

▶ What PAs need to know about statutes of limitations

Do you remember the details of interactions with every patient you had two months ago? What about one year ago? The reality is that a Physician Assistant (PA) cannot rely on memory to recall details that could make the difference in successfully defending against a lawsuit. After all, most of us can't even recall what we had for dinner two nights ago.

The statute of limitations refers to the maximum amount of time between an incident and when legal action can occur. Medical malpractice lawsuits could occur months or years after you last care for a patient. Fortunately, following best practices for documenting and retaining records will help protect you in these situations.

Why statutes of limitations?

Statutes of limitations specify the amount of time between when an injury occurs and when the injured party can file a valid cause of action in court. The intent of limiting this time frame is to promote fairness. After all, memories fade over time and witnesses could become incapacitated or die, making it difficult for the accused person to mount a reasonable defense.

However, statutes of limitations vary by state and the nature of the offense, and they can be quite specific. For example, in Pennsylvania the statute of limitations for filing a medical malpractice lawsuit is two years from the date of the injury, but in California it is three years or one year from the date the injured party should have known about the injury, whichever is the earlier date.

Additionally, the time associated with statutes of limitations is typically longer for minors. Most states have statutory provisions which allow individuals to have the same amount of time for commencing legal action, beginning after the minor becomes an adult.

Documentation provides protection

As a PA, you likely realize the importance of documenting what treatment you provided, but it's easy to forget (or not document completely) when you're caught up in the busy workday. However, not recording key information makes it more difficult for an attorney to defend you in the case of legal action. See Documentation tips, below.

Retaining records

Because of statutes of limitations you could be named in a lawsuit long after your last interaction with a patient. That's why it's important to retain records based on state and federal laws and regulations.

Health Insurance Portability and Accountability Act (HIPAA) rules require retention of records that contain protected health information for 6 years after the last visit. This rule preempts state laws that might require a shorter time. Some experts recommend keeping records as long as 10 years. In the case of minors, experts recommend keeping records until the child reaches the age of majority plus the maximum the length of time your state defines as the statute of limitations.

Documentation tips

Follow these tips to ensure that complete documentation—not your memory—protects you in the event of legal action in response to a complaint from a patient.

- Make sure your documentation reflects your clinical decision-making process and your professional capabilities.
- Chart promptly, so as not to forget important information.
- Keep comments factual, objective, and complete to avoid any perception of bias.
- Document all communications: face-to-face, electronic, and by telephone.
- Don't chart a symptom, such as "c/o pain," without also charting what you did about it.
- If you make an error when documenting, make the correction, noting the date/time of the correction.
- If you remember an important point after you've completed your documentation, chart the information with a notation that it's a "late entry." Include the date and time of the late entry.
- Adhere to documentation requirements from states where you practice, your organization's policies, and professional standards. If there is a conflict, use the most rigorous requirement.

Shield your practice

Statutes of limitations provide some protection against lawsuits years after you see a patient, but they also provide ample opportunity for lawsuits by individuals who may no longer be a patient. Help protect yourself from liability by documenting completely and retaining records that can provide evidence of your care.

RESOURCES

CNA, NSO. Do's and don'ts of documentation. <https://www.nso.com/Learning/Artifacts/Articles/Do-s-and-don-ts-of-documentation?refID=iiWLTNPi>.

CNA, NSO. Defensive documentation: Learn how good charting can protect you from liability. <https://www.nso.com/Learning/Artifacts/Articles/Defensive-documentation-learn-how-good-charting-c?refID=iiWLTNPi>

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By Jennifer Flynn, CPHRM, Risk Manager, Healthcare Providers Service Organization (HPSO).

