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MEDICAL MALPRACTICE: THE BASICS



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Medical Malpractice: The Basics

A guide to what happens when a medical malpractice allegation is made against you and things you can do to minimize your risk.

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Medical Malpractice: The three legal principles

Medical Malpractice law in most states is based on three legal principles: Negligence, Causation, and Damages.

Juries have a tendency to include emotional issues when reviewing cases and many judges are elected officials. As a result the actual result sometimes differs from the result that would be expected from the law.

Negligence. First the plaintiff needs to establish that negligence by the physician occurred based on the preponderance of credible evidence. Negligence is normally defined as the physician's failure to use the same level of practice and judgment usually exercised in similar circumstances by the average professional in that specialty. Negligence is the physician's failure to comply with the recognized standard of care in treating the patient.

The patient must prove that the physician's treatment failed to conform to the recognized standards of care.

- The standards of care refer to the degree of skill associated with the activities of a reasonable, prudent practitioner acting under the same or similar circumstances.
- Juries should be advised to have due regard for the state of medical science at the time the patient was treated. In other words, an injury that occurred in 1980 should not be judged by 2001 standards.
- Juries should be advised that physicians cannot and do not guarantee results and cannot be liable for failing to use unusual skills or judgment.
- If the care provided by the physician is not worse than the median (average) care then no malpractice occurred even though the care could have been better.

Causation. The plaintiff next needs to show that it was the physician's negligence that caused, wholly or partially, or aggravated an injury.

- The plaintiff needs to show that their injury was caused by the physician's negligent act or omission. Errors resulting in no harm are not sufficient grounds for malpractice lawsuits.
- The testimony or expert will be needed to support the plaintiff's allegations.

Damages. The plaintiffs then need to prove loss, which includes compensation for lost wages (past and future), pain and suffering, loss of companionship, additional costs of care/transport, etc. Damages can be compensatory and punitive in nature.

- Compensatory damages are usually awarded by judges or juries to try to make up for the plaintiff's actual losses and expenses.
- Experts may testify to establish the current value of past and future losses and expenses. Damages for pain and suffering/loss of companionship are at the opinion of the judge or jury.
- Punitive damages are intended to deter misconduct and, generally, apply where fraudulent, malicious or reckless behavior is apparent.

Malpractice laws vary from state to state. If you are sued, you will get advice from your lawyers regarding applicable law and you will need to assist your lawyer in all aspects of preparing a defense no matter how minor or irrelevant they may appear to you.

Why Are Physicians Sued?

In many cases it is a misconception that the malpractice claim is motivated by money. Although financial considerations are very important motivators, plaintiffs often have many other reasons for suing.

Providing future care to someone can be expensive and exceed resources. As a result plaintiffs turn to the courts for survival, even though doing so might not be their natural inclination, but a number of non-economic reasons are often involved. Often, a suit arises when another physician suggested that the care given by the patient's physician was below standard and might have been responsible for the adverse outcome. These suggestions are often made without a review of the complete record and with no conversations with the physicians or nurses present at the time that an incident occurred. Prior to the careless suggestion the plaintiff never considered a lawsuit. It is important to be careful before criticizing care provided by others unless and until you have all relevant information and the ability to access what happened. Especially avoid placing blame in the medical record – it could come back to bite you.

Plaintiffs often file claims to obtain information. Statistics show that nearly 20% of plaintiffs indicate that they sued because they were frustrated with their attempts to find out what actually happened and became suspicious that the physician and hospital were engaged in a cover up. The information is likely to come out so it is in the best interests of the physician to provide comprehensive information in an understandable manner promptly after the incident.

Some plaintiffs file suits based on the belief that the physician did not listen to the patient or answer questions, or failed to warn them about the risks. It is important that the records be properly documented when conversations take place. It is also important to realize that the patient and the family may be under stress, which may make them less able to understand the consequences. They may need to be told of the dangers several times.

Some plaintiffs sue because they consider the physician to be incompetent. Anger can motivate them to seek to protect other patients or seek revenge. Prompt and properly thought out communication with distressed and angry patients/families is vital in affecting their course of action.

Sometimes patients or their families complain that the physicians did not fully inform them. Even when you disclose everything fully, you should be aware of the potential for misunderstandings as many people will be under stress, may not understand medical terms or may fail to advise you when they are confused or are not clear on an issue. Grief and denial can cause patients/families to mishear or not hear what is said and they may state later that they were never provided information. You need to be aware of these issues and overcome them as best as possible. One good way is to ask the patient/family members to tell you, in their own words, what you have told them, especially regarding any potential long-term consequences of illness or medical intervention. You must document these conversations in the medical record.

Some motivations are beyond your control but quality health care, consistency and compassionate communications are likely to decrease patient dissatisfaction and may reduce the potential for litigation.

Statute of Limitations

The statute of limitations is the deadline for filing suit in civil matters. The statutes vary substantially by state and can be run from as little as one year to three years. Some states limit the overall time even in the case where an injury was not discovered but most states run the time limitation from the point of discovery of the injury, how it was caused and who caused it.

The statute of limitations time clock for malpractice suit begins when the patient discovers an injury that may have been caused by negligence. Actual knowledge is not usually required. If the patient, through reasonable discovery, should have known the injury might have been caused by negligence then, legally, discovery may be considered as having occurred (for statute purposes only).

Statutes of repose exist in some states and are the maximum time period in which the lawsuit must be filed or otherwise the claim is barred by law. The statute of repose is often around three years from the date of the incident but may have certain exclusions such as when objects are left improperly inside a patient after surgery.

In most states minors have a period of time from the age of majority in which to file suits on their own behalf, irrespective of when the medical incident occurred. The limitations for mentally disabled patients may not run until they have been determined to be mentally competent.

It is important to tell patients as soon as an adverse occurrence has occurred. This will start the statute of limitations running. Even if the physician believes that the mistake may not cause any harm it is important that the patient/patient's family is told. A future issue could

arise and the error could be blamed which could result in a suit way into the future. By telling the patient and documenting the medical files properly this issue can be obviated.

Communicating With Lawyers

Subpoenas and Letters

Requests for medical information or correspondence from patients' attorneys or a court (such as subpoena, summons, complaint, or other written request) should generate a call to your insurance carrier. You need to remain on top of the issue; however, as may legal documents require a response within a limited time frame or may require a personal appearance. In any response you should only respond to what has been asked for and not speculate as to what the requestor may be looking for.

Do not negotiate directly with a plaintiff or plaintiff's attorneys. Doing so might prejudice your position should a lawsuit follow.

Caution should be exercised in discussing a patient's medical treatment with anyone not a part of the treatment team. Details regarding the patient's treatment must be treated with the same confidentiality as the medical record.

Before engaging in a conversation with anyone who represents, or purports to represent, someone other than you, you should verify the person's identity and determine whether or not that person is properly authorized to obtain confidential medical information about the patient. This can be accomplished by taking the person's name and phone number and calling back after checking on the information and with the patient. Be sure to check that the patient has authorized release of medical information. Because this information could be used in a case against you, it is very important to seek assistance from a lawyer or from your insurance company in determining the nature and extent of the attorney's request before replying.

You are under no obligation to engage in informal conversations with any third parties other than those representing your interests and should contact your insurer or your attorney if you have questions regarding the propriety of a request. Your insurer or legal representative should be able to help you in verifying that the individual has a legitimate interest in obtaining the information and has the appropriate authorization for release of medical information. If you become a defendant in a lawsuit or believe a situation could result in a potential lawsuit, do not speak with an outside attorney unless advised to do so by your legal representative or your insurer.

Communicating with Lawyers Appointed by the Insurer

In the event of a lawsuit, defense counsel will be retained by the Insurer to represent you. Your assistance and cooperation in the investigation of potential or actual claims and preparation for defense is very important.

It may be time consuming, but your lawyer will need to speak with and meet with you in order to fully understand the facts of the case. Communication with these lawyers is privileged by virtue of the attorney-client bound relationship. Discuss all aspects of your case candidly and in good faith, withholding nothing. Your duty is to cooperate fully so that your lawyer can be fully prepared. Don't let there be surprises later at depositions or at trial. If you have any problems or concerns about your legal representation you should call your insurance company. Involvement in litigation is stressful but your legal representative is there to help you.

Your lawyer and your insurance company will need to determine quickly whether liability is associated with an incident, and if so, develop a plan to deal with the situation. Difficult questions will be asked, the type of questions that opposing attorneys might ask. Some questions may even appear critical about your or another employee's involvement in the matter. The intent will not be to criticize but to prepare you and to determine how you will answer these questions so that the case can be properly managed. If you think of questions that the opposition may ask, you should discuss them with your lawyer.

Do not discuss ANY information provided during interviews with the lawyers relative to the claim or potential claim with any party other than your lawyer or as instructed by your lawyer. Discussion could result in some of the information ceasing to become privileged.

Litigation Against You

The litigation process has three stressful phases, which can take time. The physician needs to realize that it is important to take the time to be properly prepared and take time to handle each area with a reduced emotional involvement. The three areas are:

1. Notification
2. Discovery/Deposition
3. Trial

Notification:

Call and write to your Insurer if you receive a summons or complaint. Depending upon the state, summons and complaints may need to be delivered in person, but delivery to your office or residence may suffice. Do not try to avoid accepting a summons if you are a named defendant. If you receive a summons, call and fax a copy to your insurance company immediately. A formal response will be needed, possibly in as little as 14 days, and a lack thereof could result in a default judgment.

Don't overreact. Service of a lawsuit will probably cause you shock, anger and denial. The complaint's accusatory language is typical and often covers generalizations or charges that you will regard as outrageous. You may want to discuss it with your colleagues. You are better off not doing so as the plaintiff's lawyers will ask whether you have discussed the case

with anyone and may depose your colleagues as a result. If you have discussed the case with others, a person(s) with whom you have spoken may be subpoenaed to testify about your comments.

After a lawsuit is filed do not discuss the case with the patient or patient's family, their attorneys or the news media without specific instruction from your lawyer. Decline to comment on any active or pending case. You will have the opportunity to tell your side of the story later. Only your lawyer should threaten counter suits for malicious prosecution after a full assessment of the case.

Regarding discussions with colleagues, you may discuss general topics, like coping with the litigation process, but refrain from discussing the details of the case. Discuss any issues with your defense lawyer. These conversations are privileged and confidential and should be candid.

Discovery and Deposition:

Assessing a case. You and your lawyer will review the medical record and discuss the case's clinical issues. You can help by suggesting references and experts to support your position.

Discovery may last years. Each side may ask questions through interrogatories and ask the other side to produce all case-related documents, including patient documents, in their possession. For this reason, refrain from keeping personal records on patients in the medical file.

Interrogatories are sets of written questions submitted by one party in a lawsuit to the opposing party. Each side must then respond in writing under oath within a specified time and it must be comprehensive, precise and honest.

Months may pass without contact. The lawyer interviews key people involved with the patient's care, obtains expert opinion and gathers supporting information. You may feel stress as a result of the litigation process, which could result in diminished confidence, isolation, defensive practice and careful selectivity. You should discuss your case with your lawyers from time to time so that your reaction is appropriate. Remember these cases may take years to come to a conclusion.

Depositions:

Depositions are a method of taking testimony under oath but also give the opposing lawyers the opportunity to test your competence, discover what you know about matters relating to the case and evaluate the impression that you will make in a courtroom environment. The testimony is recorded so you must take time to ensure that you understand the questions being asked and answer just that question. Testimony will be transcribed which may give you the opportunity to correct an error. Do not give up that right.

Each side may depose any person with knowledge about the case, including expert witnesses. You may face your accusers or you may just see their lawyers. You may feel anxiety or relief at getting to tell your side of the story; however, it is important not to provide more information than is asked for. It is also important to make sure that you only answer one

question at a time. Some lawyers will ask you a question that is, in fact, more than one question. Ask them to reword so that only one question is asked and answered at a time. You will be asked difficult questions so your defense attorney should spend considerable time with you preparing for the deposition. The time from notification to trial conclusion varies by state but some can take longer than ten years.

Trial:

Any courtroom environment causes apprehension; however, the discovery process will also have allowed your lawyers and insurer to evaluate the strengths and weaknesses of the Plaintiff's case. Other physicians serving as expert witnesses will support your action. Whatever the outcome, you will survive.

Practice good courtroom demeanor and behavior.

- Be candid but not volunteering.
- Act knowledgeable but not arrogant.
- Look confident but not defensive.
- Wear a conservative business suit, not your lab coat. Dress smartly.
- While physicians are not excluded from jury duty, juries are typically not composed of peers. Therefore, look at the jury when you answer, focus on anyone who nods or smiles back.
- Always refer to the patient by proper name (e.g. "Ms. Smith"), not in the third person ("he" or "she").
- Use what you learned during the deposition

Lawyers may assault your professionalism.

Plaintiff lawyers will:

- Create a false sense of security hoping you will become careless. For example, the lawyer may prompt you to boast about the extent of your medical reading. If you do, you may then be held accountable for its content;
- Ask whether a particular person, textbook or volume is an authority. While you may agree in general, you may not agree with particular statements. So the prudent course is to ask the lawyer to specify a section of text, review its language and then pause to consider your response;
- Ask leading questions to put words in your mouth;
- Hope you will volunteer and give more than a "yes" or "no" answer;
- Try to get you to define some "absolute" standard of care, which could later be used against you;
- Question your recollection (Good documentation is important!);
- Try to catch you in a contradiction or inconsistency;
- Try to uncover a prejudice against the patient or bias for other defendants;
- Try to make you admit that your answers were rehearsed or coerced;
- Bait you.

The key to successful testimony is to be honest, calm and brief. At any point prior to a just verdict a settlement may be reached. Judges, insurance carriers, the attorneys for both sides,

the plaintiff and/or you may press for settlement for a variety of reasons. Settlements clear court calendars; they limit defense costs and the uncertainties of jury verdicts.

Testifying at Depositions or at Trial

The following are general tips for giving testimony at depositions or at trial:

Be prepared. Be familiar with the information.

- You are not required to memorize or recall every detail about a patient.
- Carefully review the patient's medical records prior to giving testimony to refresh your memory and help you testify in a logical order.
- Do not take the original records or copies with you into the deposition or to court unless the subpoena (called a subpoena duces tecum) commands it. The attorney requesting your testimony will generally provide a copy of the record for reference during your testimony.
- Do not make personal notes or take them with you because you will be asked to make them part of the record.

Listen carefully to each question.

- You are only obligated to answer the question you are asked.
- Do not speculate or attempt to answer something you do not know, such as, "What was the primary physician thinking when he recommended the course of treatment?"
- Simple "yes", "no", "I do not recall" answers are appropriate if that is the truth. If you cannot remember or do not know, do not force an answer.
- If asked to respond with a yes or no, and you do not believe that is possible, you may answer and explain your response. If you are unsure, before responding, ask the judge if you may explain your answer.
- Avoid answers containing "I never" or "I always".

Stop and think before you answer.

Testifying may un-nerve you. Don't be tricked into answering too quickly or answering before you have contemplated and are certain that you understand the question.

- Listen carefully. Understand the question before you answer.
- If a lawyer's query is unclear or contains multiple questions, ask the attorney to rephrase it, or say that you do not understand the questions and ask that it be repeated. The attorney's job is to ask the question appropriately so that you can answer.
- Take as much time as you need to think about the question. If necessary, ask the court reporter to read it back. You should not feel under pressure to answer within a certain time.

Understand the attorney's motives.

The lawyers for each side are trying to establish that the "preponderance of evidence" is in their side's favor. Juries need only to be more than 50 percent sure to make a decision.

- Each wants to establish your experience or lack of it. You may be asked exactly how many similar cases you have seen.

- Your impartiality may be questioned. Plaintiff attorneys may attempt to make you seem biased by questioning your objectivity. Payment for testimony, friendship with (or hostility toward) the patient or your colleagues, sympathy for the medical profession and/or your attitudes toward physician accountability may be discussed. Be prepared to answer truthfully and non-defensively.

Answer truthfully.

- Do not attempt to withhold facts or tailor answers. These ploys may be interpreted as attempts to provide only “half” truths.
- Occasionally, an attorney may instruct you to not answer a question. The attorneys may then engage in a legal debate over the question’s appropriateness. The judge will then tell you whether you should respond.
- Do not attempt to create an answer under pressure merely to satisfy an aggressive attorney. Once again, if you do not know or cannot recall, simply say so.

Be polite, appropriate and professional.

- Although attorneys may attempt to undermine your confidence or force you to answer in a certain way, focus on giving your best possible answer.
- Never lose your temper.
- Never answer a question with another question.
- Depositions may last hours or even days, in part to wear you down. If you feel you are losing your temper or your concentration ask to take a break and go off the record for a few minutes.
- If an attorney’s conduct is inappropriate, the other should object or ask for a conference off the record.
- Plaintiff attorneys often repeat questions to see if your answer changes. If your lawyer does not object when this happens, ask the court reporter to read back a previous response.
- Think carefully and be clear when asked, “Isn’t it possible...” Remember, the attorney is trying to establish a preponderance of evidence, so consider answering in terms of general probabilities. You can convey your point to the jury and still maintain your professionalism.
- Similarly, beware of questions that ask whether you would have done anything differently. Base your answers on the information you had at the time. Correct errors in previous responses.
- If you remember a fact that you could not recall earlier, or if you recall the answer differently after you have testified, correct it.
- State that upon reflection regarding an earlier question, you now realize that you remember the answer or that the answer should be corrected.
- It is far better, more appropriate, and necessary to correct the answer during the original deposition or hearing than to try to do it at a later date.

Quality Care/Risk Reduction

The physicians' aim is to provide quality care for all patients and their families. This includes the technical aspects of care, access, timeliness and good manners and concern. These must be the highest priorities. Providing quality care may also reduce your chances of becoming involved in malpractice lawsuits. Although the following quality care recommendations are based on common sense, they are often not followed despite their importance. Failures in these areas provoke patients' anger and may convince them to file a malpractice claim:

- Spend quality time with your patients.
- The time to develop a trusting relationship is before, not after, an adverse outcome.
- Look and act professional.
- Listen for questions, spoken and unspoken.
- Where appropriate, sit on the bed or in a chair alongside the patient or family. Likewise, where appropriate, touch the patient to show concern.
- Answer questions and explain situations in language that patients and their families understand.
- Create reasonable expectations about treatments and outcomes. Be honest.
- Involve patients in decision making.
- Provide information about alternatives and risks required for patients to make truly informed choices.
- Ask patients and family members to repeat in their own words what you have discussed so you may be sure they have understood.
- Respect patients' decisions and maintain their confidence.
- Anticipate families' questions and provide appropriate answers. Patients may not know what questions to ask, so be prepared to provide some information commonly requested by similar patients.
- Report test results as quickly as possible. Patients and their families wait anxiously for these results. Nothing is more important to them than learning the outcome(s) and your interpretation of it. Be sensitive to their need.
- Never demonstrate or express anger or contempt. The uncontrolled emotions cause more harm than good. Neither should you get caught up in a patient's anger. A health professional's controlled reactions, expressing his or her reasoned disappointment or dissatisfaction, are more likely to be productive.
- Employ the golden rule: Treat patients as you would like to be treated. Always communicate changes in patient status or treatment. Failure to communicate changes in patient status and treatment regimen among physicians may lead to adverse outcomes and malpractice suits. Communicate changes to the patient, especially if they involve the possibility of a complication or an unexpected outcome. Surprises or disappointments may lead to unnecessary litigation. Therefore, forewarn patients about circumstances (e.g. fever, infections) that may lead to problems and/or extended treatments or hospital stays.

Recognize your limitations.

- Recognize your limitations of training, competence or experience.
- Recognize your limitations due to physical, mental or emotional status.
- Recognize that you will not be able to establish good rapport with every patient.

Document the course of treatment in the medical record.

- Document all examinations, even if findings are normal.
- Note follow-up on abnormal lab results, including tests ordered and treatment(s) instituted.
- Record all elements of the informed consent process (for details, refer to the next section, Informed Consent).
- Use accepted abbreviations only.
- Keep the record legible.
- Pay special attention to medical dosages (especially decimals) as errors may have life-and-death implications.
- Record all patient non-compliance to medical advice.
- Record the substance of every pertinent conversation and how you evaluated patient/family understanding.
- Describe your thought processes and list the various clinical factors you have considered.
- Stick to recording objective facts related to patient care.
- Stifle opinionated discourse and judgmental comments.
- Don't argue with your colleagues in the chart. Talk to them in person, come to a mutually agreeable understanding and let the chart reflect that understanding.

Ethical, moral and legal issues:

- An impaired health professional is one who may be unable to perform his or her responsibilities because of use or abuse of drugs or alcohol, extreme fatigue, stress, or problems of a psychological nature. Doctors who assume responsibilities for an impaired physician have an obligation to take necessary actions to ensure that patients are not harmed by the impaired physician.
- All physicians have an ethical duty to ensure that impaired health professionals are evaluated and receive proper help. If a health professional must be taken off duty for impairment, the appropriate authorities must be notified immediately. If you are the appropriate authority then you must arrange for a review of all patients that have been treated by the impaired physician while he or she may have been impaired.

Familiarize yourself with hospital policies. If you work or have privileges in a clinic or hospital then you must comply with hospital or clinical policies, procedures and protocols. Ignorance is no excuse for failure to comply.

Eliminate unwarranted criticism of colleagues. Many malpractice lawsuits are initiated only after a patient hears a health professional criticizing the care they received. Such criticism is generally unwarranted, or is at least premature, if the critic has heard only the patient's version of his or her care and has not fully investigated the medical record.

- Unjustified criticism of other medical professionals undermines patient confidence and leads to lawsuits.
- The practice of medicine and nursing is an imperfect art.
- Remember, you may have heard only one side of the story. Patient recall may be incomplete or inaccurate. You may not be fully competent to evaluate another's work without significantly more information than you possess. Communicate after adverse outcomes occur. Your attitude of care and concern, i.e. good bedside manner, may defuse potentially inflammatory situations. After all, people do not generally sue their friends. But patients become dissatisfied and seek legal counsel when they feel that you don't care, have been unresponsive, and/or have billed them improperly.

When the outcome is less than optimal, take the initiative to seek out the family. Face the situation openly and honestly. **DO NOT AVOID THE PATIENT** and his or her family. Delays can appear to be an attempt to cover up something. Accept and acknowledge their disappointments or expressions of displeasure. Courteous treatment of the patient's family helps generate the climate of concern that promotes positive feelings about the care that has been given, even in the face of a disappointing result. Make contemporaneous notes of all such oral communications with a patient or family. Occasionally, patients or family members faced with adverse outcomes attempt to conduct their own informal investigations into whether malpractice has occurred. Some have attempted to identify and interview nurses and aids associated with their cases. While understandable, such behavior is counterproductive. If a patient or family member questions you about the actions of other health professionals, refer them to the attending physician responsible for the patient's care. That way the physician will have a chance to discuss the matter directly with the patient.

Informed Consent

A person's legal right of self-determination and autonomy means that the patient, not the doctor, chooses the course of medical care. Proper informed consent creates an alliance in which both patient and physician assume responsibility. The patient must be presented with sufficient information to allow truly informed consent to treatment.

The content of the explanation should be what a reasonable, prudent physician would say under similar circumstances in this or a similar community. Proper informed consent and its medical record documentation include, but are not necessarily limited to:

1. Diagnosis of the problem.
2. Nature of the recommended treatment(s) and benefit(s).
3. Risks, discomforts, disability or disfiguring aspects of proposed medical treatments or surgical procedures.
4. Realistic expectation of outcome.
5. Realistic explanation of outcome or risks if the problem is not treated.
6. Alternative treatments, including additional consultation.
7. Identity of the treating physician and/or surgeon.
8. Existence of any financial or research interests you may have in recommending a particular course of treatment.

Not every treatment requires informed consent, but professional ethics suggest that you provide it routinely. Discussion of informed consent must be documented if the treatment could cause serious side effects. Not every risk or side effect must be disclosed, particularly those that are remote. Remote risks must, however, be disclosed if they carry the possibility of life-threatening, catastrophic, or severe consequences.

Informed consent is a process, not a preprinted form.

- Informed consent is “considered” consent, so give patients time between hearing the information and signing the form.
- Failure to provide informed consent to a patient may be judged negligence per se.
- If preoperative medication is to be given, the consent form must be signed prior to administration of the medication.
- Supplement standard forms with verbal discussion to assess patient comprehension.
- Informed consent should be free from coercion and undue influence by the physician or other hospital personnel.
- Attending physicians are ultimately legally responsible for ensuring that informed consent is obtained.
- Attending physicians may delegate this responsibility, but are better off delegating only retrieval of a patient’s signature.
- If the patient lacks the capacity to give consent for treatment, the patient’s legal guardian or representative may be an appropriate decision maker. In an emergency, consent is implied if the patient is unconscious.

Witness to informed consent:

- The consent form should be signed by the physician and a witness. Any adult may witness the patient’s (or legal guardian’s) signature on a permit, including those active in the patient’s treatment. Therefore, an operating room nurse may witness a signature, even though he or she may be directly involved in the patient’s care.
- The witness affirms only seeing the patient sign the permit.
- When you act as a witness and the patient asks questions indicating that he or she is less than fully informed about the procedure, you should halt the process and contact the attending physician.

Revocation of consent:

- Patients may revoke consent at any time, either verbally or in writing. The attending physician should be notified immediately, and the revocation should be prominently noted in the patient’s chart.
- If a patient revokes consent to a treatment or procedure, it may not be performed.
- If a patient revokes consent during a procedure, it should be terminated as soon as it is reasonably and safely possible.
- If a patient revokes consent out of fear and/or misunderstanding, it may be appropriate to counsel and instruct them. It is never appropriate to use coercion in such circumstances.

Generally, informed consent retains its validity but common sense tells you that a patient's informed consent is good as long as there is no material change in circumstances. Therefore, if informed consent was obtained previously, consider whether there have been any changes in:

- The patient's condition;
- The risk/benefit ratio of the treatment to which the patient consented;
- The validity of any information presented to the patient about his or her treatment.

If the circumstances have changed, the process of informed consent must be repeated. In addition, since memories fail, it is prudent to repeat the informed consent process if 30 days have passed before the treatment is instituted. Therefore, review the information with the patient. If he or she remembers it, proceed; if not, repeat the informed consent process in its entirety.

Exceptions to informed consent:

A physician is authorized by law to treat a patient in limited circumstances. Exceptions to informed consent should be considered only in these unusual cases:

- **Emergency:** The injury must be life threatening and require immediate attention to preserve life or to prevent deterioration or aggravation of the patient's condition and the patient must be unable to make an informed choice due to shock, unconsciousness, drug or alcohol intoxication or similar circumstances. Only necessary intervention may be provided.
- **Therapeutic privilege:** Where disclosure of all facts would be detrimental to or have substantial adverse affect on the patient, the physician may withhold certain information. Therapeutic privilege is rarely justified. Exercise caution when invoking this exception and use care to determine the manner and extent of limiting exposure.
- **Compulsory or court-ordered treatment:** Courts may order treatments over objections of patients and their families. These orders take legal precedence. Examples included care given to an abused child, in emergency situations and certain treatments for incarcerated individuals or persons with mental disabilities.
- **Diagnostic tests pursuant to law enforcement agencies:** Some states allow medical personnel to draw blood for testing blood alcohol levels in patients involved in motor vehicle accidents. Generally the driver can refuse to have their blood drawn, but if they make this choice, their driver's license may be revoked. Never underestimate your patient's desire for information.

Consent for treatment of minors:

Generally, consent for treatment of patients less than 18 years of age must be obtained from the patient's parent(s) or legal guardian before treatment is administered. Exceptions include, but are not limited to, emergencies; child, drug or alcohol abuse; prenatal care; treatment for sexually transmitted diseases or other situations. The reason for treatment under any of these exceptions must be clearly documented in the medical record, along with notifications about any attempts to notify the patient's parent(s) or guardian(s) when indicated.

What about treatment in the face of religious objections?

Some religious tenets regarding medical treatment are constitutionally protected, other are not. For example, Amish may refuse immunizations; Jehovah's Witnesses may refuse blood; and Christian Scientists, Orthodox Jews and others may object to the use of certain procedures or products.

If the patient is an adult:

- The physician and patient should work out the best course of action in consultation with one another.
- The physician must, with very narrow exceptions, honor the patient's refusal of treatment.
- Never be deceptive, perhaps thinking that treatments can be administered without the patient's knowledge.
- Be realistic. If you think you will need to employ a treatment to which the patient objects, be sure that its likelihood or probability is explained and that the patient understands.

If the patient is a minor:

- If the minor's life or safety is at risk and the physician believes that refusal of treatment constitutes neglect, if you are in a hospital or clinic, inform the appropriate authority immediately. If you are the authority call your local Department of Social Services or Human Services and ask for Child Protective Services to obtain a court order placing the minor under custody for the purpose of medical consent.
- In some cases, you and the social worker may decide that their involvement is not required and may directly obtain court permission to institute medically necessary treatment.
- Hospitalization of a child can occur without parental consent if the health care professional has reasonable cause to suspect that the child's life or physical or mental health is in imminent danger. Specifically, the physician should:
 1. Take steps to ensure the child's safety (e.g., when the child and parents are apart, ask a nurse to take the child to a safe location. If the situation warrants, ask Security to stand by)
 2. As outlined above, contact a Social Worker and ask for the child to be put under custody for consent to medical treatment for whatever is causing the life-threatening or dangerous condition. Often custody will be granted for 24 hours or until the next Juvenile Court session, at which time a judge will make a decision regarding ongoing custody.
 3. Inform the parents. Explain the situation and the steps you and the social worker have taken. If necessary, explain that the parents' refusal to allow medical treatment of their child constitutes neglect, and that the courts would not look favorably upon the parents if they continued to refuse treatment for their child. Be direct, honest, realistic and businesslike. Do not get caught up in the parents' emotions.
- Follow the same procedure if, once admitted, a family decides to take the child out of the hospital against medical advice.

The Medical Record as Evidence of Quality Care

It has been said that the medical record is the patient's other self. Patient charts document the quality of patient care. Since memories fade, medical records constitute extremely important evidence in a lawsuit.

- The chart serves to trigger a health care provider's memories of a particular case.
- A patient's lawyer uses the medical record to investigate the patient's allegations and decide whether a complaint has merit.
- Juries usually rely on the chart as the authoritative account of what transpired. You can be helped or harmed by what is or is not included in your patients' medical records. Notes by non-physician health professionals are important; read them carefully

Good charts are:

- Comprehensive
- Timely
- Legible
- Objective
- Unaltered
- Internally consistent

Good charts include (but are not limited to):

- Medical evaluations of the patient
- Consideration of appropriate diagnoses
- Formulation of treatment plans
- Evidence of diagnostic testing and their interpretation
- Notification of test results to the primary physician
- Documentation of informed consent to procedures and treatments that involve risks

Problem records are usually:

- Inadequate: They lack progress notes, consultation reports, justifications for continued hospital stays, reasons for undertaking or modifying treatment, data and judgments that lead to admission decisions, conspicuous notes about patient allergies (notes that known or suspected allergies were investigated), dates and times for all entries or records of telephone conversations (including prescriptions, refills, advice and follow-up plans). Records of phone conversations and telephone messages should be retained.
- Unsigned or untimely: If transcribed reports are unsigned or uninitiated, uncorrected or obviously unread, juries may react negatively, reasoning that substandard charts reflect substandard care. If a report is delayed, and the patient outcome is unfavorable, that patient's attorney will argue that the report was slanted to justify the physician's judgments and actions. Late entries are accepted as long as they are labeled as late entries and the delay is justified by the circumstances. The note should not appear to be self-serving.

- Illegible or haphazard: Unreadable records may adversely affect care, and they hinder attempts to demonstrate that a reasonable course of treatment was identified and followed. Juries may infer haphazard care from scribbled entries, unintelligible handwriting or non-standard abbreviations. Misplaced decimals and/or uncertain spellings of drugs with names similar to other drugs represent significant hazards.
- Critical or subjective: The medical record is not the place to criticize colleagues or the institution, to place blame, or to suggest fault is with words like “inadvertently” or “accidentally”. Gratuitous comments or inappropriate patient characterizations should be avoided. Stick to the facts. If you record a patient’s or family member’s opinion of an incident, place their words in quotation marks and attribute the comment to them so it does not appear to be your opinion.
- Altered or missing: Even innocent deletions, white-outs or obliterations are unacceptable and may be constructed by juries as a “cover up”. Correct errors by putting a single line through erroneous information, and write “error”, the date and your initials above that section.

Do NOT conduct “chart wars” with colleagues who have differing opinions about the diagnostic or therapeutic aspects of care. Instead, speak with your colleagues, come to a mutually agreeable understanding, and let the chart reflect that understanding.

Retain adult records a minimum of 10 years from the last visit. Records of minors should be retained until the minor is 24 years old. Records of mentally disabled persons should be kept 10 years after their death or 3 years past the date they are judged no longer mentally disabled. Deceased patients’ records should be kept 10 years following death. X-rays should not be destroyed until 4 years from the date of the last visit. Any willful violation of the law regarding medical records, including their destruction, falsification or unauthorized release may result in civil or criminal liability to you.

Patient Access to Medical Records

A patient or patient’s legal representative may have reasonable access to records.

- Medical records should not be turned over to patients and family members on demand, but a copy be provided within a reasonable amount of time.
- The patient should complete an authorization for release of medical records and a copy of the record will be provided to the patient or patient’s legal representative at their expense.

Patients may ask to read their charts for several reasons:

- Curiosity. They never saw one before and want to know how it is organized.
- Need for information. They claim they cannot get answers about test results by asking.
- Suspicion. They have a poor relationship with their health care team and want to know what is being written about them. Patients and/or family members may read the medical record if the physician decides to allow it and if the patient consents. A physician or other staff member should stay with the patient or family member during

this process to ensure that questions are answered and appropriate interpretation of information is provided and that nothing is removed from or changed in the medical record.

- At no time should a patient or family member be given the original record for their own use.

Reporting Adverse Occurrences

An adverse occurrence is an unplanned or unexpected event causing injury or the potential for injury to a patient. Your insurance company should be notified immediately of the adverse event and will help you and advise you.

Reporting adverse occurrences is important for several reasons:

- Monitoring “incidents” helps identify potentially recurring problems that might affect quality patient care.
- Arrangements for further patient care or treatment can be made if necessary.
- Prompt reporting allows the Risk Management staff to properly assess situations from a liability standpoint.

The following should always be advised:

- Surgical problems:
 1. Invasive diagnostic or surgical procedure performed on the wrong patient.
 2. Wrong invasive diagnostic or surgical procedure performed on a patient.
 3. Adverse result from anesthesia.
 4. Laceration/tear or perforation/puncture of an organ or other body part as a result of an invasive procedure.
 5. Unexpected return of a patient to the operating room during the same admission, or transfer to the operating room following delivery of a baby.
 6. Surgery for removal of a foreign object left in the operative site unintentionally.
 7. Acute myocardial infarction during or up to 72 hours following surgery.
 8. Sponge, needle, foreign object or other material left in operative site unintentionally or because of impossible retrieval.
 9. Unplanned removal, partial removal or repair of a normal body organ or body part during an operative procedure.
 10. Unexpected nerve damage not addressed during informed consent.
 11. CVA during or within 72 hours of elective surgery.
 12. Death occurring within 72 hours of elective surgery.
- Newborn/Infant injury or death:
 1. Infant injury during labor/delivery.
 2. APGAR less than 5 at 5 minutes in an infant > 34 weeks EGA.
 3. Any unexpected death of an infant up to 4 weeks of age during hospitalization.

- Other patient injury or death:
 1. Patient injured in any kind of transport.
 2. Equipment or instrument breakage or malfunction resulting in injury.
 3. Patient falls resulting in injury.
 4. Intubation resulting in injury.
 5. Injury due to documented improper technique, personnel error, equipment failure or unexplained etiology.
 6. Cardiac or respiratory arrest outside of an intensive or emergency care setting that is not attended by the STAT team and where there is no DNR order on the patient's chart.
 7. Any incident that occurs to a patient that causes harm, injury or undetermined adverse effects.
 8. Any unexpected death.

- Transfusion or medication problems:
 1. Transfusion acquired AIDS or hepatitis.
 2. Hemolytic transfusion reaction.
 3. Medication error resulting in harm or potential for harm.

- Patient dissatisfaction or procedural problems:
 1. Any suggestion or implication by the patient or family of seeking legal counsel regarding any incident.
 2. Family anger or hostility over care or treatment given a patient, either in-patient or out-patient.
 3. Absence of or improper informed consent.
 4. Discharge against medical advice.

Important Considerations for Your Protection:

Other than the patient's record, no written, photocopied or recorded personal accounts of adverse occurrences should be kept by the involved individuals. Never enter a note in the patient record that an occurrence report has been completed or that parties other than the patient or their families have been notified. If the existence of an occurrence report is noted in the chart, it signals that someone believes an untoward event has occurred, thereby allowing the plaintiff attorney to subpoena whoever wrote the note to testify as to the contents of the occurrence report (even though the document itself may be confidential).

- If any injury is due to equipment, discontinue the equipment's use without any alterations, adjustments, cleaning or manipulations. Notify the insurance company and be sure to communicate that injury was involved. They will advise you. Make sure that you follow up if action is not taken within one working day. **DO NOT** send broken devices back to the manufacturer. **DO NOT** discard any part of the equipment or its packaging.

Communication with Distressed or Angry Patients/Families

Despite your best efforts, not everyone recovers completely. Telling patients or their families about disappointing results, and then dealing with their reactions, is not easy. Nevertheless, with care and compassion, such communication maintains the climate of concern that characterizes quality care. Conversely, failing to communicate concern after an adverse outcome is a leading cause of malpractice claims. Often patients state that the reason they went to a lawyer was because their health professional(s) showed no concern, no warmth, wouldn't listen, wouldn't talk or wouldn't answer questions. When the outcome is less than optimal, take the initiative to seek out the family. Face the situation openly and honestly. **DO NOT AVOID THE PATIENT** and his or her family. Delays can appear to be an attempt to cover up something. In addition, delays allow patients and family members to be negatively influenced by well meaning, but over reactive, staff and/or friends.

Although you should never assume the meeting will go the way you think it will, the general outline that follows may help you prepare for difficult conversations:

1. Select the setting: Give bad news in a private place, where the patient and/or family may react and you can respond appropriately. Hearing bad news in elevators, lobbies and busy corridors makes it difficult for patients to respond, can lead to self-consciousness and embarrassment in front of strangers and generally prompts indignation toward you. Respect their dignity and confidentiality.
2. Set the stage: "Mr. and Mrs. Wilson, I know you are aware there were risks involved in your pregnancy..."
3. Clearly deliver the message: There must be no mistake that the adverse outcome is understood – "I must tell you that your son was born with _____ and that means _____."
4. Discuss transition support: Tell what the next steps might be with respect to medical, social or other forms of support.
5. Wait silently for a reaction: Allow an opportunity to deal with the family's questions. Give the family time to consider what has happened.
6. Deal with the reaction: Be prepared to handle various responses.
 - The usual "mixed" reaction. The person displays a range of emotions such as denial, anger, resignation and acceptance. Listen to them. Acknowledge their feelings. Discuss the next steps. Afterwards, document a summary of the discussion.
 - The shocked response. The person becomes quiet and unresponsive, may cry, may "shut down" and stare at the floor. Take time to discuss individual feelings. Ask questions like "Are you okay?" Give the family time to accept the news before leaving. If appropriate, bring in professional support staff. Persons experiencing the shocked response could be at risk for accidents or injuries to themselves.
 - The controlled response. The person appears nervous and avoids eye contact. Verbal behavior seems positive, but the person's body may become rigid with jaws tensed. Make sure the person clearly understands the adverse outcome.

In order to help them open up, ask, “How do you feel about what has happened?” or “Tell me what you’re thinking.” Urge the person to draw on any support networks to help them. These persons could be at risk for “blowing up” later or even trying to get revenge.

- The angry response. The person gets red in the face, raises his or her voice and becomes openly critical of you or the institution, may stand up or assume an angry posture. Remain calm. Do not get caught up in the anger or become defensive. Allow the person to blow off steam. Anger is generally secondary to fear, helplessness or embarrassment. Avoid vague expressions of sympathy like, “I understand how you might feel that way,” since such comments may be interpreted as admissions of wrongdoing. Be specific, “It’s always sad when someone like your father doesn’t recover from a heart attack. You and your family have my sympathy.” Be careful that empathy with the patient’s feelings is not misinterpreted as an admission of negligence. As an alternative, acknowledge their feelings. For example, you might say, “I see you are angry. What makes you feel that way?” In extreme cases, this person may be at risk for physical violence or vandalism against property. This is extremely rare, however, and typically occurs only when no support has been provided.
7. Conclusion and interaction: Insure that the patient and/or family understands what has happened, what the next steps/decisions might be, where they can get help, and what, if anything, will be done for them by you and the institution. If you are unsure about what can be offered, ask colleagues for guidance. Be sure the patient/family knows how to get in touch with you. Finish by reassuring them about your continued willingness to talk with them and answer questions. Afterwards, document a summary of the discussion.
 8. Consider scheduling a follow-up meeting: It is often prudent to meet again with the patient or family after the crisis has subsided. Be prepared for the meeting and bring the medical record if needed. Despite your best attempts, you will occasionally encounter patients or family members who simply cannot be satisfied. Some people seek control over every situation. Others want more attention or information than could ever be provided. Document your good faith attempts to deal with such persons.