the REPORTER

CME: DISASTER PREPAREDNESS FOR PHYSICIAN PRACTICES

TMLT
Texas Medical Liability Trust

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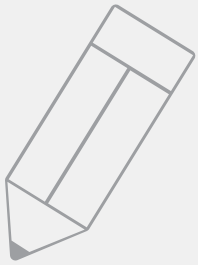
CONTINUING
MEDICAL
EDUCATION

CME: DISASTER PREPAREDNESS FOR PHYSICIAN PRACTICES

by Laura Hale Brockway, ELS, Vice President, Marketing



EDITOR'S NOTE

This article was planned for publication in the months before the Hurricane Beryl disaster struck Houston. TMLT is dedicated to the support of our physician policyholders across Texas, and we stand ready to help the Houston physician community.

OBJECTIVES

Upon completion of this educational activity, the participant should be able to:

1. summarize the necessary components of a HIPAA-compliant emergency contingency plan;
2. describe practical methods for recovering medical records damaged or lost due to a disaster;
3. define liability protections for physicians who offer volunteer or charity services during an emergency or disaster; and
4. list federal and association resources for emergency and disaster response.

COURSE AUTHOR

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DISCLOSURE

The author of this activity has no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning practical ways to reduce the potential for malpractice liability.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive CME credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

PRICING

The following fee will be charged when accessing this CME course online at http://tmlt.inreachce.com.

Policyholders: $10
Non-policyholders: $75

INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to http://tmlt.inreachce.com. Log in using your myPortal account information to take the course. Follow the online instructions to complete the forms and download your certificate. To create a myPortal account, go to www.tmlt.org, click the log in button, and follow the on-screen instructions.

RELEASE/REVIEW DATE

This activity is released on August 1, 2024, and will expire on August 1, 2027.

Please note that this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

On July 8, 2024, Hurricane Beryl hit Houston. In a matter of hours, it left a trail of devastation that included flooded streets, severely damaged homes and property, and downed power transmitters that left millions of people without power.

Hurricane Beryl is the latest example of the kind of far-reaching disaster that can affect a community for weeks. This type of disaster — along with cyberattacks, electronic health record (EHR) issues, pandemics, winter storms, and supply chain shortages — can be a major disruption to a physician's practice and a threat to patient safety.

In addition to the important, practical role physicians play during a disaster, much of the physician community's ability to respond when disaster strikes is due to the high levels of organization, dedication, and preparation demonstrated by physicians and their staff in their day-to-day work lives.

That preparation includes establishing well-designed contingency plans for when disruption or disaster strikes. An up-to-date, comprehensive action plan could be the difference between an orderly return to seeing patients or weeks of downtime and frustration for your practice. Disaster preparedness plans can also enhance patient safety during emergencies and contribute to a coordinated community response to disasters.

For these reasons, HIPAA enforces a federal security rule that requires physician practices to have contingency plans in place that outline the steps an organization would take in an emergency.[1] A contingency plan is critical to protecting practice resources and data, minimizing disruption to patient care, and restoring normal practice operations.

"Contingency plans should cover all types of emergencies, such as natural disasters, fires, vandalism, system failures, cyberattacks, and ransomware incidents. The steps that must be taken for each scenario could well be different, especially in the case of cyberattacks vs. natural disasters. The plan should incorporate procedures to follow for specific types of disasters." [2]

This article will discuss the requirements for contingency plans, including how and what to communicate during a disaster and guidelines for plan testing and employee training.

CREATING YOUR CONTINGENCY PLAN

A first step in developing a contingency plan is to analyze and identify where your practice may be vulnerable.[3]

- "Perform an analysis of potential disasters affecting your facility by reviewing patient, staff and physical safety as well as the protection of medical and business records. Are there potential hazards located nearby? Is there a river that may overflow or a volatile chemical plant?
- Consider all possibilities such as utility failures, a natural gas explosion, a broken water main or a lightning strike causing a fire in your office when every treatment room is filled.
- Prioritize events that may be unique to your setting such as women's health centers being targets for bomb threats and violence.
- Develop a specific plan for the prevention of workplace violence as well as domestic violence that could be brought to the work setting.
- Consider collaborating with resources such [as] neighboring health care facilities, local law enforcement and the fire department.
- Plans should also consider that your office may need repair, and you may not be able to return for an extended period of time. Explore how long your practice could be shut down before impacting your finances." [1]

Use this information to address the four main elements of a HIPAA-compliant contingency plan.

1. "**A data backup plan** ensures that when disaster strikes, PHI is not lost or destroyed. A viable copy of all ePHI must be created that allows exact copies of ePHI to be restored, which includes all forms of ePHI such as medical records, diagnostic images, test results, case management information, and accounting systems. It is a good best practice to adopt a 3-2-1 approach for backups: Create three copies of data, store them on at least two different media, and have one copy stored securely offsite. Backups must also be tested to ensure the recovery of data is possible."

2. "**A disaster recovery plan** should establish the procedures that must be followed to restore access to data, including how files should be restored from backups. A copy of the plan should be readily available and stored in more than one location."

3. "**An emergency mode operation plan** must ensure critical business processes continue to maintain the security of ePHI when operating in emergency mode, for example when there is a technical failure or power outage."

4. **Procedures for testing and revision of contingency plans** — "all elements of the contingency plan must be regularly tested and revised as necessary. OCR recommends conducting scenario-based walkthroughs and live tests of the complete plan." [2]

RECOVERING DAMAGED MEDICAL RECORDS

If your practice experiences an IT system failure or structural damage as the result of a disaster, please refer to these guidelines for recovering damaged medical records.

Report the loss to your general liability/ property/cyber insurance carriers. Keep the documentation sent to and from your property insurance carrier verifying water damage or other event. In the event of a medical liability claim, this documentation could be important. Having the appropriate documents could protect you against an allegation of intentional "spoliation" of records.

If applicable, immediately contact your EHR vendor regarding recovery of data and back-up records.

If any records are salvageable, try to preserve them. There are companies that specialize in paper and digital document remediation. Be sure to obtain a HIPAA Business Associate Agreement with any vendor (IT service, document restoration or destruction).

If the records are not salvageable and what's left of them needs to be destroyed, be sure that the destruction (shredding, erasing of hard drives or servers, etc.) is complete and well documented. Keep a list of all patients whose records were destroyed, along with details of what happened, dates, etc.

Try to re-create records as best you can by requesting outside records such as lab reports, diagnostic testing, operative reports, and other records. It may also be worthwhile to upload information from practice management software and investigate the recovery of any recorded or transcribed records from outside services or voice recognition software.

Any "re-created" records should be clearly labeled as such, with the current date. You may also wish to make a copy or photograph of the records.

The documentation should reflect what happened (water damage, record destroyed) and that the patient's history is uncertain due to lost information as of (date), etc. At your discretion, you may consider whether to obtain new history forms and/or talk to the patient to gather additional history.

Conduct an assessment to evaluate the potential or actual breach of protected health information and determine your next steps. Contact your liability insurer to investigate whether you have coverage for possible privacy breaches. If so, they will be able to assist you in determining whether patient notification is required and how to proceed.

Health insurance carriers may require attestation forms regarding lost/destroyed records. Check with your carriers about this.

OTHER KEY ELEMENTS OF CONTINGENCY PLANS

Plan activation and timing

Ask yourself, what event(s) will cause the activation of the contingency plan? Who has the authority to activate the contingency plan? What must be done during the first hour, day, or week? Ensure that all members of your staff fully understand the conditions of plan activation and timing.[2]

Staffing

Complete and update a staff emergency contact form. Contact information should be kept on the physicians, the practice administrator or manager, other key staff members, IT staff, building management, internet service provider, electricity provider, and cyber insurance carrier. If possible, include phone number, cell phone number, email address, physical address, and, if different, a mailing address for each contact.

Employees should have the contingency plan and contact information available on paper, with copies stored at home and in the office.[3]

Patient care

If your office is directly affected by the disaster and you are unable to see patients, refer your patients to alternative sources of care such as colleagues, specialists, the emergency department, or an urgent care clinic. Carefully document any instructions given to patients.

If it is accessible, review your office schedule to determine which patients missed appointments during the disaster, and review upcoming appointments. If possible, contact these patients to confirm their situation and document these efforts in their medical records.[1]

Medications

Some patients may have left necessary medications behind as they evacuated their homes and may need replacement prescriptions. When contacting your patients, ask about their current situation, their medications, and any need for refills. If possible, call any needed refills into a local pharmacy.[1]

Medical records and practice management software

- Determine how the practice would function regarding documenting care, communicating with patients, placing orders, and billing for services if your practice software and EHR were unavailable.

- What paper forms would you need to run the practice without the EHR?

- Create an emergency contact list of vendors and phone numbers. Keep copies of the contact forms and any other forms you need to operate if you can not access your systems.

- Key employees should have the contingency plan and the contact forms available with copies stored at home and in the office.[3]

Phone lines, website, social media

Ensure phone lines continue working or are backed up and brought back quickly. Even if your office is not ready to reopen, create an outgoing phone message to keep your patients and staff updated on your status. Update the message as new information regarding your practice becomes available. You can also post updates on your practice website, patient portal (if available), and social media.[1]

Practice paperwork

Important documents — insurance policies, lease agreements, real estate records, contracts, equipment warranties — can be scanned and stored digitally. Paper copies of these documents are best stored in a safe or safe deposit box. Maintain a record of the location of these documents.[1]

Evacuation and shut down

- Know where your office gas, electricity, and water connections are in case you need to turn them off. If feasible, keep back-up generators or a storage plan for your refrigerating systems.
- Be prepared for an orderly evacuation, including communicating with your business neighbors.
- For surgical or diagnostic facilities, determine whether it is safe for a procedure to continue or whether patients can be transported to another facility.
- If working in multistory buildings, be prepared to use the stairs, not the elevator.
- If conditions are safe, staff and patients should meet outside at a predetermined location.
- Designate staff to ensure all patients, visitors, and staff are out of the building.
- If your practice has a web-based or cloud-based

EHR — and you have advance warning — make sure you take at least one mobile device with you so you may access it. If the practice has a local server, power down the server and move it. However, IT staff may be the only ones with the admin password needed to power down the server. In any case, take copies of the back-up if stored on site.
- If time permits, turn off equipment and secure drug cabinets and medical supplies.
- Secure cash/receipts and remove them, if possible.
- Place calls on forwarding to a secure source.
- Redirect arriving patients and post signs at the building and on your website and social media warning that the building is closed.[1]

Insurance discussions
"Review the available coverage for physical repairs, record restoration, setting up a temporary practice location and other practicalities to allow you to return to the practice of medicine." [1]

Disaster documentation
"Create and retain a record of the disaster event and a list of any patient records affected, with recovery efforts, successes and failures outlined. This will allow for easy retrieval of general information should any legal or accreditation issues arise subsequent to the emergency." [1]

Documentation of the incident can also help you prepare for other potential disasters and emergencies. "An after-action report is a great learning tool, as are post-incident meetings, in which all responders come together to discuss best practices, lessons learned, and areas to improve."[4]

ESTABLISHING A COMMUNICATION PLAN

Each emergency situation requires communicating with key individuals including emergency government resources, physicians/advanced health care professionals, patients, vendors, and staff.

- Power may be down, so it may be helpful to have printed plans and an emergency contact list that includes phone numbers and emails for government emergency agencies, local hospitals, partners, colleagues, vendors, and others.
- Develop a staff communication tree designating the staff members who will communicate with those on the contact list.[1]

CAN YOU SHARE PATIENT INFORMATION?

During disasters, questions may also arise about what kind of health information can be shared with friends and family, public health officials, and emergency personnel.[5]

The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts, and to assist patients in receiving the care they need. While the HIPAA Privacy Rule is not suspended during a public health or other emergency, the Secretary of the U.S. Department of Health and Human Services (HHS) may issue temporary, limited waivers of certain HIPAA provisions during a disaster or declaration of a public health emergency.[6] These waivers are typically issued as HIPAA bulletins on the HHS website. (As examples, the bulletin issued during Hurricane Beryl can be seen here: https://www.hhs.gov/sites/default/files/2024-hipaa-bulletin-texas.pdf; the 2021 Texas winter storm bulletin can be seen here: https://www.hhs.gov/sites/default/files/2021-texas-winter-storm-hipaa-bulletin.pdf.)

PREPARING, TRAINING, AND TESTING

HIPAA rules require physician practices to test and assess their plans. Contingency planning for HIPAA compliance "should be an ongoing process with plans regularly checked, updated, and tested to ensure any deficiencies are identified and addressed." [2]

- Train staff about their roles during an emergency.
- Conduct drills at least twice per year. Always look for ways to improve your response to emergency situations.
- Restoring your patient data from a backup may be required if your practice is hit with a ransomware or other hacking attack. To ensure the backup will fully restore your systems, test these backups at least once per year.[1]

Contingency planning can help you provide the best possible care for patients during an emergency or disaster. "An office emergency preparedness program removes the anxiety of dealing with unusual issues, keeps necessary medications and equipment current and in working condition, and identifies problems prior to an actual emergency so that they can be resolved." [7]

VOLUNTEER AND CHARITY CARE

Each year thousands of physicians and other health care professionals volunteer to help those in need of medical treatment after a natural disaster or other emergency. One of the challenges of volunteering in the health care field is the fear of malpractice liability associated with providing these services. Fortunately, both state and federal laws offer some liability protection to volunteer health care professionals. This article covers applicable laws in Texas. If you practice outside of Texas, please refer to your state medical board for guidance.

Texas state law
Texas has both a charitable immunity law and a Good Samaritan law. Good Samaritan laws protect health care professionals providing care in emergency situations. Charitable immunity laws protect health care professionals who provide non-emergency care for certain charitable organizations.[8]

In general, these laws make it more difficult for plaintiffs to win a liability claim but do not guarantee that volunteers will not be sued. The legal immunity provisions prevent liability awards. They do not prevent lawsuits. Anyone who can afford a filing fee can file a lawsuit. The physician is then left to assert the immunity statutes as an affirmative defense (Affirmative defense means that after the lawsuit is filed, the physician must prove the law provides protection.)[9, 10]

Texas Good Samaritan law
Under the Texas Good Samaritan law, a physician who "in good faith administers emergency care is not liable in civil damages for an act performed during the emergency unless the act is willfully or wantonly negligent."[11] The law applies to a person who administers care using an external automated defibrillator or who administers emergency care as a volunteer first responder.[11]

Physicians providing emergency care at the scene of an emergency are immune from civil liability unless:
- their actions are willfully and wantonly negligent;
- they expect payment for the care;
- they regularly administer care in a hospital emergency department (unless they are at the scene of the emergency for reasons not related to their work);
- their actions caused the emergency; or
- the physician was at the scene soliciting business or seeking to perform a service for remuneration.[11]

It should be noted that the Texas Good Samaritan law does not apply when a physician is practicing in a hospital emergency department.

Charitable immunity
A state law known as the Charitable Immunity and Liability Act of 1987 provides physician volunteers with civil liability limits for performing nonemergency care for certain charitable organizations.[12]

Under the act, a "volunteer" is a person rendering services for a charitable organization who does not receive compensation in excess of reimbursement for expenses incurred. This includes a person serving as a director, officer, trustee, or direct service volunteer.[12]

There are 10 types of health care providers who may be "volunteer health care providers," provided that they are either licensed or retired and eligible to provide health care services under Texas law. These include practicing or retired: physicians, physician assistants, registered nurses (including advanced practice nurses), vocational nurses, pharmacists, podiatrists, dentists, dental hygienists, and optometrists or therapeutic optometrists.[12]

According to the law, a volunteer health care provider who is serving as a direct service volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if the following requirements are met:
- the provider acted in good faith in the scope of volunteer duties within the organization;
- the act or omission was committed in the scope of providing health care services;
- the services are provided within the scope of the volunteer's license; and
- the volunteer obtains a written statement signed by the patient or the patient's legal guardian that acknowledges limitations on the recovery of damages from the volunteer and stipulates that the volunteer does not expect compensation for

the service.[13] (Please see sample disclosure form on page 10.)

For a complete list of qualifying charitable organizations, please see Texas Civil Practice and Remedies Code, Chapter 84, Section 84.001-84.004.[12]

In 2019, the Texas Legislature passed Senate Bill 752 to "fill the gap" in existing law to limit civil liability for health care professionals who are not affiliated with a charitable organization. SB 752's liability protections are in place "regardless of whether services are provided in connection with an emergency (some care may not be emergent), or whether the services are provided in connection with a nonprofit or at the direct request of a governmental entity."[14]

SB 752 does not apply to "reckless conduct, or intentional, willful, or wanton misconduct during the provision of care, advice, or assistance. Accordingly, a health care institution may still be held vicariously liable for a volunteer health care professional who engages in this prohibited conduct while providing services during a natural or man-made disaster."[14]

Federal law

Physician volunteers are also protected under the federal Volunteer Protection Act (VPA).[15] Passed by Congress in 1997, the VPA provides all volunteers for nonprofit organizations and government entities with protection from liability for harms caused by their acts or omissions while serving as volunteers.

This federal statute pre-empts any conflicting state law, although states may enact broader protections. Four requirements must be met for the law to apply:

- the volunteer is acting within the scope of his or her responsibilities;
- the volunteer is properly licensed, certified, or authorized by the state to practice;
- the harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or conscious indifference to the rights/safety of the person injured; and
- the harm was not caused while the volunteer was operating a motor vehicle or other vehicle for which a license or insurance is required.[15]

The liability limitations only apply to the volunteer (not to the organization) and "volunteer" includes individuals serving as directors, officers, trustees, or a direct service volunteer. Volunteers must not receive compensation or anything in place of compensation that is in excess of $500.[15]

Under the VPA, two types of organizations qualify as nonprofit organizations: a 501(c)(3) organization as defined by the Internal Revenue Code and exempt from tax under 501(a); and any nonprofit organized for the public benefit and operated primarily for charitable, civic, educational, religious, welfare, or health purposes. The organizations must also not practice any action which constitutes a hate crime.[15]

The VPA does not limit liability for crimes of violence; international terrorism; acts that constitute a hate crime; sexual offense; civil rights violations; or if the volunteer was under the influence of alcohol or any drug at the time of the misconduct.[15]

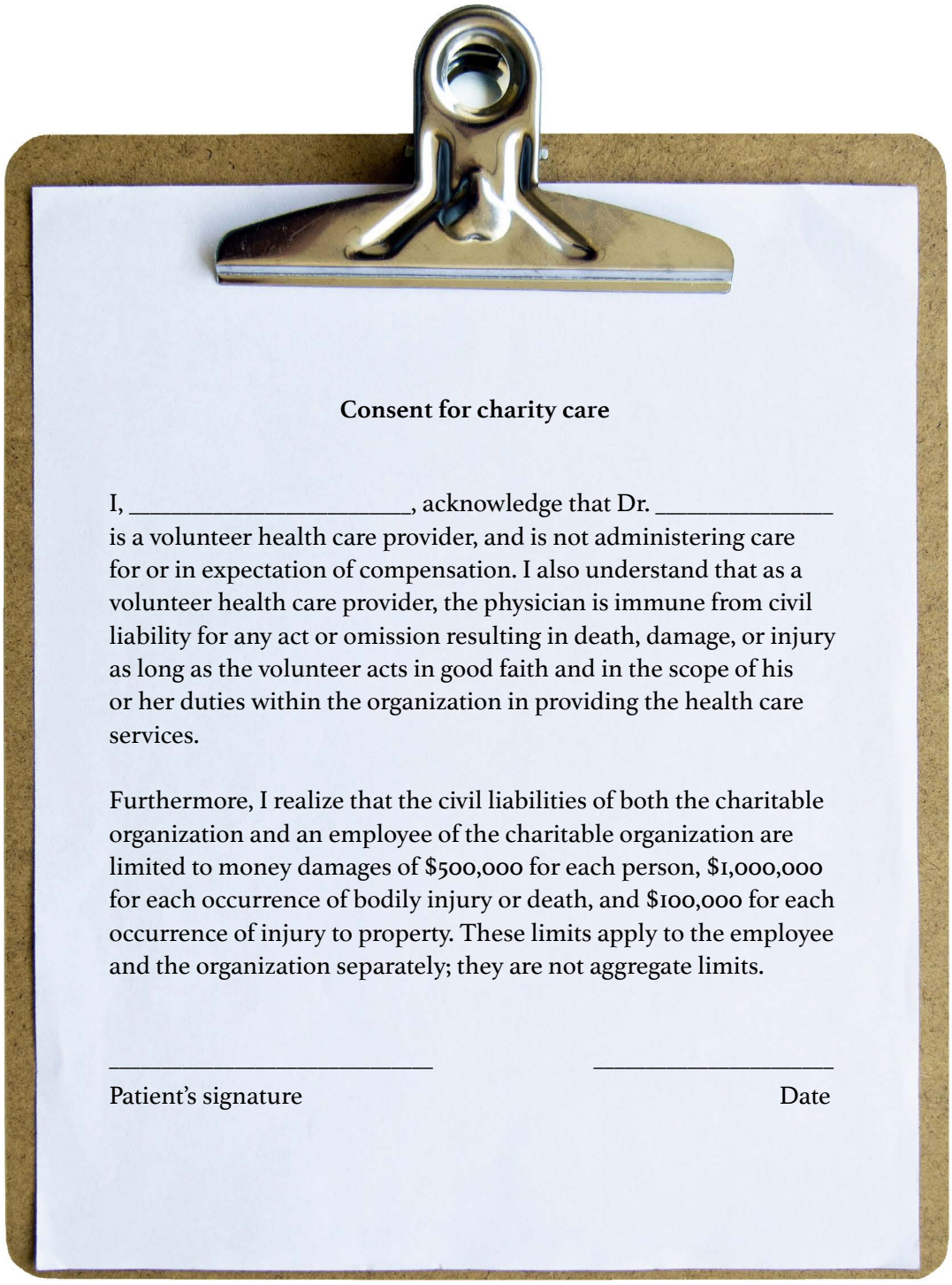
Risk management considerations

- Though the federal and state laws described in this article make it more difficult for a plaintiff to win a liability suit, they do not guarantee that a physician volunteer cannot be sued. This being the case, follow the same risk management practices you follow when caring for any patient — stay within your scope of practice, refer when appropriate, thoroughly document encounters in the medical record, communicate patient instructions clearly, etc.

- In certain situations, you may not have access to the patient's medical records or be able to contact any previous treating physicians. You may have to rely on the patient to obtain a medical history. Because patients may provide incomplete or inaccurate information and the patient's medical history could become a contested issue in a malpractice claim, document this information in a way that makes it clear this is what the patient told you. For example, "patient reports no drug allergies" or "patient says his last cardiac work-up was normal."

- Specifically, when volunteering or providing charity care, stay within your scope of service and license, and obtain written consent from the patient. (Please see sample disclosure form on page 10.) This will increase the likelihood that you will be protected by state and federal charitable immunity laws.

SAMPLE CONSENT FORM FOR USE BY VOLUNTEER HEALTH CARE PROFESSIONALS IN NON-HOSPITAL CHARITABLE ORGANIZATIONS.



Consent for charity care

I, _____, acknowledge that Dr. _____ is a volunteer health care provider, and is not administering care for or in expectation of compensation. I also understand that as a volunteer health care provider, the physician is immune from civil liability for any act or omission resulting in death, damage, or injury as long as the volunteer acts in good faith and in the scope of his or her duties within the organization in providing the health care services.

Furthermore, I realize that the civil liabilities of both the charitable organization and an employee of the charitable organization are limited to money damages of $500,000 for each person, $1,000,000 for each occurrence of bodily injury or death, and $100,000 for each occurrence of injury to property. These limits apply to the employee and the organization separately; they are not aggregate limits.

_____ _____

Patient's signature Date

EMERGENCY AND DISASTER RESPONSE RESOURCES

Federal
- Centers for Disease Control and Prevention — https://www.cdc.gov/
- Federal Emergency Management Agency — https://www.fema.gov/
- U.S. Department of Health and Human Services, Emergency Preparedness & Response — https://www.hhs.gov/programs/emergency-preparedness/index.html

Texas, state
- Center for Health Emergency Preparedness and Response — https://www.dshs.texas.gov/center-health-emergency-preparedness-response
- Texas Public Health Regions — https://www.dshs.texas.gov/regional-local-health-operations/public-health-regions
- Texas Division of Emergency Management — https://www.tdem.texas.gov/
- Texas Homeland Security Preparedness — https://www.preparingtexas.org/index.aspx
- Disaster Behavioral Health Services — https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/disaster-behavioral-health-services
- Texas Critical Incident Stress Management Network — https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/behavioral-health-services/disaster-behavioral-health-services/texas-critical-incident-stress-management-network

Texas, local
- Local health departments and districts of Texas — https://www.dshs.texas.gov/regional-local-health-operations/public-health-regions/texas-local-public-health

Associations and professional organizations
- Texas Medical Association — https://www.texmed.org/
- Texas Medical Board — https://www.tmb.state.tx.us/
- Texas Association of Local Health Officials — https://www.taccho.org/Home
- Association of State and Territorial Health Officials — https://www.astho.org/
- National Association of Counties & City Health Officials — https://www.naccho.org/
- Council of State and Territorial Epidemiologists — https://www.cste.org/

SOURCES

1. Porcaro J. Disaster preparedness for physician offices. American Society for Health Care Risk Management website. December 12, 2018. Available at https://forum.ashrm.org/2018/12/12/disaster-preparedness-for-physician-offices/. Accessed June 17, 2024.
2. Alder S. HIPAA rules on contingency planning. The HIPAA Journal. December 14, 2023. Available at https://www.hipaajournal.com/hipaa-rules-on-contingency-planning/. Accessed June 17, 2024.
3. Bryant C, Toerner K. Contingency planning for your practice. TMLT webinar. February 2022. Available at https://hub.tmlt.org/webinars/contingency-planning-for-your-practice. Accessed June 17, 2024.
4. Odisha State Open University. Disaster Strikes — Environmental Health Responds: Stories from the Field. Reporting, Documentation, & Record-Keeping. Available at https://osou.ac.in/eresources/reporting-documentation-record-keeping.pdf. Accessed April 10, 2024.
5. U.S. Department of Health and Human Services. Emergency Situations: Preparedness, Planning, and Response. September 13, 2023. Available at https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html. Accessed June 17, 2024.
6. U.S. Department of Health and Human Services. Is the HIPAA Privacy Rule suspended during a national or public health emergency? Last reviewed December 28, 2022. Available at https://www.hhs.gov/hipaa/for-professionals/faq/1068/is-hipaa-suspended-during-a-national-or-public-health-emergency/index.html. Accessed June 17, 2024.
7. Rothkopf L, Brennan-Wirshup M. A Practical Guide to Emergency Preparedness for Office-Based Family Physicians. Family Practice Management. March/April 2013. Available at http://www.aafp.org/fpm/2013/0300/p13.html. Accessed June 17, 2024.
8. Texas Medical Association Office of General Counsel. Charitable immunity whitepaper. July 2014. Available at https://tma.custhelp.com/app/answers/detail/a_id/759. Accessed June 17, 2024.
9. Berlin, J. Pandemic poses legal pitfalls: TMA seeks better liability shields. Texas Medicine. August 2020. Texas Medical Association. Available at https://www.texmed.org/Template.aspx?id=54308. Accessed June 17, 2024.
10. Brockway L. Volunteer and charity care. TMLT Resource Hub. Available at https://hub.tmlt.org/tmlt-blog/volunteer-and-charity-care. Accessed June 17, 2024
11. Texas Civil Practice and Remedies Code. Chapter 74. Section 74.151 Liability for emergency care. Available at https://statutes.capitol.texas.gov/Docs/CP/htm/CP.74.htm. Accessed June 17, 2024.
12. Texas Civil Practice and Remedies Code. Chapter 84. Charitable Immunity and Liability. Section 84.001-84.004. Available at https://statutes.capitol.texas.gov/Docs/CP/htm/CP.84.htm. Accessed June 18, 2024.
13. Texas Civil Practice and Remedies Code. Chapter 91. Liability of volunteer health care practitioners. Section 91.001-91.004. Available at https://statutes.capitol.texas.gov/Docs/CP/htm/CP.91.htm. Accessed June 18, 2024.
14. Texas Medical Association Office of General Counsel. Disaster Liability: Limiting liability for volunteer health care professionals during a disaster. A General Overview of Senate Bill 752 (86th Legislature). August 2019. Available with login at https://www.texmed.org/Template.aspx?id=51291. Accessed April 10, 2024.
15. U.S. Code Title 42. Chapter 139—Volunteer Protection. Section 14501-14505. Available at https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter139&edition=prelim. Accessed June 18, 2024

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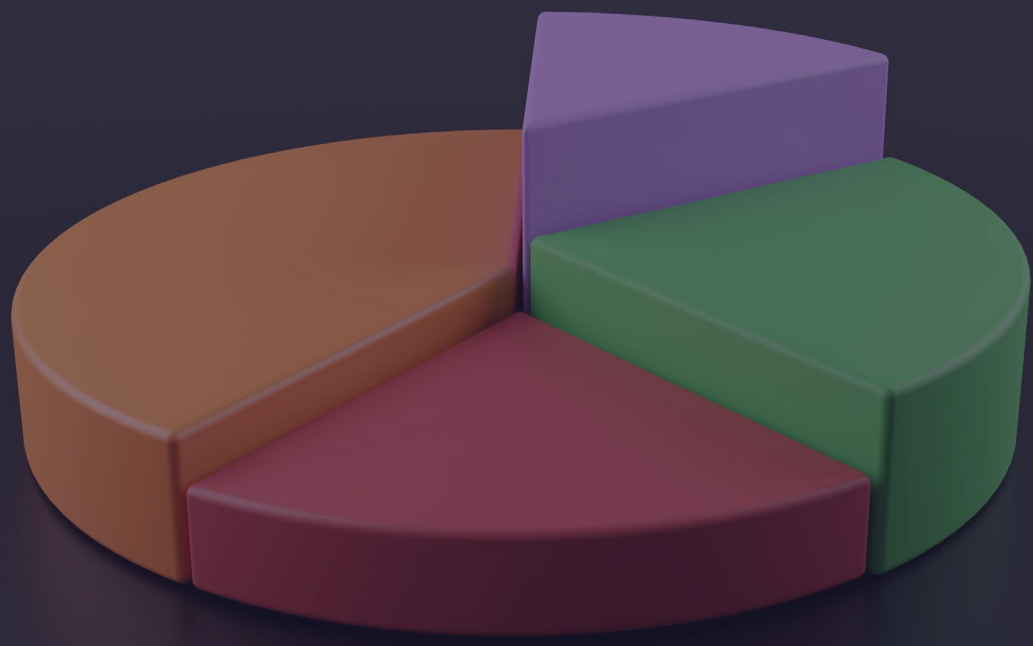
RISK MANAGEMENT'S "GREATEST HITS"

by Tanya Babitch, Assistant Vice President, Risk Management, and
Robin Desrocher, Director, Risk Management



The Risk Management Department at TMLT provides a variety of products and services to help physicians determine and minimize potential risk exposures that may contribute to medical liability claims. Greater understanding and awareness of these risk exposures — often involving interpersonal communication, documentation, or administrative factors — can help identify "problem areas" in a practice; avoid litigation or a medical board action; offer guidance in difficult situations; and increase patient safety.

The Risk Management team frequently observes certain liability exposures and patient scenarios that physicians have historically struggled to address. These risk management "oldies but goodies" keep coming up for good reason — they are challenging across care settings and specialties.

Here are a few of TMLT's "Risk Management Greatest Hits."

1. MEDICATION ERRORS ASSOCIATED WITH ANTICOAGULANTS

As a high-risk class of drugs, anticoagulants have been implicated in serious adverse events for many years. Specifically, medication errors in the management of warfarin continue to occur with some frequency.

While there are newer oral anticoagulants that do not require lab monitoring or careful consideration about dietary vitamin K intake, they are not appropriate for all conditions. These newer medications are also very expensive, and not all patients will qualify for assistance.

Therefore, warfarin is still widely prescribed. Because routine lab monitoring is required for warfarin, non-compliance, tracking, and communication are areas where things can and do sometimes go wrong leading to adverse outcomes.

Managing the risks associated with anticoagulation therapy falls in the hands of physicians across all specialties. Some risk management considerations to help reduce the chances of adverse effects include the following.

- When delegating any portion of the anticoagulation monitoring process to a staff member, ensure competencies are up to date and documented in employment files.

- Develop and implement evidence-based clinical protocols that address the frequency of monitoring labs, dose adjustments, patient education, patient compliance or non-compliance, identification of critical values, and when physician notification is required.

- Include a few key safety components in patient discussions and written information shared with patients and their families. Providing these details about the risks is not meant to scare patients. But it is important for patients to be fully informed so they can partner with their physician or health care professional and be an active participant in their medical care.

  Key pieces of information to share with patients include the following.

  - Fully explain the reason the medication is being prescribed.
  - Include the risks and benefits of the medication.
  - Clearly delineate the prescribed dosing and need for compliance. Does the patient know what to do if they miss a dose?
  - Educate patients on possible drug interactions (including prescription drugs and over-the-counter medications or supplements). Instruct patients to notify you before starting or stopping medications.
  - Describe dietary factors that can interfere with warfarin. Provide handouts or links to credible resources.
  - Instruct patients on warning signs that require contacting you and when to go to the emergency department. What should they do if they cut themselves? If they develop a bloody nose?
  - Provide written instructions when prescribing anticoagulation along the continuum of care. It is a lot of information to absorb and may be challenging for patients to retain information from an oral discussion.

Even when all of these actions and discussions have taken place, patients may still experience adverse events. Creating and following safe practice protocols and documenting all patient discussions and education efforts are helpful steps to increase the defensibility of claims involving this high-risk class of medication.

2. ELECTRONIC HEALTH RECORDS

Electronic health record (EHR) systems were initially developed and designed to assist medical organizations with billing and coding. As these platforms evolved, improvements were made to automated processes and usability. However, there is still room for improvement.

One issue in EHR documentation that is still a concern is "cloning," or cutting and pasting data from one patient visit to another. Cloning is a common practice among EHR users that can result in documentation errors. If cloning data from one patient encounter to the next, it is important to take the additional steps of confirming that the information is still correct and/or editing the data to bring it up to date. There are patient safety concerns that could trickle down through the continuum of care if the data is inaccurate. Accurate billing may also become a concern if actions not actually performed are documented as being performed and bills are incorrectly generated.

There are also EHR features where the system prepopulates data with a click of a button. As with cloning, prepopulated data must also be reviewed and verified by the user for accuracy before signing and locking the notes.

3. FOLLOWING UP ON TESTS

At TMLT, we often see failure to follow up on test results as an allegation listed in our claims. Unfortunately, a delay in following up on test results and referrals or failure to follow up can result in devastating patient outcomes. However, patient non-compliance, heavy workloads, multiple physicians and health care professionals managing a patient's care, and a lack of systems or tools to facilitate timely follow up are all factors that can make tracking challenging. Because of these issues, tracking processes are often absent, inconsistently used, or incomplete.

When a physician or other health care professional orders a test or refers a patient to a specialist or another health care professional for treatment, it is the ordering physician or health care professional's responsibility to follow up.

For practices still using paper medical records, the tracking system may be on paper or in the form of an electronic spreadsheet. In the tracking document, include areas for capturing the order date, patient's name, date of birth, the name of the test, the date results are received, the date of physician review, and the date and method that results are communicated to the patient. This list should be regularly reviewed and completed with close attention given to outstanding test results.

Now that most practices use EHRs, built in tracking systems are helping to manage this process. It is important to fully understand and become accustomed to the tracking features and other available functions of the EHR. Does the system allow the test result to get filed into the patient's record without physician review? If so, put a safety measure in place to avoid this step from occurring.

Some EHR systems will also share test results with patients in the patient portal, including abnormal results or results requiring additional testing or follow up with the physician. Find out if there is a way in your EHR tracking system to tell whether the patient received and reviewed the result posted in the portal. This is especially important when the result is abnormal and requires further action.

When it comes to EHR tracking systems, they are not all created equal. If you have not done so, reach out to your EHR vendor to learn more about the tracking system.

4. ENDING THE PATIENT-PHYSICIAN RELATIONSHIP

Terminating a patient relationship is often difficult and uncomfortable, but it may sometimes be necessary. Patients who are rude, aggressive, or disruptive; fail to keep appointments; refuse to adhere to practice policies; or do not follow the treatment plan often leave physicians with few options but to terminate the relationship.

A few basic tenets for ending a patient-physician relationship include the following.

- When terminating a relationship with a patient, you should do so with appropriate notice — such as with a letter or in-person conversation that stipulates an "end date" to the relationship. This end date will depend on several factors such as physician specialty, patient access issues, and the availability of other physicians. Give the patient a reasonable amount of time to find a new physician and remain available to care for the patient until the specified time elapses. Avoid terminating without notice, as that could be seen by your medical board as patient abandonment.

- Whether to end the relationship in person or in writing is at the physician's discretion. But if you are certain that you do not want to see the patient again, it is recommended to do so in writing. In most cases, we recommend sending termination letters via both certified letter (return receipt requested) and First-Class Mail. Some physicians choose to hand the patient a letter after an in-person discussion. Whatever method you choose, document the termination — with specific details such as timeline, medical records transfer instructions, patient response, etc. — in the patient's medical record. If using a letter, retain a copy in the patient's chart.

- In Texas, you are not legally required to give a reason for ending the relationship. If you choose to provide a reason, keep it fact-based, reasonable, objective, and brief. Avoid accusations or an accusatory tone if possible. Bottom line — keep it professional. If you practice outside of Texas, please consult your state medical board for guidance on whether you are required to provide a reason for termination.

- If the patient is in a health crisis, in the post-op period, or late in pregnancy, the physician should care for the patient until the patient is stabilized, or until another physician is found to assume the patient's care. That said, there are exceptions for dangerous or violent patient behavior, or if the practice can manage a quick, safe transfer of care to another provider.

- Check your provider/payor contracts (Medicare, Medicaid, private health insurance companies) to confirm that you are allowed to end relationships using your standard process. You may be contractually obligated to keep patients in the practice or to follow specific steps to notify the provider of the termination.

- Inform your front office staff and schedulers that you have terminated this patient relationship. Add an alert or a status change to the patient's record so that office staff will no longer schedule the patient. This may be set up in your practice's scheduling software or EHR.

Additional resources on patient termination, including sample letter templates, articles, and more, are found on the TMLT Resource Hub at https://hub.tmlt.org/patient-relationships.

5. PARENTAL CONSENT TO TREAT AND ACCESS A CHILD'S MEDICAL RECORDS

Many practices struggle with consent issues for children with divorced parents. This can be challenging for the practice — especially if practices are hearing completely different accounts from the two parents.

Physicians and administrators often assume that only the parent who has primary custody of the child can consent to their treatment — which may not be the case. In Texas, if parents are named as "joint conservators" with shared custody, both parents generally will have full rights to consent to the treatment of their child. Even if one parent is named the "sole managing conservator"— or the custodial parent— often, the other parent can still consent to most medical or dental treatment of the child.

The other parent may be named as the "possessory conservator." If the child is with them, during a visit or extended stay, this parent then has the right to consent to most medical treatment, with exceptions for invasive treatments, such as surgery, and psychological or psychiatric treatments. The sole managing conservator has the right to consent to these treatments, but the possessory conservator may not.

In emergency situations involving immediate danger to the child, both managing and possessory conservators may consent to invasive treatment.[1]

There may also be individual limitations on either parent that could have been put into place by the courts, so these limitations must be determined and honored.

That may feel like a tall order. But the bottom line is that there will likely be court documents in place that outline who may consent to what treatments — or not — for their child. Practices must become comfortable with asking for this paperwork, especially if one parent tells them that the other parent does not have the right to consent to treatment for their child.

When in doubt, ask for the documents. Once the individual rights of the parents have been determined, retain a copy of any pertinent court documents in the child's records.

Access to a child's medical records by divorced parents can be another contentious issue. In most situations, both parents have the right to access their child's records.[1,2] But, again, there could be limitations put in place by the court. It is never wrong to ask about court documents if an argument arises between parents regarding the right to access the child's medical records or if one parent's access becomes limited or restricted.

Texas laws that address consent for treatment and access to records for minors with divorced parents are in the Family Code, chapter 153.073, of the Texas Constitution and Statutes.[3]

For more information about these topics or any risk management question, product, or service, please contact TMLT's Risk Management Department online at https://www.tmlt.org/contact/risk-management or by phone at 1-800-580-8658.

SOURCES

1. Texas Medical Association, Office of the General Counsel. C*onsent for Treatment of Minors*. November 2019. TMA log-in required. Available at https://www.texmed.org/Template.aspx?id=2094.
   Accessed July 15, 2024.
2. Bryant C, Toerner K. Medical care for minors. TMLT webinar. January 2024. Available at https://hub.tmlt.org/webinars/medical-care-for-minors.
   Accessed July 15, 2024.
3. Texas Constitution and Statutes. Family Code. Chapter 153, Section 073. Rights of parent at all times. Available at https://statutes.capitol.texas.gov/Docs/FA/htm/FA.153.htm.
   Accessed July 15, 2024.

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CLOSED
CLAIM
STUDY

PERFORATION OF SINUS

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

On March 6, a 78-year-old woman came to Hospital A's emergency department (ED) after coughing excessive amounts of blood overnight. The patient had a history of hearing loss, rhinitis, deviated nasal septum, dementia, depression, anxiety, hypertension, atrial fibrillation (AFib), hypercholesterolemia, tachycardia, COPD, and heavy, daily use of nicotine and alcohol.

An exam and CT revealed bronchial thickening with no masses and some pulmonary nodules inconsistent with cancer. The emergency medicine (EM) physician documented that the patient likely had irritation in the back of her nasopharynx that caused the bleeding.

The EM physician instructed the patient to follow up with her primary care physician and a pulmonologist for possible bronchoscopy. The patient did not follow these instructions. Instead, she went to see her otolaryngologist (ENT) whom she regularly saw for treatment of chronic ear infections.

PHYSICIAN ACTION

On March 11, the patient came to the ENT reporting a cough with hemoptysis and to inform the physician of her visit to the ED. The patient stated that the bleeding had improved, but that her throat was "itchy."

The ENT examined the patient and ordered X-rays of the sinuses. The films showed bilateral maxillary sinusitis, more pronounced on the right. The ENT noted that the bleeding was probably from the nose. The patient had a severe left septum deformity with an apparent nodule/polyp. The ENT recommended septoplasty with biopsy.

The next day, the patient was taken by ambulance to the ED for coughing large amounts of blood and phlegm. The patient informed the ED staff that she had seen her ENT, who told her that he believed there was a blood vessel bleeding on the right side of her nose and a biopsy was scheduled for the back of her throat in two days.

The EM physician examined the patient and noted that the right nasal passage had minimal bleeding, and the bilateral nasal mucosa was inflamed, but there was no active bleeding. The EM physician prescribed azithromycin for sinusitis and called the ENT to confirm that the patient was scheduled for the septoplasty with biopsy. The patient was instructed to follow-up with the ENT.

During a pre-operative visit with the ENT on March 18, the patient was diagnosed with bilateral inferior turbinate hypertrophy and chronic maxillary sinusitis. An outpatient surgery at Hospital A was scheduled for March 20.

On March 20, the ENT performed a septoplasty, nasopharynx biopsy, partial reduction of the inferior turbinates, and right and left antral irrigation with temporary antrostomies. In his operative report, the ENT stated "the bony cartilaginous junction divided. A portion of bone was removed posteriorly. The remainder was infracted at the midline. There was significant sphenoid deviation which was fractured in the midline as well as possible." The patient was discharged home.

At 8:17 p.m. that night, the patient experienced a grand mal seizure at home and was taken by ambulance back to Hospital A. The patient experienced another seizure in the ED, became hypoxic and unresponsive, and her eyes were rolling laterally from left to right. The patient was obtunded and intubated with a Glasgow Coma Scale (GCS) of 3.

The patient was given levetiracetam for persistent rolling eye movements, which indicated she was likely still having seizures. A CT found a "large volume of free air within the head apparently from previous sinus surgery." The EM physician called the ENT. The patient was transferred to Hospital B for neurosurgical evaluation.

At Hospital B, the patient was seen by Neurosurgeon A, who found her to be unresponsive with no tracking of the eyes. A head CT showed suspected acute left-sided hematoma along the tentorium and significant pneumocephalus, with tension pneumocephalus "likely related to osseous defects along the cribriform plate." The left sinus also "appeared violated as the inner table was not present."

The patient was taken to the OR for evacuation of the pneumocephalus, as well as a repair of the left sinus. Neurosurgeon A performed an emergency

bifrontal craniotomy for decompression of tension pneumocephalus, exploration of the anterior cranial fossa floor, and placement of dural graft over the cribriform plate.

On March 21, the patient's family requested that she be transferred to Hospital C. The patient underwent a second craniotomy by Neurosurgeon B at Hospital C for repair of the floor of the anterior fossa surgery. The same day, the ENT called Hospital C to check on the patient. The ENT did not have privileges at Hospital C and did not have access to any additional information after the patient's transfer.

On March 24, the ENT made an entry in the patient record that he called "Problem Story." He noted that, based on the evaluation of the CT, the patient developed pneumocephalus in the ED because of unexplained continued lethargy. "The patient has some dementia and kept trying to blow her nose in the recovery room which was discouraged probably to no avail. The fracture should be along with sphenoid probably on the left side. If a CSF leak develops/persists they could consider a transsphenoidal pituitary approach fat graft obliteration."

On March 25, the ENT called Hospital C and was informed that the patient was on a respirator and had been taken to surgery for a total ethmoid with fascia lata graft. The ENT made an entry in the patient's record: "Probably some delirium tremens (DTs) from alcohol abuse. I think it probably would have been better to watch her expectantly to see if she had a persistent CSF leak and do intervention later if needed. She tends to not heal well and again has some dementia."

During her stay at Hospital C, the patient experienced intermittent AFib, sinus rhythm, and sinus tachycardia. A cardiology consult noted that "the patient was found to have pulmonary emboli and was not started on anticoagulation. Then, the patient had occipital hematoma and bifrontal hematoma."

The patient was kept on a ventilator and a percutaneous endoscopic gastrostomy (PEG) tube was placed. A neurologist noted that the patient appeared to have a severe brain injury, was nonverbal, and did not follow commands.

On May 6, she was transferred to a hospice facility. The family agreed to the removal of life support. The patient died on May 28. The death certificate stated the cause of death to be pneumonia, postoperative tension pneumocephalus with cerebral spinal fluid leak, and chronic sinusitis.

ALLEGATIONS

The patient's family filed a lawsuit against the ENT, alleging injury to the dura, cribriform plate, and anterior cranial fossa during the septoplasty procedure. The plaintiffs further alleged that these injuries caused tension pneumocephalus within the cranial air cavity and a cerebral spinal fluid leak. This — along with complications from pneumonia — caused her death.

LEGAL IMPLICATIONS

During his deposition, the ENT stated that his procedure caused the perforation in the patient's sinus that allowed air to enter the brain. However, he believed that if he had been notified by the ED upon the patient's arrival, he could have taken steps to prevent elevated air pressure in the patient's sinuses to keep air from being forced into the brain.

The ENT explained that when the cribriform plate and dura are perforated, cerebrospinal fluid would escape, since it is under some pressure and is contained within the dura. If the patient was not being subjected to procedures that would increase air pressure within the sinus (bagging, pressure masks, etc.), the area of the leak can typically be repaired before any significant air enters the skull. He said that once the perforated area is closed, the patient can recover when the air is absorbed by the body, and cerebrospinal fluid is replaced.

Instead, the ENT firmly stated that the patient's condition was mismanaged ("overly aggressive") by the neurosurgeon and ventilation assistants at Hospital B.

Expert consultants for the plaintiff were critical of the ENT for not attempting more conservative care before recommending surgery. One consultant stated that the technique of fracturing the bones of the septum, especially higher in the nose, is below the standard of care. This consultant concluded that

the infracture of the bony septum to the midline and the fracturing of the sphenoid deviation to the midline, with damage to the base of the skull, led to the tension pneumocephalus, the need for multiple craniotomies, and the cascade of events that led to the patient's death.

Two expert consultants for the defense were also critical of the ENT. While both conceded that inadvertent injury to the cribriform plate is a known complication of the procedure, they said they did not know of any colleague who had encountered this complication.

DISPOSITION

This case was settled on behalf of the ENT.

RISK MANAGEMENT CONSIDERATIONS

The defense of this case presented several challenges. Septoplasty is a common treatment for a deviated septum and pneumocephalus is a rare complication. Tension pneumocephalus is even more rare. Unfortunately, the patient had to be bagged in the ED, which forced additional air into her brain through an opening created during the ENT's procedure. Several experts stated that fracturing the patient's bones higher in the septum was below the standard of care.

The ENT's documentation was detrimental to the defense. He documented several criticisms and subjective opinions about the patient. He referred to her as a "problem," due to her alcohol use and dementia.

In accordance with good risk management practices, entries in the medical record should clearly state the patient's condition and the care provided, avoiding speculation. Using subjective, unsubstantiated language in the medical record could stigmatize the patient and negatively affect their health care.

This type of language could also be interpreted as stereotyping and could paint the provider as having implicit bias. Discriminatory or defaming language used to describe a patient's condition, lifestyle, race, ethnicity, sexuality, sexual orientation, religion, or living conditions would be difficult to explain to a jury or medical board.

A better way to document that a patient does not reliably fill prescriptions or take medication, is that the patient is "noncompliant in taking medication," instead of describing them as "unreliable," "irresponsible," or "erratic." Also, avoid referring to a patient in non-medical terms such as a "drug addict." If conditions are confirmed and diagnosed, use of medical terms such as alcohol or substance "use disorder" or "dependence" is preferred. Symptoms and observations may also be reported, such as that the patient "exhibited drug-seeking behavior," "had slurred speech," or reported "heavy drinking almost every night."

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CLOSED
CLAIM
STUDY

FAILURE TO STABILIZE A WRIST FRACTURE

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

On August 15, a woman fell at work and fractured her left wrist. On referral from her employer, she immediately went to an urgent care clinic that would provide care for occupational injuries.

X-rays revealed that the patient suffered a left distal radius fracture and ulnar styloid fracture in the left wrist. The patient was instructed to return the following day for an orthopedic evaluation with a hand surgeon.

PHYSICIAN ACTION

The patient was seen the next day by Hand Surgeon A. He examined the patient and reviewed the X-rays. Despite significant swelling and tenderness, the patient had motor strength at 2/5; intact sensation; and no symptoms of compartment syndrome. Hand Surgeon A recommended an open reduction internal fixation (ORIF) with a plate and pins.

On August 23, Hand Surgeon A took the patient to surgery at a nearby hospital. Based on the pre-operative X-rays, the surgeon planned to use an ORIF kit that contained a standard volar plate in the procedure.

Once in the operating room, the surgeon discovered the fractures were more severe than they appeared on the pre-operative X-rays. The distal radius was shattered and compressed into the metacarpal bones. There were 5 to 6 intra-articular fragments on the volar aspect of the radius and many smaller fragments on the dorsal side of the radius. Additionally, there was a large distal fragment about 1 to 2 cm in size and an ulnar styloid fracture.

The standard volar plate was not long enough to stabilize the fractures. A dorsal spanning plate was also needed to fixate the radius, but this plate was not included in the surgery kit.

Hand Surgeon A reduced and attempted to temporarily secure the fracture with a Kirschner wire (K-wire). He attempted to reduce the dorsal fracture by removing multiple smaller fragments and filling in the remaining bony defects with bone putty. Fluoroscopy confirmed that the fracture had been adequately reduced and the K-wire was in good position.

Hand Surgeon A planned to perform a second ORIF procedure to insert a dorsal spanning plate to stabilize the fractures. He did not document this plan in the surgical report.

The patient returned the next day, August 24, for a follow-up visit with Hand Surgeon A. She reported intense wrist pain following surgery. Hand Surgeon A noted swelling of the left wrist and removed a few sutures on the volar side of the patient's wrist. He then removed the K-wire from the wrist with surgical pliers.

Hand Surgeon A wrapped the wrist and put it back in the splint. He did not replace the removed sutures. His progress notes did not include the need or plan for a second surgery, nor did they include his reasoning for removing the K-wire. The patient was instructed to ice and elevate her left arm and return for a follow-up visit in six days (August 30).

The next morning, the patient went to the ED with intense pain. The EM physicians had difficulty finding palpable pulses in her left hand. The patient was admitted to the hospital and given IV morphine and IV hydromorphone. Hand Surgeon A was informed of the patient's admission and condition. The next afternoon, August 26, the patient was discharged after her pain improved.

The patient returned to the hospital and was re-admitted in the early morning hours of August 27. She reported intense pain, swelling, and numbness in the left hand and wrist. Hand Surgeon A evaluated the patient during her admission. She was again discharged after her pain improved with medication. She was instructed to follow up on August 31.

The patient returned to Hand Surgeon A on August 31. Her pain and swelling were improved, but there was diminished sensation in her fingertips. The surgeon discussed a second surgery to insert a dorsal spanning plate. The patient agreed to the surgery and was told to return on September 7.

A scheduler was instructed to schedule a left distal radius fracture ORIF with a dorsal spanning wrist plate. However, the patient's workers' compensation carrier required preauthorization. A request was sent to the preauthorization office asking for clearance on September 6, six days after the patient's appointment.

On September 1, the patient met with a worker's compensation case manager and said she wanted a second opinion on her wrist. The case manager scheduled an appointment with Hand Surgeon B for September 13, the earliest available appointment.

The patient and case manager returned to Hand Surgeon A on September 7. The pain and swelling had improved, and the surgeon removed the remaining sutures. Hand Surgeon A said that he was still waiting for approval for surgery from the workers' compensation carrier.

On September 13, the patient and case manager met with Hand Surgeon B. She reviewed the patient's radiographs and stated that the fracture was significant and difficult to repair. She recommended a second ORIF surgery. The patient transferred her care to Hand Surgeon B.

On September 21, Hand Surgeon B performed a dual exposure ORIF surgery with a volar locking plate and a dorsal spanning plate. A complete carpal tunnel release was also performed.

At a follow-up visit in April, Hand Surgeon B documented the patient's wrist had good pronation but no supination. She was also noted as having 10 degrees of wrist extension but no wrist flexion. She had wrist arthrodesis but was not experiencing pain.

ALLEGATIONS

A lawsuit was filed against Hand Surgeon A, alleging failure to provide adequate fixation to secure the comminuted wrist fracture. This failure resulted in permanent injury and impairment to the patient's wrist.

LEGAL IMPLICATIONS

Hand and wrist surgeons who reviewed this case for the plaintiff stated that Hand Surgeon A breached the standard of care by failing to reduce and fixate the fracture during the August 23 surgery. They specifically criticized the surgeon's failure to insert a plate to secure the fracture. They also claimed the K-wire was an inadequate substitute.

Hand Surgeon A was also criticized for not accurately describing the procedure in his operative report and for failing to perform a second ORIF procedure in a timely manner. These factors made Hand Surgeon B's repair surgery more difficult.

Defense consultants disagreed about the emergent nature of a second ORIF procedure. They felt that the second surgery was scheduled appropriately. However, they pointed out that Hand Surgeon A did not tell the patient that he did not have the proper fixation equipment to stabilize the fracture.

Documentation was also an issue in this case. Hand Surgeon A's operative report was not detailed and did not state the reason for using K-wire as a temporary solution. While this may have been his plan, he did not document it or communicate it to the patient. The patient, her husband, and the case manager all testified that Hand Surgeon A did not tell them he was unable to place a plate on August 23.

DISPOSITION

This case was settled on behalf of Hand Surgeon A.

RISK MANAGEMENT CONSIDERATIONS

The defense of this case was compromised by Hand Surgeon A's lack of documentation and communication with the patient and other providers. If he had more fully communicated his intention for a second procedure to better stabilize the wrist, she may not have sought a second opinion. The patient's decision to obtain a second opinion and to transfer her care further delayed the second procedure.

It is important to maintain clear, contemporaneous, and comprehensive documentation. This includes reasoning for clinical decisions and intentions. Poor documentation can delay care and may convey to others that the physician is uncaring and not engaged. Had the surgeon's operative note been more detailed, the patient's care may have been more timely and next steps made clearer to all providers and staff members.

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August 2024
To all TMLT policyholders

RE: 2025 Board of Trustees nominations and election

I invite you to participate in TMLT's annual Board of Trustees Election for 2025.

TMLT is governed by a board of nine Trustees. Once elected, a Trustee serves a term of three years and may be re-elected for two additional three-year terms. No Trustee may serve more than nine consecutive years. The terms of each seat, or Place, are staggered, so that only a portion of the Places are up for election each year. This year, Places 7, 8, and 9 are up for election.

As required by the Trust Instrument and Bylaws, the Trustees have nominated three physicians for these positions. The following nominations have been submitted to and approved by the TMA House of Delegates for 2025:

- Place 7: Leah H. Jacobson, MD (re-election)
- Place 8: Sarah Way, MD (re-election)
- Place 9: Jorge Sainz, MD

Should you wish to nominate another eligible voting participant, you may do so as follows:

- Any nomination by any eligible voting participant must be in writing and supported in writing with the signatures of at least four other eligible voting participants. All nominees must be qualified to serve under the Trust Instrument and Bylaws.
- Nominations MUST be made for a ***SPECIFIC*** Place and designated as a nomination for Place 7, 8, or 9.
- Nominations must be submitted to the Secretary of the Board of Trustees, TMLT, P.O. Box 160140, Austin, Texas 78716-0140. They must be received by TMLT in Austin, Texas no later than **Monday, October 7, 2024.**

After all nominees have been determined, election ballots and candidate biographical sheets will be sent to all eligible voting participants via email or regular mail. Ballots will state the deadline for their return. A candidate must receive a majority of the votes cast for their specific Place to be elected.

When you receive your ballot, please take a moment to consider the candidates and cast your vote. Voting in our annual election is an important opportunity for all policyholders to play a role in the direction, governance, and future of TMLT.

Sincerely,

Robert Donohoe
President & Chief Executive Officer

PLACE 7

Leah H. Jacobson, MD, FAAP
Pediatrics, San Antonio
TMLT policyholder since 2003

Leah H. Jacobson, MD, FAAP is a board-certified pediatrician and a Fellow of the American Academy of Pediatrics. She graduated with honors from Texas A&M University in College Station. Following college, Dr. Jacobson completed medical school and her pediatric residency in San Antonio at The University of Texas Health Science Center (UTHSCSA). Dr. Jacobson worked for six years as an assistant professor in the UTHSCSA Department of Pediatrics and Family Practice.

Since 2002, she has worked in private practice in San Antonio. In 2023, Dr. Jacobson opened Personal Pediatrics by Leah Jacobson, M.D., a direct patient care membership-based practice.

Dr. Jacobson is active in organized medicine, both at the local and state level, working for patient advocacy and the betterment of health care for children. She is a member of the San Antonio Pediatric Society (SAPS), Texas Pediatric Society, Bexar County Medical Society (BCMS), Texas Medical Association (TMA), and American Academy of Pediatrics. Dr. Jacobson currently serves on the Boards of SAPS, TMA Board of Councilors, TMLT, and Morgan's Multi-Assistance Center. She served as the president of BCMS in 2017.

PLACE 8

Sarah Way, MD, JD
Emergency Medicine, Dallas
TMLT policyholder since 2007

Dr. Sarah Way is an emergency room physician in Dallas, Texas. She has served her community for more than 20 years throughout the North Texas area, but her primary practice has been at Texas Health Presbyterian Hospital Dallas. She is board certified by the American Board of Emergency Medicine.

Dr. Way is also an attorney and a member of the State Bar of California. She graduated *Magna Cum Laude* in 1997 from California Western School of Law in San Diego. During law school, she interned with the U.S. Court of Appeals for the Ninth Circuit.

In 2004, Dr. Way received her medical degree from Northwestern University Feinberg School of Medicine in Chicago. She completed a residency in Emergency Medicine at Parkland Memorial Hospital in Dallas, in 2007.

Dr. Way is the chief quality and medical officer at Texas Health Dallas. Dr. Way is on the TMLT Claims Review Committee and has reviewed claims as a consultant since 2019.

Her professional affiliations are with the Dallas County Medical Society, Texas Medical Association, and the American College of Emergency Physicians.

PLACE 9

Jorge Sainz, MD
Pediatrics, El Paso
TMLT policyholder since 2008

Jorge Sainz, MD is a pediatric critical care specialist in El Paso, Texas. In 2002, Dr. Sainz completed his pediatric residency and a post-doctoral fellowship in pediatric critical care at The University of Texas Health Science Center in San Antonio (UTHSCSA), where he also earned his medical degree in 1999. He has practiced in El Paso since 2005.

Since 2016, Dr. Sainz has served as the president of pediatric services at Pininos Pediatrics Services. He also currently serves as medical director of the pediatric intensive care unit (PICU) and as medical director for neonatal and pediatric specialty transport services at Memorial Medical Care Center.

At the Las Palmas Medical Center (LPMC), he is the chief of staff, medical director of the PICU, and medical director for neonatal and pediatric specialty transport services for the LPMC and the Del Sol Medical Center (DSMC). He also serves as president of medical staff at LPMC and DSMC.

Dr. Sainz is board certified in general pediatrics and pediatric critical care medicine by the American Board of Pediatrics. He has contributed locally and regionally to the development and support of adult and pediatric transport systems.

DEADLINE FOR ADDITIONAL NOMINATIONS:
MONDAY, OCTOBER 7, 2024
See page 25 for instructions.

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