance of this. In their stress and grief the family felt that hospital staff had been uncaring and unsympathetic. The notes

showed a different story that was helpful in responding to the patient complaint. The baby had been bathed and dressed in newborn clothes, the staff did a foot imprint for the parents to keep and took photos of the family, and left them to share time alone with their baby.

16. Try to always complete notes/documentation when you have the patient in front of you, or at least before you see the next patient. This even applies to doctors who are seeing dozens of patients a day – in fact it applies even more so to them, because such numbers enhance the risks of mistakes. It is very useful if issues later arise, if you can honestly say that you have a consistent practice in this regard.

17. Never make notes which are false, misleading, or self-serving.

Take care with what you write

18. Young lawyers are taught to always write as if, one day, what they have written might be before a judge - be it a letter, an email, or a filenote. And they are also taught, or should soon learn, that judges dislike emotive language, rudeness, bald assertions, hectoring and undue aggression.

19. I suppose another way to think about it is to remember that your notes and documentation could one day be before someone sitting in judgment of you, who is not your friend or colleague, does not necessarily understand what you do, and who may have a natural sympathy for another party.

20. As you will be aware, patients always have the right to request their notes, so never write anything in the notes that you would not want the patient to read.

21. Always be courteous, always be clear, always stick to the facts, and (within the reasonable bounds of efficiency) cite evidence when you can. Qualify opinions, and make it clear that they are opinions

22. I have a good friend who is a surgeon. As a general rule she is a very gentle, compassionate, and considered person. Sometimes, however, when she is in a situation of professional or business conflict, those qualities hide behind the sofa. She consults me on correspondence in these circumstances. I will say: “what do you want to say?”. She will say: “they’re wankers and they’re wrong”. We workshop it for a while, and usually eventually agree to leave the first bit out, and work on putting some politely expressed reasoning behind the second bit.

Take extra care around informed consent

23. Engage with patients and provide them with as much information as possible and appropriate for true informed consent. As you will well know, many patients these days google and present with information. Whilst this can be a problem if patients mis-inform themselves, you cannot stop it, or dismiss it. Direct patients to reputable sources of additional information and/or provide them with printouts to take home.

24. Document all consent issues discussed with a patient. For example this might be indication for surgery plus the anticipated benefits and risks (both generalised and risks particular to this patient). This information may subsequently become important in ways you could not have anticipated at the time. NZMPI is currently assisting a doctor with an ACC treatment injury case where the initial surgery was undertaken in 2006.

25. The issue of informed consent has been in the news lately, after the HDC made adverse findings against a surgeon. The patient, Mr A, had a CT which found a 17mm polyp in the sigmoid colon, and diverticulosis. Dr D concluded that the best option for Mr A was surgery. He did not inform Mr A of other options or of the risks of surgery for him. He did not discuss Mr A's case with his colleagues or at a multidisciplinary meeting. The surgery was undertaken, and more surgery was subsequently undertaken. Mr A later died of complications. There was a complaint to the HDC.

26. The HDC findings recorded that Mr A had the right to the information that a reasonable consumer in his circumstances would expect to receive. This included an explanation of the treatment options available, and an assessment of the expected risks, side effects, benefits and costs of each option. Dr D did not provide this information to Mr A following his diagnosis. Accordingly, Dr D breached Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights, which says that every consumer has a right to:

> *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.*

Without this information, Mr A was not in a position to give informed consent to the surgery. Accordingly, it followed that Dr D also breached Right 7(1) of the Code, which says that:

> *Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

Timely follow-up

27. Use the technology available to you in the best possible way e.g MedTech and Eclair to ensure timely follow-up on test results and referrals. Complaints about delay in diagnosis and treatment are common.

Call ups and call backs – make the message loud and clear

28. Provide clear directions to patients on when they need to present for medical assistance. Provide this in writing. Stressed, anxious parents for example cannot always take in all of the information provided by doctors.

29. There is an increasing expectation that doctors should remind patients of when they need to re-present for particular treatments. I acted for a GP who had told a patient that he should have a colonoscopy at a certain age given his family history. The patient neglected to get the colonoscopy, subsequently contracted bowel cancer and died. The GP was criticised for not diarising the matter and recalling the patient.

Don't be afraid to be an advocate for your patient

30. Doctors in fact have a duty to be advocates for their patients. This can include advocating for patients to be seen by specialists despite public hospital waiting list prioritisation. The HDC recognised this advocacy role in a case involving a referral for colonoscopy and a delayed diagnosis of bowel cancer.

Use a chaperone for intimate examinations

31. Use a chaperone for all intimate examinations. In a recent case a doctor was ultimately cleared of any wrongdoing but the conditions imposed on him in the interim prevented him from working for over a year. Be aware of not turning an examination inadvertently into an inappropriate intimate examination that can result in a complaint. Do not for example lie across a patient when conducting an examination.

32. Always record that fact that a chaperone was present, and who it was, in the notes. If a patient declines a chaperone, record that too.

Take care at handover

33. Ensure with handover that there are clear lines of responsibility assumed. Different specialties can have particular issues in this regard. An example is O & G cases where the LMC may not be employed directly by the DHB.

34. Patients can be left in limbo with dire consequences if handover is not done well. The medico-legal risk often falls on the doctor who was responsible for the handover.

35. This includes clearly documenting in your discharge letter that the patient has been discharged back to the care of their GP.

Front complications

36. Properly consented patients will appreciate that complications are a possibility in medical treatments. As you well know, complications are often not related to mistakes or any inadequacy in care.

37. Front complications. This doesn't mean for a moment that you admit liability for them. It just means that you acknowledge them, and address them. Discuss them candidly with the patient, and colleagues as necessary. Show the patient that you care, and appreciate this makes things more difficult for them. Form a plan, and share it with the patient.

38. Don't blame the patient. Don't say: "*well, the other 100 of these I've done went well*". That is really just to make you feel better. The patient doesn't want to know.

You are not alone...

39. Never be afraid to ask for assistance. Escalate concerns up the hierarchy – via registrars and consultants if necessary. Never let the fear of waking someone up and getting them to come in bind you to a situation you are not equipped to deal with.

40. Be aware of the experience and expertise of others around you in a multi-disciplinary approach. It is not just doctors who can come to your aid.

41. Doctors can and do feel a great and lonely weight of responsibility. This sense is only heightened when complaints, mistakes and issues arise. Never forget that there are colleagues who can help. The old line about a problem shared is a problem halved rings very true in the medico-legal context. I have dealt with many doctors who have said things to me like:"*I was absolutely beside myself until I spoke to Dr X, who said: "that's nothing, here's what you do – and if that's the biggest issue you have in your career you'll be lucky*"".

Keep your contact details up to date

42. Keep your contact details up to date with your insurer, the MCNZ, and your DHB. There have been cases where correspondence from the MCNZ or HDC initially went undelivered because contact details had not been kept up to date. When the correspondence was finally received, the doctors were already behind the eight-ball in terms of dealing with the complaint, and time extensions had to be sought – never a great start.

Take care of yourself

43. Take care of yourself, and work safe hours. Extreme tiredness and stress can cause mistakes and accidents. But being tired and stressed will not be an acceptable justification for poor care that impacts on the health and safety of patients.

What to do when medico-legal issues do arise

Notify promptly, and in a full and candid way

44. There is no shame in an insurance notification. Many notifications arise out of situations where the doctor is entirely blameless. Many notifications eventually come to nothing, and that is fine.

45. Notify your insurer as soon as possible when a medico-legal issue does arise. This is both a legal obligation, and good common sense. It gets you help early, and will prompt you to gather the evidence that you will need later. A failure to notify in a timely way can be a basis for cover to be declined.

46. Prepare a written statement while events are still fresh in your mind. Obtain a copy of the relevant notes. This is particularly important if you are moving between DHBs. Getting access to the notes may be more difficult further down the track.

47. You have a duty of good faith to your insurer. That means that you must be candid. Present the problem, and yourself, warts and all. A failure to do so can also affect cover. More significantly, it can have a very negative effect on the ability of your insurer and lawyer to help you.

Seek help

48. Again, you are not alone. Your insurer and your lawyer are there to help. You can and should also seek support from colleagues, and, where appropriate, experts.

49. I was recently involved in a very difficult coronial enquiry, where there was criticism of a GP's conduct in an unusual and tragic emergency situation. A senior specialist in the relevant field took a collegial interest in the case. He gave evidence to the Coroner which gave real context to the GPs actions, and substantially exonerated him.

Own a mistake, but don't commit ritual seppuku

50. If you make a mistake, own it. Reflect, and show insight. Report candidly on what has occurred. Take steps to ensure it is a mistake you, or others, will not make again. These are the right things to do. Taking these steps can also make a big difference to the medico-legal consequences of mistakes.

51. This is not to say that you have to fall on your sword in every instance, and take responsibility for everything that went wrong. Often mistakes have multiple contributing factors, not all of which are apparent at first blush.

52. I acted for a highly rated surgeon, who felt he had made a mistake in a complex procedure. He fronted it with the patient, and his DHB, with utter candour. He made it quite clear that his main concerns were the welfare of the patient, and ensuring that such a mistake could not recur. He took advice from me on the way through, and I was able to assist him with tone and approach. But he showed leadership and integrity throughout. At no point did he seek to hide from what had occurred. I know it caused him a great deal of stress, but there were no medico-legal consequences.

Never alter records

53. Sometimes, when a complaint arises, doctors look back at the notes/documentation, and decide that they do not present a full or accurate picture of what happened. Never seek to address that by altering the notes/documentation. That is tantamount to interfering with evidence and can land the doctor in more serious trouble than the complaint itself.

54. If the notes/documentation are wrong, or incomplete, set out how and why separately, in a further written, dated document. Then consult with your advisors on the best way to present that.

55. Apart from being inherently wrong, and generally unlawful, doctors will generally not get away with altering records. Modern computer forensics will see to that.

Tell the truth

56. Again with the irony. A morality directive from the profession that brought you Lionel Hutz, Saul Goodman, and far too many politicians. But you would be surprised how many doctors, when put under enough personal and professional pressure, will lie.

57. I have acted for hundreds of clients over more than 20 years in practice. They have included more than a few fraudsters and rogues. But the most palpable porky ever told to me, was told to me by a doctor in trouble for a breach of patient rights.

58. Obviously there is a moral imperative to telling the truth which ought to be enough on its own. But there are other very good reasons for telling the truth. Probably because they don't do it often, doctors are generally poor liars. And even good liars (if there is such a thing) usually get tripped up by something inconvenient, like the facts. Either way, liars are eventually caught out, with disastrous results. Decision makers hate being lied to, particularly by someone in a position of great trust, and it can have a major effect on their treatment of the liar.

59. There was another HPDT case relating to a GP with a patient who died of bowel cancer. The Tribunal found that the GP had been guilty of professional misconduct by:

    (a) Failing to encourage the patient to have certain symptoms investigated;

    (b) Making additional entries in the patient's notes without recording that they had been made retrospectively; and

    (c) By misleading the Commissioner about what she had done with the notes.

60. The HPDT considered that misleading the Commissioner was the doctor's most culpable misconduct. The fine for that misconduct was double the fine for the other misconduct.

61. It should be noted though, that saying you must be truthful is not the same as saying that you have to confess to everything you can think of at the first possible opportunity. Doctors do have a right to silence in certain circumstances. It is also always useful to take time to consider how to best express any acknowledgement of wrongdoing, and get advice on it. But always make sure that whatever you do say is true.

Final remarks

62. I hope this hasn't ended up as a sort of medico-legal "*Scary Movie*". Whilst things can go wrong, the conscientious, well-meaning and intelligent approach taken by most doctors generally shines through. Most medico-legal issues are dealt with in a way that doesn't see the doctor concerned dismembered by a figurative legal Freddy Kruger.

63. If there are some key take-outs they might be these obvious calls: listen to and empathise with your patients, keep good records, be proactive, front complications and mistakes, when issues arise get help and notify your insurer early, and, of course, be honest.

64. Finally, in case all of this legal talk has been sounding a little smug, I leave you with a transcript from a US Court case that tells a sorry tale of just how stupid we lawyers can be:

> *Attorney*: Dr., before you performed the autopsy, did you check for a pulse?
>
> *Witness*: No.
>
> *Attorney*: Did you check for breathing?
>
> *Witness*: No.
>
> *Attorney*: So then is it possible the patient was alive when you began the autopsy?
>
> *Witness*: No.
>
> *Attorney*: How can you be sure Dr?
>
> *Witness*: Because his brain was in a jar on my desk.
>
> *Attorney*: Could the patient still have been alive nevertheless?
>
> *Witness*: It is possible that he could have been alive and practising law somewhere.

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