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Alerts

Minimizing Medical Malpractice Liability Risk During the COVID-19 Pandemic

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Health Care Alert

The federal government and several states have carved out legal immunities for providers treating COVID-19 patients on the front lines. These legal immunities, however, are temporary and in some cases narrowly drawn. In addition, no one is immune from a lawsuit being filed, even if legal immunity might result in eventual dismissal of the claim. As of May 7, 2020, eight medical malpractice lawsuits have been filed in states across the U.S., and more are likely to follow.

In most states, the standard of care governing medical malpractice cases takes into account what a reasonably careful provider would do under the same or similar circumstances. This typically is established by expert testimony. Under the present circumstances, the standard of care will likely be defined in a way that is more forgiving to medical providers. But experts hired by plaintiff's attorneys will define one.

Below, we outline four areas of care that could expose medical providers to future legal liability in connection with treatment of COVID-19 patients.

Allocation of Resources

Due to the COVID-19 pandemic, resources necessary to prevent the spread of infection and to treat critically ill patients—such as personal protection equipment (PPE), COVID-19 testing materials, ventilators, ICU beds, and personnel—are projected to be scarce. Resource allocation decision-making often involves the use of objective scoring systems, such as the one by the Department of Surgery at University of Chicago Medicine and Biological Sciences, which developed and published the "Medically Necessary, Time-Sensitive Procedures (MeNTS)" scoring system as one way to triage elective surgery patients. The MeNTS scoring system identifies 21 factors, split between three general categories, "to facilitate decision-making and triage for MeNTS procedures, and appropriately weighs individual patient risks with the ethical necessity of optimizing public health concerns." The factors to evaluate include:

- **Procedure Factors**: (1) Estimated length of stay; (2) Estimated blood loss; (3) Surgical team size; (4) Probability of postoperative ICU care; (5) Probability of intubation; and (6) Surgical site.
- **Disease Factors**: (1) The effectiveness of nonoperative treatment options; (2) Exposure risk of the nonoperative treatment option; (3) Impact of a two-week delay in the disease outcome; (4) Impact of a two-week delay on surgical difficulty; (5) Impact of a six-week delay in the disease outcome; and (6) Impact of a six-week delay in the surgical difficulty.
- **Patient Factors**: (1) Lung disease; (2) Obstructive sleep apnea; (3) Cardiovascular disease; (4) Diabetes: (5) Immunocompromised; (6) Symptoms such as: fever, cough sore throat, body aches, diarrhea; or (7) Exposure to known COVID-19-positive person in the past 14 days.

Each MeNTS factor is evaluated on a scale from 1 to 5, with the overall score ranging from 21 to 105. The MeNTS scoring system—and other objective scoring systems like it—provides objective evaluation criteria for providers and medical facilities to prioritize medical care, while simultaneously ensuring allocation of scarce resources and the protection of patients and health care providers. Utilizing objective criteria when allocating resources and triaging patients can minimize the risk of potential discrimination, or the perception of bias in the delivery of care. Medical providers who use these scoring systems should identify them and the scoring calculation in their care documentation.

Informed Consent

As state departments of health have given the go-ahead for elective surgeries and other care to resume during the COVID-19 pandemic, including the Illinois Department of Public Health (IDPH), the need arises for providers and patients to have appropriate informed consent discussions and provide informed consent documentation. Providers should make it clear that any COVID-19 discussions and forms act to supplement general consent concerning the underlying procedure or treatment. In many states, including Illinois, informed consent includes a discussion of the risks, benefits, results, and alternatives that a reasonable medical practitioner would disclose.

Preliminarily, providers in Illinois should make their patients aware that the Illinois Department of Public Health (IDPH) requires the following criteria be met before undergoing elective surgery:

- Within 72 hours of the scheduled procedure, the patient must undergo a preoperative COVID-19 RT-PCR test resulting in COVID-19-negative status;
- After being tested, the patient must self-quarantine until the day of his or her procedure; and
- A temperature check on the day of the elective procedure must result in less than 100.4 degrees.

Generally, a COVID-19 consent discussion should provide patients with the information needed to make an informed decision about whether to proceed with the elective procedure during the pandemic or defer the operation until a later time. Potential topics include the following:

- General COVID-19 counseling, including the potential risk of becoming infected with COVID-19 before, during, and/or after treatment associated with the procedure;
- The risks of proceeding with the surgery versus the risks of delaying it;
- The procedure may be canceled if the patient develops symptoms, is suspected of being exposed to COVID-19, and/or if there is increased community need for resources;
- The potential unavailability of necessary resources should the patient become infected with COVID-19 during treatment associated with the procedure;
- Procedure prioritization—i.e., making it clear that the patient's procedure may not be absolutely required at this time and could be deferred to a later date;
- Safeguards to minimize infection, including COVID-19 testing policies for patients and staff, PPE use, social distancing measures, and cleaning;
- Advance directives;
- Guidelines regarding patient and family visitors; and
- Post-discharge follow-up in light of COVID-19.

While providers should consider developing a consent-to-treatment form specifically tailored to COVID-19, additional patient care documentation in the context of a global health pandemic may take on more a more meaningful role when considering potential future legal risks.

Documentation

When a medical malpractice lawsuit is filed, attorneys for both the plaintiff and defendant obtain a copy of the patient's chart to investigate the primary documented evidence of the care provided. During a pandemic, effective charting can help reduce a provider's risk of legal exposure in the first instance, and also enhance an attorney's ability to portray the heroic efforts the provider undertook to render medical care. Without effective charting, that message can become more difficult to convey. Providers documenting patient care during the COVID-19 pandemic should consider the following:

> **Source and Timing of Information.** Information about patients afflicted with COVID-19 may not come directly from the patient at all—particularly if intubated—but rather from nurses on the prior shift, consulting physicians, family members over the telephone, and from past medical records. Documenting the source of information, as well as the timing of when the information was generated, can help attorneys reconstruct the series of events after the fact.

Phrases like "patient caretaker now states," or "on prior shift patient reported," can help clarify the source and timing of the information.

Late-Entry Charting. Late entries in charts are to be expected in the midst of pandemic. Providers should familiarize themselves with hospital policies and regulatory guidance regarding how quickly documentation must be completed following a patient encounter. However, when late entry charting is necessary, providers should consider including an explanation for the late entry, identify both the time of the entry and the time at which the care was provided, and separate out any information acquired after the time of the patient encounter. Additionally, providers should review charting entries at the time of writing to determine whether the data is reflective of the information known at the time of the patient encounter.

Limitations on Treatment. In some areas, shortages of diagnostic tests, drugs, ventilators, staff, hospital beds, or other equipment may limit the treatment options available for a patient. In addition to familiarizing themselves with all protocols and scoring systems governing ethical stewardship of medical resources, providers should document the basis upon which such decision making was made, including communication with the patient.

Differential Diagnosis. In the event of limited testing availability or a period of delayed testing results, if providers include a differential diagnosis that could account for the patient's symptoms beyond presumptive COVID-19, they should consider indicating why other conditions are less likely and identify steps taken to rule out less likely conditions.

Treatment Plan. When documenting a treatment plan, include confirmation that the risks, benefits, and alternative treatments were discussed with the patient; the patient acknowledged them; and that the patient agreed to the treatment plan. If treatment is withheld, or the patient refuses treatment, consider including a description of the likely outcome in the absence of treatment and that the patient has acknowledged this.

Patient Education. If patient education is administered, consider documenting that, as well as the nature of the education offered. In the context of COVID-19, demonstrating that Centers for Disease Control and Prevention (CDC) guidance and state department of health recommendations were reviewed with and acknowledged by the patient is good practice, and can later help confirm that the care occurred during the pandemic.

Non-Patient Protection. Documentation relating to measures taken to avoid the spread of COVID-19 is also important, such as "Advised patient that household contacts should isolate and self-quarantine" or "risk of transmission of infection discussed and guidelines for quarantine covered with patient, who acknowledged." Documenting a shortage of PPE or the unavailability of it can further help protect against claims relating to the spread of the virus made by both patients and non-patients.

Next Steps. Before concluding a patient encounter note, identify the next steps of the patient care plan. If the patient needs to be seen again unless the condition improves, clearly state that. Canned text entries that the patient should return to care if condition worsens do not fit every clinical scenario at discharge or the end of an encounter. Document patient acknowledgement and whether instructions were given to call or return to care.

Licensing

Many states have temporarily relaxed licensing requirements to allow providers licensed in other states, or retired providers, to care for patients. Additionally, to address workforce concerns related to COVID-19, the Center for Medicare and Medicaid Services (CMS) has temporarily waived regulations to allow both physicians whose privileges will expire, and new physicians, to be able to practice before full medical staff review. CMS has also waived certain regulations regarding details of the credentialing and privileging processes.

Regulations allowing out-of-state providers to practice medicine during the pandemic—and easing payment restrictions to do so—do not necessarily eliminate the risk of a lawsuit for negligent credentialing claims. Following established guidelines for licensing of retired or out-of-state providers, as well as for granting privileges during emergency situations, can help reduce potential liability risk exposure. Hospitals that have enacted a disaster management plan should consult

with their plan's provisions, or with state disaster management laws, to determine whether privileges can be extended to providers.

The Joint Commission provides information on requirements to be met in granting disaster privileges to volunteer practitioners, which are found in the "Emergency Management" (EM) chapter of the *Hospital and Critical Access Hospital Accreditation Manuals* at EM.02.02.13. Generally, before granting emergency privileges, the organization must obtain the following: a valid, government-issued photo ID (e.g. driver's license, passport); either a current picture identification card from a health care organization that clearly identifies professional designation, or a current license to practice; and primary source verification of licensure, which should occur as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents himself or herself to the hospital, whichever comes first (see also EM.02.02.13 EP 8 & 9). Additionally, the organization should obtain identification indicating that the individual is a member of a recognized state or federal response organization or group. Generally, an institution would be well served to follow existing protocols and policies relating to credentialing as then presently practicable under the circumstances, but to complete the formal process as soon as time and circumstances will allow thereafter. Out-of-state providers should confirm with the state department of professional regulation, or with the regulatory guidelines, that they have completed the necessary paperwork required to treat patients out of state.

Providers seeking to reactivate licensing under the temporary provisions, or expand the scope of their current practice, should clarify their role and have a clear understanding of what activities they will be asked to do, whether those activities fall within their skills and training, and what kind of training will be provided. Further, physicians should be aware of any limitations to clinical privileges—particularly if the circumstances require working outside the normal scope of their practice. In some instances, medical staff bylaws, rules and regulations, or protocols may allow for the provision of services not otherwise specifically delineated in core privileges for categories of providers in emergency situations.

Providers expanding the scope of their practice, practicing in another state, or reactivating a license after retirement, should consult their professional liability insurance carrier regarding the scope of practice and any limitations in coverage.