

Surgical Malpractice: Myths and Realities

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The fear of malpractice suits pervades medicine and grabs headlines because a malpractice suit is more than a possible claim on your assets. Even if a suit is successfully defended, you can still pay an emotional price: embarrassment, depression, and self-doubt. Why go there if you don't have too.

But how can you avoid going there? Which advice is helpful and which is just the perpetuation of malpractice mythology? A few myths shared among surgeons, are examined below.

Myth 1 *A consent form signed by the patient and a statement by the physician that “all risks, benefits, and alternatives to surgery” have been discussed, are adequate documentation of informed consent.*

Reality Creating truly “informed” consent is a process (not a piece of paper). Unfortunately, few of us are formally taught how to do this, and our poor instruction shows. Getting “the consent”—getting the form signed—is often a duty delegated to someone lower down on the totem pole. Too often, the attending surgeon doesn't do a great job of communicating with the patient or doesn't document very well what was said.

Patients only hear about 25 percent of what we say to them—even less if they are stressed, in pain, or preoccupied with other thoughts (“Who will help my family while I'm having surgery?” or “How am I going to pay for this?”). Most of us don't take the time to repeat important information because we assume it was heard and understood the first time we said it. And saying that all the patient's questions have been answered doesn't mean much if we don't give them adequate opportunity to ask.

What we need to do is provide counseling to our patients at every opportunity. We can all recall hours spent learning abnormalities of metabolism or the action of antibiotics, useful technical information. But, how much time did we spend learning how to teach people things? Teaching our patients, and each other, is a huge piece of what we do and we are ill prepared to do it.

Patients who sue for lack of informed consent are usually saying, “Things didn't turn out the way that I heard you say they would and I wasn't prepared for this.” While a signed consent form might help to protect you, your best insurance is a well-prepared patient and family.

Myth 2 *“Perfect” surgeons won't be sued.*

Reality Physicians often think that the quality of their work is tied to technical competence: one's work is measured on the basis of one's knowledge, judgment,

and technical maneuvers (“If I am a great technical surgeon, no one will sue me”). Patients don't always see it that way. They care about the courtesy with which they are treated, how their questions are answered, and how easy it is to park when they see you. What may be superficial to you, is important to them, as is how you treat them as a person before they become “a procedure.”

Patients expect you to be technically competent, but in our service-based economy, many patients also expect the “fluff,” (other industries call it customer service) that often is lacking in medicine. In our defense, customer service is not so easy in an environment where patients are often dehumanized. Patients become their diseases (the hypertensive in 205...the diabetic in 207...the kidney in 211) and, in the process, less human.

The perception (or reality) of “poor service” spices the recipe for an allegation of malpractice. Mix a serious medical problem with a bad outcome, add a dash of dehumanizing, a pinch of arrogance, and a lawsuit is likely. If the medicine was perfect, the lawsuit is unlikely to succeed, but nevertheless, it is a tremendous nuisance.

An effective countermeasure is to remember to treat each patient the same way that you would like yourself or a family member to be treated in the same situation. Competence is important and each of us is held to high standards for it. But competence alone will not protect you. A little caring is inexpensive insurance.

Myth 3 *Protocols are for sissies.*

Reality Physicians are asked to deal with a daunting and ever expanding volume of information. No one person can remember everything; what we can remember is confounded during stressful clinical situations.

Ever gone to a “code” where things seemed a little disorganized? Where the code team is so focused on the arrhythmia that it forgets to ventilate the patient. We all know that there are well-elucidated protocols for the treatment of many emergency conditions. Why is it that we consider it a matter of “pride” to memorize things that don't need to be memorized? You can't run a code without a crash cart. Why can't the crash cart have a protocol on it? And if it does, why doesn't it get followed?

Even for routine tasks, airplane pilots use checklists. The senior pilot who has done thousands of takeoffs uses a checklist. A routine, mundane, yet complex task, where the omission of steps can lead to disaster, deserves a protocol to guide management and a protocol that de-

serves to be followed. Protocols aren't for sissies. They are for pilots, nuclear power plant operators, and physicians. We are fallible and distractible. Protocols simply help us take care of sick patients while under stress.

Myth 4 *Residents need times when they are minimally supervised, in order to learn effectively.*

Reality Residency should be a time of mentoring and apprenticeship, not unfettered experimentation. Residents and fellows need us as mentors to guide them through the care of difficult patients. We cannot substitute for learning through actual experience, but we also cannot substitute for having the residents benefit from *our* experience.

Problems with communication between house staff and attendings lead to serious problems in patient care; poor outcomes; and, often, lawsuits. While house staff are your eyes, ears, and hands when you are not in the hospital, they need your brain and judgment to do their jobs competently. And there is only one way for them to get that: communicating with you in person, on rounds, in the OR, and by telephone.

While it may be a "point of honor" to not call an attending at night, the "point" is missed if patient injury is the result of inexperience leading to bad judgments. Some things in medicine happen very quickly and the damage that results from incorrect decision making can be irreversible. While no surgeon can be "there" all of the time, the link between house staff and attendings needs to be close enough that you are essentially there all the time. Residents and fellows have their futures in which to earn gray hairs; residency and fellowship is not the time to learn on patients by trial and error.

Myth 5 *My ability to communicate with other physicians, nurses, and patients is superfluous "touchy-feely" stuff. They should just do their jobs like I tell them to.*

Reality Miscommunication between physicians, physicians and nurses, attendings and house staff, and physicians and their patients lies at the center of many bad outcomes (and virtually every malpractice claim). We talk at each other, past each other, but not with each other. Too often, communication is treated as a one-way mountain road, with information traveling downhill but not back up.

We stifle communication in many ways. Arrogance or an intimidating attitude (perceived or real) can discourage valuable information from being made available to you. You cannot possibly act on information that you do not have, but by not actively encouraging communication, you blind yourself to what is really going on. Teaching staff probably spend the least amount of time at the bedside and yet play the most important role in guiding patient care. In order to take the best care of your patients, you need access to relevant information. If you make yourself appear unresponsive, that information will never make its way to you. This is not to say that physician's orders are really physician suggestions up for continuous debate. But it does suggest an openness to dialog and an open mind to other viewpoints and ideas. The care that your patients receive will improve as will your work relationships.

Myth 6 *I can't really protect myself from a lawsuit.*

Reality Some malpractice suits really are lightning strikes; you did everything right but were in the wrong place at the wrong time. Many are not, however, and you can do quite a bit to avoid those.

- 1 Practice the best medicine that you know how to practice. Stay current in your field.
- 2 Know your limitations. Ask for consultations with other specialists. Don't be afraid to seek out the opinion of other surgeons when patients' problems are puzzling or difficult.
- 3 Take care of the whole patient, recognizing that they are not just a "case" of whatever they have. Treat them with compassion as fellow human beings.
- 4 Make sure that you write down what you are thinking and why. Don't let a blank record speak for you. If there is a lawsuit, being able to show that you thought about a problem, even if your decision turned out to be the wrong one, can be a great help in your defense.

The myths that surround malpractice try to tell us that the little things don't matter, but they aren't really little and they really do matter. Consent, protocols, communication, and how we treat our patients outside of the confines of "technical" medicine do matter. They matter a lot, and can be the difference between spending your time in the operating room or the courtroom. ■