

The Medical Defence  
Association of Victoria Ltd

# THE TEN DEADLY SINS THAT RESULT IN CLAIMS OF NEGLIGENCE

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STEPHANIE KLEIN-DAVIS | The Roanoke Times

Mellisa Williamson, 35, a Bullitt Avenue resident, worries about the effect on her unborn child from the sound of jackhammers.

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# 1. Don't worry about detailed records

*“I only need some very brief notes to remind me of what went on”*

eg:

“c/o 3/7 sore throat Rx: Pen”

“ BP 110/80 Spec✓ PV ✓ Rpt Yasmin”



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# 1. Don't worry about detailed records

***A medical record should be able to be read with understanding by another doctor.***

## **WHY?**

**So another doctor can read your notes and understand:**

- **how you came to make the diagnosis;**
- **what treatment you suggested and why;**
- **what information you gave about the diagnosis & treatment;**
- **what arrangements were made for follow up.**



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# 1. Don't worry about detailed records

## *Document information disclosure.*

- A signed consent form may be helpful, but it is not a substitute for a detailed and **DOCUMENTED** discussion with the patient about risks, benefits, etc.  
**(Consent –v- Informed Consent)**
- It is as important to record a brief summary of that discussion in the notes as it is to record the history and findings on examination.



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## 2. Alter records

***“I know what I meant – I’ll just add it now to the end of the entry I made three days ago.”***



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## 2. Alter records

<b>Good Records</b>	<b>=</b>	<b>Good Defence</b>
<b>Poor Records</b>	<b>=</b>	<b>Poor Defence</b>
<b>No Records</b>	<b>=</b>	<b>No Defence</b>

### ***Altered Records = No Defence***

- Review your records to check for mistakes or omissions;
- Do not alter a record. You can add to it, if indicated, but must indicate the date and time of the addition;
- If the new entry significantly contradicts the original entry, add an explanation.



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### 3. Don't follow up referrals

***“But I told the patient to see the specialist; it’s their fault if they didn’t go!”***

**The doctor has a duty:**

- **to convey clearly the reason for referral *and* the possible consequences of not attending the specialist.**
- **to have a system to detect, from tracking whether a letter has been received back from the specialist, that the patient attended.**



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## 4. Don't follow up test results

**If you give a patient a note to go for a blood test or X-Ray, they might choose not to attend. If they were properly advised at the time the test was suggested, that's their choice.**

- **But what if they did go, but the report has gone astray?**
- **What if the report was received but was filed without you seeing it?**



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## 5. Don't check history when writing scripts

- **Sometimes scripts are not recorded.**
- **Sometimes they are clearly recorded but, when in a hurry, someone forgets to check.**

**It happens. It shouldn't!**

- **Never write a script from memory;**
- **Always call up the patient's record and check it is the right drug, in the right formulation, at the right dose, etc., etc...**



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## 6. Diagnose and treat over the phone

**Every time you diagnose and treat over the phone you deny yourself the benefit of a proper history and an appropriate examination. It's always a risk!**

**If you do decide to give advice, you must make a note of the phone call – recording the patient's name, the time of the call, the symptoms offered and the advice given. (Use MDAV's "Clinical Message Pad")**

**Never allow staff to give phone advice!**



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## 7. Don't care whether patients like you

***"The most important factor in many cases, besides the injury itself, is the quality of the patient's relationship with the doctor.***

***I've never had a client come in and say, 'I really like this doctor, and I feel terrible about doing it, but I want to sue him.'***

***People just don't sue doctors they really like.***

***The best way to avoid getting sued is to establish good relationships with your patients, and to treat them with respect. That requires taking time to talk with them, and more important, to listen."***

***Alice Burkin, a plaintiffs' lawyer in Boston***



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## 8. See patients very quickly

- Work out how much time, on average, you think you need to see patients properly, and work at that speed.
- The same applies to procedural medicine. If squeezing another ‘emergency’ on to a list means all the patients on the list get shorter shrift, that’s *bad medicine*.
- Work overload may be accepted as an explanation, but it will not be accepted as a defence.



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## 9. Don't say anything if something's wrong

- A 1994 study in London showed that the commonest reason given by the people for commencing litigation was 'to find out what *really* happened'. (*The Lancet* Vol 343 June 25th, 1994 1609-1613)
- Saying, “**I'm sorry this happened to you**” is not the same as saying, “**I'm sorry I did this to you.**”
- An appropriate statement of sincere regret is not an admission of liability.

## 10. Don't talk To Your MDO



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***“I only talk to them when I’m hit with a writ. If I tell them about every damn thing that happens, they’ll up my premium”***

# The 10 Risk Management Commandments



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***“Rules are for the obedience of fools....  
...and the guidance of wise men”***

**Douglas Bader**

***“Rules are there to make you think before  
you break them.”***

**Anon**



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# The 10 Risk Management Commandments

- 1. Keep good records, and document consent**
- 2. Never alter or add to records**
- 3. Follow up referrals**
- 4. Follow up test results**
- 5. Check the history before writing a script**
- 6. Don't diagnose and treat over the phone**
- 7. Care about the quality of the relationship**
- 8. Make sure patients perceive they've had "enough" time**
- 9. If something's gone wrong, make sure the patient hears about it first from you.....and.....**

## 10. Talk To Your MDO



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*Protecting your reputation while ensuring fair  
compensation to patients*

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