

Medical, Legal, and Ethical Issues

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KEY TERMS AND DEFINITIONS

Abandonment. Unilateral dismissal by the physician without proper notice to the patient or failure to keep an express promise when there is still a need for continuing care.

Civil Law. A codified system of written laws adopted by a jurisdiction.

Common Law. Laws made largely by judicial interpretation.

Fiduciary. Having a special relationship toward another that imposes legal duties to act responsibly and in good faith to protect that party's interests.

Informed Consent. The physician's fiduciary duty to give the patient all the information needed for the patient to make an intelligent decision about therapies offered.

Malpractice. Patient injury secondary to failure to exercise that degree of care used by reasonably careful physicians of like qualifications.

Negligence. Failure to extend the degree of diligence and care that a reasonably and ordinarily prudent person would exercise.

Tort. A civil wrong for which legal action can be taken to recover damages resulting from negligence.

A doctor who knows nothing of the law and a lawyer who knows nothing of medicine are deficient in essential requisites of their professions.

—David Paul Brown 1795–1872

British North America inherited its law, as it did its language, from England. Most of the European countries originally occupied by the Romans adopted a form of law based on the Roman law codes. That law is called *civil law*. England's law, on the other hand, was based mainly on Scandinavian (Danish) law with a dose of folk law of undetermined origin thrown in. It was called the *common law*. One should not be deceived by its name. It was not law designed to protect the common man. It takes its name from the fact that it was the law that was common to all of England by about the year 1240. The two forms of law differ significantly.

Civil law is a codified system of law. That is, the law is spelled out in a series of written laws adopted by the jurisdiction. Civil law, therefore, tends to be fairly static. Common law is largely law made by judges. It may incorporate some statutory elements on specific issues, but even statutes are subject to judicial interpretation. Judges in the civil law are academics specially trained for their positions and act as prosecutor, judge, and jury. Civil law is, therefore, inquisitorial in nature and heavily dependent on the written word. In contrast, common law is an adversarial system in which the oral argument between the parties plays a much larger role. Judges are chosen from the practicing bar and are not usually academics. The judge is essentially a referee and instructs the jury, who make the ultimate decision on the merits of the case. In common law, the law is made by judges who hear a disputed case on appeal. Those decisions become

precedent for future cases. However, higher appellate courts or future appellate courts of the same level can overturn or overrule a prior decision if circumstances change or new information develops. Therefore, change, albeit slow and irregular, is a constant element of the common law.

Under the early common law, cases were more or less confined to one of three categories. By far the most important cases were those in the field of property law. Real property was the basis of the wealth and economy of England, and it was natural for such cases to flood the courts. The concept of enforcing promises also played heavily in the development of commerce, and contracts were second in their demand for court time. To bring any civil action a king's writ was needed, and the writ covered only recognized wrongs that might be remedied. Finally there was criminal law, the enforcement of society's code of conduct. As one can readily see, little attention was paid to compensating the individual for personal wrongs (tort law). Doctors were therefore immune to suit for what we would call malpractice today. Technically some suits might have been pursued as contract suits, but written contracts were highly unusual between a physician and his patient, and without the written document such suits became almost impossible for the plaintiff to win.

In 1346 the black (bubonic) plague arrived in Italy. It spread over Europe rapidly, but did not reach England until 1348. The major effect of the epidemic occurred between 1348 and 1351, but bubonic plague became endemic and continued more or less uninterrupted until 1381. It is estimated that between 1348 and 1351, 50% of the population died, and by 1381 two thirds of the English population was decimated by the epidemic. (Because there was no accurate census at the time, such figures are estimates based on church records, burial records, tax rolls, and contemporary accounts.)

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The loss of manpower was a major blow to the English economy. Overnight, people became as important as real property (land) and personal property (including livestock) in the English economy. Therefore, a physician's mistake that deprived the economy of a worker became an important enough matter to be brought before the courts. Physicians suddenly lost their immunity for practice errors. Actually it was an even worse scenario: The physician became strictly liable for an unfavorable outcome, and because there was no tort law (law compensating the individual for personal wrongs), the physician was prosecuted under the criminal law for mayhem. By 1364, it had become obvious that this was too draconian a remedy, and two property terms that had been previously used in livestock cases were introduced to permit civil malpractice cases. "Trespass" (trespass by force and arms) was charged for direct injury and "trespass on the case" for indirect injury.

These concepts, refined over the centuries, were brought to the North American colonies and adopted almost entirely by the American court system after independence. In the early 1800s the modern concept of negligence replaced trespass and trespass on the case in English courts. In the period of rapid industrialization following the Civil War, American courts did the same. (The elements of a cause of action in negligence are undoubtedly well known to the majority of readers, but are repeated here for completeness):

1. A duty, recognized by the law requiring the individual or entity to conform to a certain standard of conduct;
2. A failure to conform to the standard required;
3. A reasonably close connection between the failure to conform with the standard required and the resultant damage (subject to tests of legality, reasonableness and public policy)—what is usually summed up as "proximate cause";
4. Actual injury, damage or loss.

Our founding fathers divided the court system into two separate systems: the federal court system and the state court system. Over the years, both systems have become remarkably similar in their rules of evidence and civil procedure, and today most state courts are trilevel, as are the federal courts. Federal courts have jurisdiction over:

- Cases that arise from the constitution, federal statute, and treaties
- Cases affecting ambassadors, counsels, public ministers
- Admiralty and maritime cases
- Cases between states
- Cases between a state and a citizen of another state; between citizens of different states; and between an American citizen and foreign state or foreign citizens

Federal cases must involve a substantial financial value (an ever increasing value as determined by statute. The federal court system is definitely not interested in jurisdiction of small claims).

Under Article VI (commonly referred to as the supremacy clause) of the constitution, federal law "...shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby;..."

There is at least one federal district court for each state. District court cases are heard before a single judge. The opinions are published and may be cited in future cases, but carry minimal

weight as precedent. There are 13 circuit courts of appeal, which hear appeals from district courts. Cases before circuit courts of appeal are heard by three judges. Their published opinions become precedent. Finally, appeals from the circuit courts of appeal go to the United States Supreme Court. Published Supreme Court cases are the highest level of precedent.

As can be seen from the list of federal jurisdictions, most tort cases including malpractice cases will be heard in state court systems. As mentioned earlier, most are organized much as the federal system. Most frequently each county has a court. These courts are frequently named superior courts to distinguish them from lesser courts such as municipal or justice of the peace courts. The county court cases are rarely published and have no practical value as precedent. Appeals from the county courts are heard by one or more state courts of appeal. Cases from state courts of appeal cases are published and have substantial value as precedent in that state's cases and some value as precedent in other states' cases. Appeals from the state courts of appeal are heard by the state supreme court. The state supreme court's published opinions have the highest value as precedent in that state and are given careful consideration as precedent in other states.

REPRODUCTIVE MEDICINE AND THE COURTS

No area of medicine has received as much court scrutiny, legal scholar review, social comment and even presidential directives as have the fields of obstetrics and gynecology. In addition, three of the six most expensive malpractice claim categories for 2003 fall within the realm of the obstetrician/gynecologist's practice (pregnancy/birth claims, failure to diagnose breast cancer, failure to diagnose cervical cancer). Unfortunately each of the issues that has come before American courts deserves a volume of its own to discuss adequately and a chapter in a general textbook of gynecology can do little but cover the generalities and list the more important issues the courts have addressed.

Since a 1927, eugenics case validating a Virginia compulsory sterilization law (*Buck v. Bell*, 274 U.S. 200 [1927]. See also, *Skinner v. Oklahoma*, 316 U.S. 535 [1942]), the United States Supreme Court has issued a continuing series of opinions that have established our present gynecologic legal environment. In *Griswold v. Connecticut*, 381 U.S. 479 (1965) (see also *Carey v. Population Services International*, 431 U.S. 678 [1977]), the Supreme Court held that the right to privacy applies to the use of contraceptives and struck down state laws that prohibited their distribution and sale. The well known case of *Roe v. Wade* (*Roe v. Wade*, 410 U.S. 113 [1973]) applied the same principle to state laws applied to abortion. However, even these supposedly well established court cases have long histories of challenges by state courts on issues such as waiting periods, spousal and parental notice, reporting requirements, second opinions, procedure facilities and methods, public funding, harassment of facilities and clients, and have undergone modifications based on legal concepts as varied as constitutional equal protection and informed consent. Some constitutional scholars have speculated that the whole concept of reproductive privacy is in danger of being overturned by an ever more conservative Supreme Court influenced by an increasingly militant religious right (see *Thornburgh v. ACOG*, 471 U.S. 1014 [1986], 5 to 4

decision with dissent questioning validity of *Roe v. Wade*). As a result, the prudent practicing gynecologist must research the ever-changing local, state, and federal statutes and decisions governing every aspect of his or her practice. In the next section are some general defensive strategies for the gynecologist to observe in clinical practice. These strategies are not promoted as a substitute for good communication with patients, knowledge of your jurisdiction's law, or proper, honest, fair, considerate, unbiased treatment of patients.

PHYSICIAN'S DEFENSIVE STRATEGIES

Abandonment

Unilateral dismissal of the patient by the physician without proper notice to the patient is popularly conceived of as being the entire tort of abandonment. However, failure to keep an express promise (being present for a delivery, making a house call, or treating with a particular modality are common examples), failure to give proper discharge instructions, or abrogating your authority to a less qualified individual are much more likely to result in charges of abandonment. This is particularly true in the case of the obstetrician/gynecologist, in which the courts consider the physician/patient relationship to be particularly personal and private.

Physician's Defense Strategy

Explain your coverage arrangements in a patient brochure and document that the patient has received it. Do not sign out to family practitioners or partially trained gynecologists. If house officers are going to be involved in the patient's care, explain their role and do not allow them to exceed the stated role. Do not make express promises if there is even a minimal chance a change of circumstances will prevent you from keeping your promise.

Abortion

See the preceding discussion. Two subsequent Supreme Court cases (*Webster v. Reproductive Health Services*, 109 S. Ct. 1759 [1989]; *Planned Parenthood v. Casey*, 112 S. Ct. 2791 [1992]) have greatly expanded the local control of abortion, and preabortion procedures.

Physician's Defense Strategy

Seek local legal counsel. Make sure all aspects of your abortion practice conform to local, state, and federal law. Insist on an opinion letter that covers preabortion, abortion, and post-abortion issues. Do not do the procedure without "on advice of counsel" protection. Get timely legal reviews.

Acronyms

In every teaching hospital in the country that the authors have visited or reviewed records from, resident physicians have a system of acronyms or codes that they think of as secret to communicate comments about patients. Unfortunately, those

acronyms and codes rarely are original or defy interpretation. Juries view them as the work of flippant, uncaring, pompous, and condescending care givers, and use of such codes badly injures the hospital or physician's defense and is unprofessional.

Physician's Defense Strategy

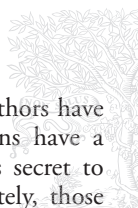
Avoid bad acronyms (some of the more common to avoid: NTB, not too bright; AMF, adios my friend; MFC, measure for coffin; FLK/FLM/FLF, funny looking kid/mom/father; UKD, ugly kid disease; GORK, god only really knows) and symbols even if they truly express your frustration in caring for a patient. DIIK or a sketch of Casper the Ghost (Damned if I Know and Spooky) may truly be as close to a diagnosis as anyone will ever make prior to autopsy. But when the autopsy physician comes up with a diagnosis mentioned in a footnote in a last month's *New England Journal*, a foolproof case for the defense is in serious jeopardy.

Assisted Reproductive Technology

The entire area of assisted reproductive technology (ART) is plagued with unresolved issues. Not even the legal status of the embryo, preembryo, or fetus has been established with any uniformity. Furthermore, the use of fetal tissue has been the subject of state bans, federal court cases overturning the bans (see *Margret v. Edwards*, 794 F.2d 994 [5th Cir. 1986]; See also, *Lifchez v. Hartigan*, 735 F.Supp. 1361 [N.D. 1990]), presidential directives, and the dissolution of ethical advisory committees. Cases involving the marital status, economic status, parental suitability, and psychological screening of patients have all come before the courts (as a result of "do it yourself" manuals and "mail order" sperm banks, four states have specific statutes requiring artificial insemination by a physician). Cases involving the medical screening, genetic screening, psychological screening, frequency of use, and payment of sperm donors have also come before the courts. The disposal of unused fertilized eggs or preembryos has been the subject of a series of court cases since the mid 1970s (actually predating the first reported successful in vitro fertilization [IVF] pregnancy). The use of surrogate mothers, the rights of surrogates, and the payment of surrogates has been a constant subject of law review articles and has been addressed differently by several state legislatures and still other opinions by state attorneys general. Numerous governmental inquiries and several cases involving ART clinic record keeping, informed consent, reporting, and statistical methods have taken place. In addition, nowhere in medicine does basic contract law play a greater role than in ART, and many a night's sleep has been lost over a failure to consider the remotest possibility in a clinic-patient-spouse contract or spouse-spouse contract.

Physician's Defense Strategy

To the best of the author's knowledge, only eight states have adopted the Uniform Parentage Act of 1973 in regard to artificial insemination (AI), but more than 40 states have a direct or indirect individual act affecting AI. When it comes to the more technical ART techniques the variability is even greater. The prudent gynecologist will engage in ART in a center with written protocols; sufficient laboratories and personnel to guarantee



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proper social, genetic, psychological, and medical screening of patients and donors; sufficient numbers of patients to keep care giver's skills sharp; sufficient storage space to keep a frozen preembryo for as long as required by law or contract; readily available legal help; and a written opinion letter from the state's attorney general's office certifying that the clinic is in compliance with the state's legal requirements.

Cancellations and "No Shows"

Cancellations and "no shows" of follow-up patients appointments are often ignored in the busy clinic or office. They can be, and are, frequently responsible for subsequent malpractice suits.

Physician's Defense Strategy

Each cancellation or no show should be documented in the chart. The chart should then be reviewed by the treating physician and, where appropriate, a letter or phone call made to the patient. All efforts to communicate with the patient should be documented.

Coverage Arrangements

As mentioned earlier improper coverage arrangements may lead to charges of abandonment. Poor communication among coverage groups frequently leads to offended patients and can be the first step on the path to a malpractice suit.

Physician's Defense Strategy

The previously mentioned strategy applies here:

1. List your coverage arrangements in your new patient brochure.
2. Sign out to qualified individuals.
3. Do not make specific promises as to your presence or procedures.
4. In addition, coverage groups should meet regularly to exchange information and maintain protocols.
5. Problem patients should be known to the entire group.
6. All after-hours care should be carefully documented and entered in the medical record either contemporaneously or at the latest the next business day.
7. All medical records should be available to all members of the group.

When you have the coverage:

1. Don't put geographic barriers between you and the patient (although it is not written in stone, The Emergency Medical Treatment and Active Labor Act and other federal regulations and cases based thereon would indicate that you should be able to reach your patient's bedside within **thirty** (30) minutes).
2. Do not drink alcohol or take drugs (even prescription drugs) that can affect your cognition or cause somnolence.
3. Document all phone calls. Err on the side of caution.
4. Emergency physicians are great, but emergency departments are often overworked and slow and you are inserting an intervening opinion between you and the patient. An "I will

meet you at the emergency room!" has been a great relief to many a patient and many a physician.

Contraception and Sterilization

Contraceptive methods and sterilization procedures can involve the physician in multiple issues of informed consent, treatment of minors, emancipation of minors, and court-ordered procedures, wrongful pregnancy as well as wrongful life and wrongful birth suits.

Physician's Defense Strategy

There is no escaping the necessity of researching your state's requirements. However, no where in obstetrics/gynecology practice is the communication with the patient more important. A thorough, unbiased informed consent is required. In addition, be careful of your terms. A tubal transection should be truly a tubal transection and a piece of tube sent as a pathology specimen is a splendid proof that the tube was sectioned. A clamped, crushed, or cauterized tube signed out as a tubal transection is a much less satisfactory form of evidence at a subsequent trial.

Fraud and Abuse

In 1972, as part of the first amendments to the Medicaid and Medicare rules and regulations, Congress passed antifraud and abuse regulations. The first such laws were hardly more than "a slap on the wrist." However, in 1977 Congress made those laws draconian. False statements, which include:

1. Knowingly and willfully making or causing to be made any false statement or representation of a material fact in seeking to obtain any benefit or payment
2. Fraudulently concealing or failing to disclose information affecting one's rights to a payment
3. Converting any benefit or payment rightfully belonging to another, and
4. Presenting or causing to be presented a claim for a physician's service knowing that the individual who furnished the service was not licensed as a physician.

These also encompass false claims, bribes, kickbacks, rebates or "any remuneration" and are felonies with a maximum of 5 years in jail and a \$25,000.00 fine possible for *each* such offense. (The law states that any provider who knowingly and willfully solicits, pays, offers, or receives, any remuneration, in cash or in kind, directly or indirectly, overtly or covertly, to induce or in return for arranging for or ordering items or services that will be paid for by Medicare or Medicaid will be guilty of a felony). These rules and regulations essentially made it impossible to practice without violating some aspect of the fraud and abuse laws. It was, however, 10 years before the laws were refined in the Medicaid–Medicare Patient Protection Act of 1987 which provided some "safe harbors" to free normal course of business procedures. Since 1987, the government has pursued fraud and abuse cases with ever-increasing vigor. In 2003, settlements in fraud and abuse cases netted the government close to \$2 billion (*Wall Street Journal*, A1, Friday, June 11, 2004). The real danger to the physician is not the fine that may force him or her into

bankruptcy or the unusual imposition of jail time (to date, the government has seemed more interested in recovering cash and calling a halt to illegal practices than it has in jailing doctors), but the felony conviction that may result in the automatic loss of the license to practice. Thus Medicare/Medicaid fraud and abuse is a far more dangerous hazard than is malpractice.

Physician's Defense Strategy

Have your patients sign in whether they have come for an office visit or just a procedure. If you are worried about privacy issues, use a privacy sign in sheet that prevents subsequent signers from seeing who has signed in before (Colwell Publishing provides several styles of such sheets and they are very likely supplied by local firms as well.)

Don't unbundle procedures that are supposed to be bundled on a physician's visit. Don't unbundle surgical procedures. Don't charge for procedures done by another licensed provider or charge for physician's services if the physician is not physically present. Send your personnel to an accredited coding course and make sure your coding is being done in an accurate manner. Do not be tempted to code up. Time studies and statistics are against you. Finally, beware of the "coding consultant" who promises to increase your accounts receivable.

Informed Consent

Physicians continually ask for a foolproof informed consent form. Informed consent has little to do with a form. Informed consent has to do with the physician's fiduciary duty to his or her patient. As the patient's fiduciary, it is the physician's duty to give the patient all the information needed for the patient to make an intelligent decision about the therapies suggested. The information given must be accurate for published studies and compared with the physician's own figures, unbiased by the physician's privileges or other agenda, and presented in language the patient in question can understand in view of her education, intelligence, experience, and social standing. The information should include the diagnosis; a description of the suggested treatment; an explanation of what the treatment is thought to accomplish; the hoped for prognosis with the treatment; the possible side effects and possible adverse happenings with treatment; the therapeutic alternatives, their benefits, and possible adverse and side effects; and the patient's prognosis with the alternative and no therapy.

Physician's Defense Strategy

Give the woman all the information called for and document it in the medical record. Ask her if she has any questions. Answer the questions, and document both the questions and the answers. Use diagrams when necessary. Add the diagrams to the medical record and ask the patient to initial the diagrams. Have the patient sign the consent form—use the statutory form if your state has one—if not, use one approved by your clinic or local medical organization and approved by your attorney. After the patient signs again ask her if she has any questions. Answer those questions, and again document both the questions and answers. Before the surgery, procedure, or therapy covered by the form, again go over the same material, answer any last-minute questions, and document the entire episode. Remember,

the duty to secure informed consent is the *physician's* duty, not the nurse's duty or a hospital admission clerk's duty. It is still questionable whether the physician is legally able to delegate that duty elsewhere.

Laboratory Tests

In my experience, one of the most common reasons for malpractice suits is the unreported abnormal laboratory or X-ray finding. The usual story is that the pathologist or radiologist returns the report and the super efficient clerk, receptionist, or nurse staples it in the medical record and then files the record. The alternative story is that the report is never sent and there is no follow-up. Of course, normal clerical errors do occur in any business; nevertheless, the physician's fiduciary duty extends to communicating the results and meanings of all abnormal tests to the patient. Therefore, the failure to communicate the results of an abnormal pap smear, glucose tolerance test, or mammogram to a patient can have disastrous legal consequences.

Physician's Defense Strategy

A gynecologist must have a system to track and document all laboratory and diagnostic tests and imaging studies ordered. There is no totally satisfactory way to do this. Old-fashioned "tickler" files are the least efficient, but better than nothing. Some office-generated computer programs have been highly successful, and some of the commercially available programs even generate an automatic notification letter. In any case, the physician must track all ordered tests and make every reasonable effort to notify the patient. The notification and follow-up must be documented. Telling the patient to call for the test results does not relieve the physician of his or her duty to notify. Finally, use the information you secure. Do not order laboratory or other diagnostic tests and then ignore or belittle those results.

Medical High-Risk Patients

Elderly, frail women with or without serious concomitant conditions and women of any age with serious gynecologic or concomitant conditions are legally and medically at high risk.

Physician's Defense Strategy

Treat these women as being at high risk. Question all of your routine procedures. Check what medications (prescription, over-the-counter, and health food store) they are taking. Watch the dosages you prescribe. Make sure your staff assists them from the moment they enter the door until they are safely over the doorstep and into someone else's capable hands. To let one of these patients get on or off an examining table by herself is courting disaster. A premises liability suit can be just as expensive as a malpractice suit, and it is much easier and cheaper to bring.

Medical Records

The 1930s wag who came up with the saying, "Medical records are the malpractice witness that never dies!" offered a truism that has only increased in value over time. The world of judges and

juries of 2007 expects much more than the hand-written scribbles on a 4 × 6 inch card that marked the medical record of 1930s.

Physician's Defense Strategy

If at all possible, all your records should be typed. Even the best penmanship can be misinterpreted. All records should be written or dictated contemporaneously with the event described. All records should be in English, as objective as possible, clear without confusion or ambivalence, dated, timed, signed legibly, and kept in chronological order. Chart by the subjective, objective, assessment, plan (SOAP) method whenever possible. Do not use abbreviations! (That includes abbreviations "approved" by the institution or organization. Even the most common abbreviations have multiple meanings. There will always be an expert that interprets the abbreviation in a manner contrary to your interest.) Scrivener's errors may be corrected en page. Errors of fact or substance should be corrected as a new entry placed in the chart chronologically. Do not obliterate, destroy, change, or "lose" any portion of a medical record. Such activities are termed *spoliation of evidence*. At best they may call for civil penalties at trial and at worst may constitute malpractice per se or invoke criminal penalties. In any case such spoliation of evidence makes any subsequent suit almost impossible to win. If your state or hospital or the American College of Obstetrics and Gynecology (ACOG) has a standard form that is widely used in the community, use that form or one even more extensive. Do not leave blanks on your form. If the question is worth asking it is worth recording. Although many sources advise keeping medical records for a period of 10 years after the last contact with the patient, a safer approach is to keep the record for a period that would allow a conception at the date of last visit to reach maturity and expire its statutory limitations or statute of repose in states where there is a discovery rule.

Prenatal Counseling

Prenatal counseling involves state requirements about the extent of testing, testing of ethnic groups, duties to inform parents, duties to inform third parties, the right to refuse mandatory testing, wrongful life, and wrongful birth.

Physician's Defense Strategy

There is no escaping the necessity of researching your state's requirements. Those requirements should be converted to written protocol for laboratory, clinical, communication procedures, plus a note about the right to refuse treatment. Any and all refusals should be documented and witnessed.

Prescriptions

Adverse drug events are among the most common medical errors, and although physicians are loathe to admit it, more than two thirds of all adverse drug events are caused by physician error. Transmission errors and compounding (filling the prescription) errors make up the remaining third of the errors. Proper prescribing amounts to several simple basics, the appropriate drug, the appropriate dose, the appropriate directions, the appropriate time of administration, the appropriate termination, and the

appropriate refill directions. Today the appropriate drug category can preclude prescribing a drug ineffective or marginally effective for the patient's diagnosis, a drug the patient is allergic to, or a drug with adverse interactions with another drug that the woman is taking. The prescription of a drug can no longer be thought of as something a physician does "off the top of his head." He needs help from an information base that can explore the medical chart, drug interactions, recorded allergies, drug doses, and the most effective therapy, and then must transmit a legible prescription for compounding. Therefore, the best approach lies in an extensive electronic medical record and database system that is updated at least monthly and that controls prescription writing. Absent such a system we can only offer homilies.

Physician's Defense Strategy

Type or block print all orders and prescriptions.

1. Prescriptions should always be written in duplicate or triplicate (one for the patient, one for the medical record, and one as your personal permanent record.) The patient's copy should always be on safety paper.
2. Do not issue oral phone orders or call prescriptions to pharmacies; use the fax line.
3. Clear, unabbreviated syntax works best. **Never use abbreviations for drugs.**
4. Always use the leading zero; never use the trailing zero (0.4 = yes; .40 = no)
5. Spell out "units" never use the symbol "U."
6. Always specify drug strength and route of administration.
7. Avoid decimals whenever possible (1500 mg rather than 1.5 g).
8. Think carefully before you sign on the "substitution permitted" line. (Generics may have blood levels that vary as much as ±20% from the original. Therefore, if blood level is important, the potential variation of up to 40% from one refill to another should rule against a generic equivalent.)
9. Use reasonable prescription pad security. Do not leave your prescription pad exposed on your desk or in your examining rooms.
10. Be careful of multipharmacy especially in the high-risk patient, and be alert to the use of multiple psychoactive drugs including opiates.
11. Give your patients printed instructions (Several good systems are on the market, don't ignore the AMA Patient Medicinal Instructions or the USP Dispensing Information), do not depend on the nurse or pharmacist.
12. Finally, check each prescription or order you write for clarity, legibility, appropriateness of drug and dosage in relation to the information available on the drug, the patient, and the diagnosis.

Addendum: A caution about drug samples. Samples should be stored properly and with reasonable security. (Neither the patient, nor nonmedical personnel should be able to gain access to samples.) Rotate the samples appropriately, and dispose of out-of-date samples safely and legally. **Samples should be distributed by personnel with prescriptive authority only.** (Some states may permit others to do so under supervision and written protocols.) **Do not distribute samples without issuing full oral and written instructions.**

When Things Are Not Going as Expected

Physicians are used to seeing cases progress in a somewhat predictable manner. Some patients progress more rapidly than others, but, in general, the course of disease and treatment follows a course that physicians are used to. When things take an unusual turn, physicians are prone to take one or both of two destructive courses. First, they irrationally get angry at the patient, or they lose perspective on the important issues.

Physician's Defense Strategy

Hold your temper in check. A woman who is not progressing as expected is the patient you need to have the best relations with. Go out of your way to let her know that something unusual

is happening and what you are doing to solve the problem. **Do not blame her!** Reevaluate your diagnostic reasoning and differential diagnosis early. Check the chart, medication orders, nurses' notes, and medications given for possible errors. Request those cultures, chemistries, and imaging studies you thought you could short cut. **Do not** reject the patient's suggestions out of hand. If it will do no harm, the expense is not overwhelming, and it is neither unethical or illegal, concede to her wishes. Do not let your ego get in your way. **Get help early!** Get a formal consultation, don't just talk to someone in the doctor's dressing room. **Get the best help available!** Don't just ask a friend because he will concur with what you are doing. Establish good relationships with quality consultants early; do not wait until you need them to help in a disaster.

KEY POINTS

- Common law is the laws passed down from England's legal system and which is interpreted by judges. It is an adversarial system.
- Most tort cases, including malpractice cases, will be heard in state court systems.
- Possibly the best advice for avoiding malpractice claims is good communication with patients and proper, appropriate, considerate, and unbiased treatment of patients.
- Informed consent has little to do with a form. Providing the patient with the information about the nature and risks of the therapies offered and documenting that discussion is the legal responsibility of the physician.
- Accurate, complete, and legible medical records that are dated and signed are critical to the physician's defense strategy.

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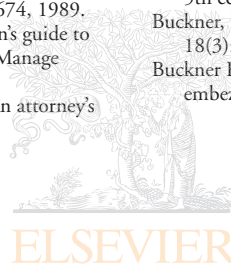
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