10 medical liability myths

by Laura Hale Brockway, ELS

Understanding how medicine and the law intersect is complicated. It can be tedious. Yet, a thorough understanding of medical liability can help keep you out of the courtroom and may even help you practice safe medicine. The following is a list of some common and prevailing myths about medical liability, each dispelled by TMLT claim and risk management experts.

Myth 1

Because of medical liability reform, litigation is no longer a problem for doctors.

Truth: While the rate of litigation has been greatly reduced, medical liability reform did not hinder a patient's ability to sue for legitimate injuries incurred during the course of medical treatment. "It is also important to remember that juries are still willing to award substantial damages when they feel the physician failed to meet the standard of care or failed in communicating with the patient," says Jill McLain, vice president of claim operations with TMLT. The bottom line — litigation is still a concern for physicians.

"Physicians are advised to continue following basic risk management principles to prevent lawsuits and enhance defensibility," says Jane Holeman, vice president of risk management at TMLT. "This includes documenting thoroughly; making sure you track test results and patient referrals; and communicating openly with patients."

Myth 2

I should contact TMLT to report a claim only after I've been officially "served" with a citation and petition.

Truth: Your policy requires you to notify TMLT as soon as reasonably possible after becoming aware of any claim covered by your policy. TMLT claim staff may have limited time to investigate and evaluate the claim, and any delay in reporting could compromise your defense.

Please notify TMLT immediately if you receive any of the following:

- A demand for compensation — any written communication from or on behalf of a patient that seeks monetary payment or other compensation because of a perceived error in treatment or an unexpected outcome.
- A notice of claim letter — a letter that refers to Civil Practice and Remedies Code Section 74.052 or refers to a notice of claim. Upon receipt of a 74.052 letter, a physician and his or her insurer have 60 days to investigate and evaluate the claim.
- A lawsuit — will contain a citation (which informs you of a lawsuit) and a petition (which lists the plaintiff versus the defendant). A lawsuit will also include the allegations made against you. The law sets out a mandatory timeframe in which an answer must be filed on your behalf. Therefore, once you are served with a citation and petition, TMLT has a limited time to respond by retaining a defense attorney to file an answer on your behalf.

Additionally, if you receive a records request from an attorney or a request for a deposition in a case involving medical liability, contact TMLT for advice on how to respond to the request.

Myth 3

A TMB complaint is no big deal — I can just respond by writing a letter.

Truth: It is not advisable to respond to a TMB complaint letter or notice without first contacting TMLT or obtaining legal counsel.

A violation of any of the laws and regulations that govern the actions of physicians can lead to disciplinary action by the Texas Medical Board (TMB). The consequences of a single board action can range from a dismissal to license revocation; enormous expenditure of stress and time; and damage to a physician's professional reputation. Therefore, it is essential that you seek an attorney's expertise early to respond to the TMB and present the information in an appropriate way.

"Many physicians make the mistake of acting as though the complaint against them is so frivolous that they merely need to explain their care and then the TMB will surely see the lack of merit in the complaint and dismiss it. Moreover, you may have the impression that the process is informal and collegial, but in truth, this is serious business."[1]

TMLT policies provide coverage that will reimburse you for reasonable legal expenses and expert witness fees incurred in defending a TMB complaint (up to $25,000 per policy period, subject to the terms and conditions of the policy). The policy states that you have 60 days to report an insured event to receive reimbursement for covered expenses. To preserve coverage, it is extremely important to pay attention to the 60-day window in which to report knowledge of a proceeding.

Myth 4

It's okay to speak with an attorney "off the record" about a medical malpractice lawsuit in which I am not a party.

Truth: Proceed with caution and contact the TMLT claim department any time you are contacted by an attorney about a medical liability case.

"It may seem innocuous and that the attorney only wants to obtain information about a case, but there is always the possibility that based on the information you provide, you could be named as a co-defendant in the case or called as a witness," says Holeman.

Physicians are strongly urged to contact TMLT before speaking with any attorney about a medical liability case.

Myth 5

Physicians are allowed to "correct" past entries in medical records after an unexpected outcome or notice of claim.

Truth: It is never acceptable to alter or correct a medical record after you have been notified of a claim.

Upon reviewing the medical record when served with a notice of claim, you may be tempted to add information that you believe will assist in your defense. Resist this temptation. Plaintiff's attorneys will try to use this information to discredit you, suggesting that you did something wrong and are trying to conceal it.

The TMLT claim staff recommends that you place the medical record in a secure location to protect the authenticity and avoid any temptation to alter information.

Absent a notice of claim, it is appropriate to make a late entry or addendum in the medical record, but only with proper identification and the reason for the delayed entry. "The entry should be clearly labeled as "late entry" or "addendum" with the date the addendum was completed and the date to which it relates," says Holeman.

"Correcting' the medical record without clearly indicating that you are doing so is considered altering the medical record; and, altering the medical record seriously jeopardizes your credibility, says McLain. "While there may be no breach of the standard of care, record alterations are difficult to defend at trial and frequently result in settlements out of court."

Myth 6

Implementing electronic medical records (EMRs) can prevent most malpractice suits.

Truth: It is a truth universally acknowledged that any medical record system — be it paper or electronic — is only as good as the person who uses it. The promise of EMRs is a more accurate, legible, and comprehensive medical record available to health care professionals at the touch of a few buttons. However, EMRs come with their own documentation pitfalls. If you are currently using an EMR or plan to implement such a system, consider the following:

- Implement a strict policy regarding passwords and security — staff members should have their own passwords and level of security clearance based on their job functions. Sharing passwords should never be allowed because the identity of the user will be incorrect.
- Ensure patient encounter records are locked — the author of each entry must take specific action to verify that the entry is his or hers and that it is accurate. Once a patient encounter entry is completed, the author should sign it and it should be locked in the system.
- Be aware that templates can import old or inaccurate information — notes should be individualized for each patient encounter, and relevant sections reviewed to avoid importing incorrect, redundant, and irrelevant information.
- Enable tracking mechanisms. Most software programs include a tracking system to help ensure that patients have completed recommended tests or consultant referrals. Employ these tracking systems. Additionally, if you are planning to purchase an EMR, do not buy one without a tracking system.
- Establish a system to appropriately capture paper and other external clinical documents. Optimally, all paper documents should be scanned into the electronic record for easy accessibility. While scanning a patient's entire paper record into the system is preferred, this is not always possible. The important step is to develop a policy for capturing patients' previous medical records and follow it consistently.
- Prescriptions are not always captured in the EMR. If physicians who use EMRs are not e-prescribing, prescriptions should be captured by scanning the paper prescription into the EMR or fully documenting the name, dose, quantity, instructions, and refill amount.
- Ensure records are backed up reliably. Creating a back-up data set is only the first step. The back-up record must be tested regularly to ensure that all appropriate data are being copied, and that data restoration is possible.
- Make sure the records are complete when providing printed copies. Because many physicians using an EMR do not regularly print a patient record, they may be unaware that clicking the print button does not always provide a complete record. [2]
- "Another issue we have seen in claims involves training and familiarity with the system. We have seen cases where wrong boxes were checked and inaccurate information was unintentionally included in the record," says McLain. "Know your EMR and how it functions." (For more information, please see the closed claim study on page 16.)

Myth 7

You can rely on patients to report an accurate and complete medical history.

Truth: For a number of reasons, patients are often poor historians of their medical information. They may not know what is important to share. They may not understand their condition or the seriousness of it. They may not remember the details or may be embarrassed or reluctant to share their health information. Therefore, relying on the patient as the exclusive source for medical history information is ill-advised. Consider the following to help you obtain more accurate medical histories.

- Make it easy for patients to update their medical history forms. Send these to patients in advance or make them available on your practice web site. Patients may provide more accurate information if they are allowed to complete these forms before the appointment.
- Ask patients to bring all of their medications when they visit your office.
- Ask patients to list any other treating physicians on their medical history forms.
- When discussing a patient's medical history, ask open-ended questions (i.e., what has changed in your medical history since your last visit). Patients who are not questioned thoroughly may leave out details.
- If details of the patient's history are unclear, contact the other treating physicians or request the patient's medical records.

Myth 8

Physicians can depend on pharmacists to discuss the risk and benefits of a new medication with the patient.

Truth: It is the duty of the prescribing physician to discuss the risks and benefits of any medication with the patient. The dispensing pharmacist may also provide this information to the patient, but this does not eliminate the physician's responsibility to counsel patients about medications.

It is unwise to rely on the pharmacist for a number of reasons. The patient may not actually receive or review the information the pharmacist provides. Physicians may be unfamiliar with the information the pharmacy is providing. What risks and benefits does it describe? This could lead to communication errors if the patient calls the physician with questions about the information provided by the pharmacy.

"Doctors should also consider that the pharmacist is relying on the package insert to counsel patients. They may have little personal, medical experience with the drug and may not know what is appropriate to share with the patient," says McLain.

When prescribing a new medication to a patient, discuss the risks, benefits, and any alternative treatments with the patient. Patients should also be instructed to call the physician with questions or to report any side effects. This discussion should be documented in the medical record.

Myth 9

You only need to obtain informed consent for surgical procedures.

Truth: Informed consent requirements apply to treatments, tests, procedures, or medications as mandated by the Texas Medical Disclosure Panel. (TMDP)

In Texas, informed consent is governed by statute and is overseen by the TMDP. The panel includes six physicians and three attorneys who review all treatments and procedures to determine which procedures require informed consent and which do not. Procedures and treatments are then assigned to a list. Those requiring disclosure of risks and benefits are put on List A. Those that do not require disclosure of specific risks are identified in List B. The panel periodically examines new treatments or procedures and assigns them to one of the lists. The lists, TMDP rules, and forms can be viewed at Title 25, Texas Administrative Code, Part 7 at http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac.

When offering any treatment or procedure to a patient, the physician must make these determinations:

- if the treatment or procedure appears on List A, then disclosure specified by the panel must be followed;
- if the treatment or procedure appears on List B, no specified disclosure is legally required;
- if the treatment or procedure does not appear on either List A or List B, the physician must then disclose all material and inherent risks that could influence a patient in making decisions.

"It is also important to realize that informed consent is a non-delegable duty. The physician is responsible for discussing the risks and benefits and obtaining consent," Holeman says. "A signed form is not a substitute for a detailed discussion."

Additionally, it is important to note that, by statute, the TMDP may not require disclosure of the risks of certain surgeries, procedures or medications. However, it is best to disclose those risks that a reasonable person would want to know in making the decision.

Documentation of the informed consent discussion — including the risks, benefits, and alternatives to the surgery — should be included in the medical record.

Myth 10

Anyone who accompanies a child to the office can consent to care for that child.

Truth: The Texas Family Code specifies who can consent to medical care for minors.

A minor is a person under age 18 who has never been married and never been declared an adult by a court. Minors cannot make health care decisions or give informed consent on their own behalf. Consent, therefore, falls to the parent or legal guardian in most situations.

When the person having the power to consent cannot be contacted and actual notice to the contrary has not been given, other persons and entities can give consent. These include:

- grandparents;
- adult siblings;
- aunts and uncles;
- an educational institution with written authorization;
- any adult who has actual care, control, and possession of the minor with written authorization;
- a court having jurisdiction over a suit affecting the parent-child relationship;
- an adult responsible for the actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county;
- a peace officer who has lawfully taken custody and has reasonable grounds to believe immediate medical treatment is needed; and
- for immunizations only, a guardian or any person authorized under law or court order to consent for the child or, if these persons are not available, any one of the persons listed above.

When documenting consent by a non-parent, it must be in writing and include: the name of the child; the name of one or both parents, if known; the name of any managing conservator or guardian of the child; the name and relationship of the person giving consent; the treatment to be given; and the date the treatment is to begin.

Conclusion

Physicians and their staffs face daily challenges in the delivery of quality, safe health care. There are no doubt more myths about medical liability, but an informed physician with a conscientious commitment to patients and effective communication skills may avoid complaints and lawsuits.

Sources

1. Simmons S, Ballard D. Surviving a TMB investigation. *the Reporter*. January-February 2008.
2. Brockway L. Potential pitfalls. Risk management for the EMR. *the Reporter*. March-April 2007.

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