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INSIDE

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AHC Media

FEBRUARY 2015 Vol. 37, No. 2; p. 13-24

Increase in 'super losses' could affect your medical malpractice premiums

A trend toward more medical malpractice with payouts of more than $5 million might affect premiums even for hospitals that have no such history and that have documented success with their risk management programs.

Losses above $5 million are accounting for a rising proportion of total dollars spent in U.S. medical malpractice claims, according to specialist healthcare insurer Hiscox, based in Hamilton, Bermuda. In the early 2000s, the percentage of total dollars spent in claims for losses of $5 million and more was in the 7.5%-10% range per year. That figure has moved up into the 15%-25% range, and Hiscox researchers say it is expected to go higher still.

> "IT'S NOT FOR LACK OF ANYTHING BEING ON THE RISK MANAGEMENT SIDE, BUT THE LOSSES KEEP RISING."

The increase in high dollar judgments does not bode well for insurance premiums for hospitals, says **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management.

"Unfortunately, judgments above $5 million have become more and more common and are no longer considered the type of outliers that they once were," Trosty says. "So many of the high awards seem to be very disproportionate to the level or severity of injury or damage caused, but juries seem to be ever more inclined to come up with these very large awards."

Making matters worse, there also is a significant rise in the incidence of the healthcare "super loss," which is a liability of $50 million or more. Half of the largest medical malpractice claims paid in history came in the

Financial Disclosure: Author Greg Freeman, Executive Editor Joy Daughtery Dickinson, and Nurse Planner Maureen Archambault report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Michael Zuckerman, guest columnist, discloses that he is a stockholder of and paid consultant for Aon Risk Services of Pennsylvania and his wife is a partner with Pepper Law and a commercial litigator with healthcare clients.

HEALTHCARE RISK MANAGEMENT™

Healthcare Risk Management™,
ISSN 1081-6534, including HRM Legal Review & Commentary™ is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
Healthcare Risk Management
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com

SUBSCRIPTION PRICES:
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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

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past five years, notes Hiscox Vice President **Justin Keith**. *(See the table on p. 15 for a summary of some of the recent super losses.)* "This increase in the proportion of dollars spent in claims on losses above $5 million for medical malpractice is a worrying trend for U.S. healthcare," Keith says. "The resources that healthcare providers have poured into risk management and patient safety and claims is tremendous. It's not for lack of anything being on the risk management side, but the losses keep rising."

Healthcare reform efforts are having a positive and negative impact on these costs, Keith says. On the plus side, he recognizes better risk management, improved patient safety programs, and a seemingly positive effect of accountable care organizations on quality, all while claims handling has become much better. Healthcare organizations also are benefitting from significant investments in resources and talent, he says.

"On the flip side, however, there is significant disruption generated by an increased number of healthcare facilities' mergers and acquisitions, accompanied by a fundamental shift in the business of delivering healthcare and a squeeze on margins," Keith explains. "When it comes to litigation, the effects of all of this change on jury pools remains uncertain at best. But as community hospitals start looking more like big business, it's no surprise juries appear to be handing out larger awards."

Risk management, claims management (in-house and from the insurance companies), quality, patient safety, and loss prevention programs have improved and become more effective in the last several years, Trosty says; however, this improvement has not stemmed the number of large verdicts and judgments. Risk managers can't be blamed for feeling a bit of frustration, but Trosty says the large verdicts probably are not the result of any failure in risk management at those institutions but rather a change in the way juries look at hospitals.

"As hospitals and healthcare systems are increasingly viewed as large entities, which look and act more like a for-profit big business, the likelihood is that juries will be handing down more large verdicts," he explains. "It often is the mentality of juries that the larger, more businesslike the facility or entity is, the better able they are to absorb these large judgments and the more entitled the plaintiffs are to large awards. With this being the direction in which healthcare is continually moving, we are likely to see more of these large verdicts."

Keith notes, however, that some recent market losses have come from high quality facilities with extensive resources. "Some of these claims

EXECUTIVE SUMMARY

Medical malpractice losses of $5 million or more are on the rise, and so are "super losses" of $50 million or more. The increased payouts might result in higher insurance premiums for healthcare organizations.

- Juries seem to be increasing awards disproportionate to the damage.
- Lack of good risk management does not seem to be the problem.
- Hospitals should anticipate larger awards in some malpractice cases.

are coming from facilities where anyone — patients, consumers, regulators, anyone — would say this is a high-quality institution that is doing things right. Even though they can demonstrate excellent leadership, risk management, and in-house claims teams, this proves that big medical malpractice claims can strike anyone at any time," he says. "If you look under the hood, you see that these institutions are spending massive amounts of money to prevent those claims. It sounds a warning to those insurers who simply see medical malpractice as a profitable makeweight to their other lines of business."

The large losses did not fall into any patterns that would suggest a problem in any particular type of healthcare, Keith says.

Safety could be affected

All of these increases will affect the bottom line, Trosty notes, and that in turn can have a negative impact on the services that a hospital or health system is able to provide.

Ultimately, hospitals have to make money to continue to survive, which means that more money for insurance has to be offset by less money from somewhere else, he says. This shift can have the potential effect of reducing services or even impacting staffing levels, which is something that can result in increased risk for the facilities.

"These types of judgments will result in an increase in premiums as insurance companies try to offset these large losses," Trosty says. "For self-insured hospitals, this also means an increase in the amount of money that will have to be paid out and the charges for insurance for the hospital."

Risk managers should see the upward trend in malpractice losses as reason to look more closely at all malpractice litigation, Trosty advises. Carefully study judgments that exceed $1 million because, while they are still not frequent, they can be a potential harbinger of what's to come, Trosty says. The same root cause or systemic issue that led to a $1 million verdict might lead to a $5 million or $50 million verdict next time.

"Once upon a time, not that long ago, awards over $5 million were the exception. We have to recognize that this is no longer true," Trosty says. "Does this mean that the trend to even higher awards will continue into the future and become less unusual? I am concerned that the answer could be 'yes.'"

As these high value judgments increase or continue, Trosty says healthcare risk managers will see an effect on insurance premiums and potentially on the amount that facilities retain for themselves to reduce potential increases. In most cases, the higher the retention level, the lower will be the premium or premium increase.

"This, of course, opens the hospital up to even greater losses from these high judgments, potentially necessitating additional cutbacks," Trosty says. "In many ways this is becoming, and can continue to be, a vicious cycle."

Hospitals are big business

The trend toward larger verdicts must not discourage good risk management, Trosty says. Instead, study the larger verdicts at your own organization and elsewhere to understand how they came about, he

Rise of the Super Loss: Recent Awards

Date	State	Award	Type of Claim
2010	New York	$60.9 million	Negligence at birth
2010	California	$670 million	Inadequate staffing at assisted-living facilities
2010	Florida	$114 million	Wrongful death suit against a nursing home
2011	Connecticut	$58.6 million	Negligence at birth
2011	West Virginia	$91.5 million	Nursing home negligence
2011	Michigan	$144 million	Negligence at birth
2012	Florida	$168 million	Brain damage following surgery
2012	Delaware	$123 million	Child abuse
2013	Maryland	$190 million	Patient privacy violations

Source: Hiscox, Hamilton, Bermuda. Web: www.hiscox.com.

suggests. Then you might be able to focus more attention and resources on certain services or problematic trends. Still, healthcare providers might need to accept that the risk of a large award, or even a super loss, has risen and isn't going down any time soon.

"Looking at trends, within your facility, geographic area, and nationally can give you a better look at where the large claims are coming from and areas that might require increased patient safety and loss prevention efforts," Trosty says. "I honestly believe that there is only so much that risk managers can do to prevent this from occurring. You can increase or enhance loss prevention and patient safety issues only so far, given the resources that exist."

Keith also warns that healthcare institutions could be in for a rough period with high dollar claims.

"Beware. You might have had a great claims experience these past five or six years, but that is not necessarily a predictor of the next five years," he says.

SOURCES

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GUEST COLUMN

Advice on how you can choose between captives and large deductible policies

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(This is the second month of a two-part series on large deductible policies and captive insurance companies. In last month's issue, Zuckerman discussed the basics about the two most popular options for risk financing: large deductible insurance plans and captive insurance companies. Part two of this report further explores captives and large deductibles, and it discusses how to reach a risk financing decision that suits your organization.)

There are pros and cons to each option when considering a large deductible policy or a captive insurance company for your organization. Deciding which is better will require assessing your particular organization's needs, strengths, and weaknesses, and your willingness to accept risk. And you might be able to use a hybrid that offers the advantages of both.

Beginning with the captive insurance option, there are material disadvantages to employing a captive to fund risk that must be evaluated. As previously noted, the formation of a captive insurance company requires an investment of capital. The insured loses commercial insurance company services and must replace these services. Also, you might be required to use a commercial insurance company front (commonly known as a front) licensed or approved to do business in the insured's state of operations so that the parent/insured can comply with regulatory, contractual, or bond covenants insurance requirements. If so, the front must be licensed or be an approved surplus insurance company and must carry a minimum required rating.

This arrangement requires a front fee that usually is a percentage of premium (e.g., 3% to 10% or higher). The parent or captive also must post collateral to protect the front's credit risk and what we refer to as Schedule F requirements for admitted or approved assets to offset the liabilities created by the reinsured's unearned premium and open loss reserves. The captive becomes a reinsurance captive reinsuring the front.

This reinsurance will be considered as a non-admitted asset by the front's regulators, which requires collateral to offset the front's credit risk and avoid a charge against its surplus. A major issue with fronting for the insured is that depending upon the front carrier, it might have to relinquish control over claims management, the level of reserve funding, or premium funding decisions to the front, but this situation is often negotiable.

Large deductible

Considering those potential downsides to a captive, many entities look instead to the large deductible insurance policy. This option offers significant advantages, starting with the fact that a large deductible does not require a front to comply with regulatory or business insurance requirements. Therefore, there is no front fee.

A large deductible also is an administratively easier path to risk retention because it does not require the insured to construct its own service infrastructure, and it does not require the need for board meetings, which usually require travel, and the development of best practices for captive governance.

That large deductible option can appeal to the younger, smaller organizations that must focus on immediate financial costs. But as an entity matures and grows financially stronger, a captive provides certain advantages over a large deductible program that might satisfy a growing risk appetite. The captive will satisfy the parent/insured's desire to take control over underwriting, claims management, and coverage terms and conditions. Certainly, direct access to the global reinsurance market by the captive can provide for a more efficient transfer of catastrophic exposure to loss. Moreover, the insured gains the flexibility to develop a truly integrated risk financing plan to fund traditional insurable hazard and operational exposures to loss as well as financial and strategic risks, generally not insurable or difficult to insure. The captive can, therefore, become a platform for the development of the Strategic and Enterprise Risk Management Insurance Program.

This discussion of both alternative risk financing vehicles has just scratched the surface. There are issues, therefore, that need to be analyzed and managed to address the entity's specific exposures to loss and risk environment. It is important to understand the differences between these two risk financing strategies, however, to do a proper feasibility study to determine which is more appropriate for your entity's risk profile.

It might not, however, require a choice between a large deductible plan and a captive, understanding that the analysis might lead to the integration of a large deductible and captive into a single hybrid risk financing structure. This hybrid can take the best from both options to create a creative and flexible risk financing program. *(For more information, see IRMI Online: England P, Beckie R, Anderson Kill & Olick, Insurance Services in New York. March 2009.* Captive Insurance Company Reports, Fronting: The Good, the Bad and the Alternative. *Dallas: International Risk Management Institute. Accessed at http://www.irmi.com.)*

Parent's needs

The whole process for developing a risk financing program begins with the entity's risk financing goals such as meeting the parent's ability to:

- make prompt payment of losses;
- maintain liquidity to be able to pay losses as they come due;
- manage cash flow uncertainty and variability of actual losses from expected losses;
- manage/minimize the total cost of risk;
- comply with regulatory, contract, and bond covenant insurance requirements;
- present the right "face" to key constituents, including bond holders, capital markets, shareholders, community, patients, and business partners.

Normally, an entity will use the large deductible concept to move down the risk financing continuum and begin to self-insure or retain risk to gain cash flow advantages without losing the security of commercial insurance services and protection against catastrophic loss, including variability in the aggregate actual losses from expected losses. Then the entity can move onto a captive as its risk appetite grows, and it can seek to take more control over its risk management/financing program. The question then is whether there is an opportunity to integrate a commercial large deductible insurance plan into a captive risk financing program to exploit the best of both.

The answer is "yes," and it can be referred to as a captive issued deductible reimbursement policy, or a deductible buy-down policy. *(For more information, see IRMI Online source mentioned above.)*

Deductible buy down

Here is how it works (assuming workers' compensation but the plan can work with other exposures to loss):

The insured purchases a large deductible program from a commercial insurance company such as, for example, $500,000 to $1 million per occurrence. A larger deductible might provide an opportunity to "unbundle" claims and loss prevention services, which allows the insured to take control by bringing them in house or employing a third-party administrator. The large deductible insurance carrier, again, will require collateral to secure its credit risk within the deductible. There also is a cost to this program known as the deductible insurance premium, which includes a credit for the deductible. The premium includes the Basic (insurer's expenses and insurance charge for catastrophe coverage) and charges for Terrorism coverage, Taxes, Boards and Bureaus (state assessments).

The large deductible plan premium also includes a variable cost for claims management known as the loss conversion factor if the carrier manages the claims within the

deductible.

The captive is used to issue a deductible reimbursement policy or deductible buy-down policy for a portion or all of the commercial insurance deductible. The insured must pay a premium to the captive for this coverage. A lower premium paid to the large deductible insurer will reduce state taxes and assessments because more of the premium is going to the captive. As discussed, there are also no fronting fees because the large deductible carrier provides compliance within the insured's state(s) of operations. There might be Federal Excise Tax for premiums paid off shore, however.

The higher the deductible, therefore, the greater the savings from lower fixed costs will be. And the fixed costs of the large deductible program should be less than the costs of a fronting policy, especially when the cost of insurance coverage received from the large deductible carrier is factored into this equation. State assessments will not apply to the captive's deductible or deductible buy-down policy. And if claims management is unbundled from the large deductible program, then the insured avoids interference in how claims are reserved and settled, which often is insisted upon by the front carrier.

In this program scheme, the insured has complied with its state's workers' compensation insurance requirements. For multi- state operations, this program scheme obviates the need to qualify as a self-insured under state regulation in multiple states.

If claims management is unbundled, then the insured gains control over this critical risk management function. The captive provides a funding source for its workers' compensation retention and access to the global reinsurance markets to minimize its exposure to loss, if the deductible is higher than the insured/parent's risk appetite would permit, which enables the captive to gain surplus relief and smooth its variation in actual loss experience over time. Similar benefits will accrue for other exposures to loss.

Learning how to self-fund

Finally, the captive is available to fund traditional insurable and non-insurable exposures to loss that might not require a front such as managed care liability (assumed via an accountable care organization), pandemic, cyber, and reputational risk. Often these exposures are difficult to measure and forecast, but the captive provides an opportunity to begin learning how best to self-fund while transferring the catastrophic risk, or uncertainty, which provides time to learn more about these emerging exposures to loss.

The analysis of cash flows and the qualitative issues would require a more detailed analysis. The real issue is that risk managers need to look beyond the differences between large deductible plans and captives. It is not necessarily always an analysis of which is more appropriate or more cost-efficient than the other. It can be a decision about how they can be used in concert to build the framework for financing risks on an integrated basis.

And when a front is required, it might be better to integrate these two risk financing techniques to blunt the often adverse impact of a front while gaining the benefit of a captive that can be used to fund a broader base of exposures to loss within the Enterprise Risk Management Framework. ■

Can the emergency doctrine ever apply in medical malpractice cases?

Applying the emergency doctrine to medical malpractice cases has long been considered a long shot at best for the defense, maybe even to the point of being ridiculous. But the idea is getting more serious attention.

It still is considered highly unlikely that a court or jury would accept the idea that the standard of care should be lowered because the situation was emergent. In effect, the defense would be arguing that the defendant healthcare professionals should not be held to the same standard in an emergency as they would be in a calm scenario with plenty of time to draw on their training and education.

This emergency doctrine is commonly used in non-medical lawsuits, such as those arising from a traffic accident, explains **John L.A. Lyddane**, JD, a senior partner with the law firm of Martin Clearwater & Bell in New York City. Case law has established conclusively that a person confronted with an emergency is not held to the same standard as one who has the opportunity to plan a response to danger, he explains. In a traffic case, for example, a defendant can successfully argue that the collision was unavoidable because an oncoming vehicle suddenly swerved into the lane and there was no time to respond.

EXECUTIVE SUMMARY

The appropriate use of the emergency doctrine in medical malpractice cases is being debated by some attorneys. The doctrine states that emergency conditions might warrant holding defendants to a lower standard of care.

- New York appellate judges have disagreed on the use of the doctrine.
- Training can become an issue when determining what response is reasonable in an emergency.
- Plaintiffs' attorneys reject the idea.

Lyddane and his colleague **Barbara Goldberg**, JD, a partner at the same firm, have argued in the *New York Law Journal* that the same theory should be applicable in some medical malpractice cases.[1] *(See the story on p. 20 for more on their analysis.)* The doctrine clearly was defined in the 1991 case *Rivera v. New York Transit Authority*, they note. The court described the emergency doctrine this way: "This doctrine recognizes that when an actor is faced with a sudden and unexpected circumstance which leaves little or no time for thought, deliberation, or consideration, or causes the actor to be reasonably so disturbed that the actor must make a speedy decision without weighing alternative courses of conduct, the actor may not be negligent if the actions taken are reasonable and prudent in the emergency context."

Furthermore, Pattern Jury Instructions 2:14 include the stipulation that a "mistake in judgment or wrong course of action is not negligence if the person is required to act quickly because of danger." But because medical care providers are more attuned to medical emergencies than laypeople are, the healthcare legal defense community has assumed that the emergency doctrine is somehow less available in the context of evaluating the response of a nurse or doctor faced with a medical emergency. Not necessarily, say Lyddane and Goldberg.

Plaintiffs' attorneys, not surprisingly, disagree. A great percentage of medical malpractice cases involve emergencies, so invoking the emergency doctrine would put plaintiffs at a significant disadvantage, says **Jeffrey M. Kimmel**, JD, a partner with the law firm of Salenger, Sack, Kimmel & Bavaro in New York City. "I don't see how it has any place in medical malpractice cases," Kimmel says. "The emergency doctrine would eliminate a great many cases, and I don't think that would be fair to patients who have a legitimate claim against a doctor or hospital."

Kimmel argues that standards of care exist to determine what can reasonably be expected of a professional in a given situation, and that situation includes an emergency for medical professionals. He has seen the emergency doctrine used only in other situations such as traffic accidents, in which it can serve as an absolute defense for the defendant driver.

"You can't have a doctor saying that it was an emergency and so he can't be held responsible for a mistake," Kimmel says. "The reality is that that's what they're trained for. Maybe you and I aren't trained to respond the right way in that emergency, but they are."

The emergency doctrine is distinct from Good Samaritan laws, notes **Richard Joslin**, JD, an attorney with the law firm of Collins Einhorn Farrell in Southfield, MI. Good Samaritan laws apply when a medical professional renders care outside the scope of his or her duties, such as when encountering a person in need while out shopping. Michigan legislators have attempted to codify the emergency doctrine for medical malpractice cases but failed, Joslin notes. The bills were opposed by trial attorneys but also by some healthcare providers who worried that it could compromise patient care, Joslin says.

"The bills proposed to provide the same type of qualified immunity as the Good Samaritan law — basically a gross negligence standard — for treatment provided to a patient that arises out of the emergency department setting," Joslin explains. "That would have extended to physicians, surgeons, radiologists, anyone providing care even though the patient was no longer in the emergency setting. That bill has gone nowhere for the past two years."

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New York case law debates emergency doctrine

Case law on the use of the emergency doctrine in medical malpractice cases varies from state to state, but New York experience shows that the theory is at least considered worthy of debate.

Judges in New York have disagreed on whether juries should be given the option to consider the emergency doctrine, explain **John L.A. Lyddane**, JD, and **Barbara Goldberg**, JD, attorneys with the law firm of Martin Clearwater & Bell in New York City. They have published articles on the topic and suggest the emergency doctrine does have a place in malpractice cases.

They note that in the 1984 case *Mertsaris v. 73rd Corporation*, New York Appellate Court judges came to different conclusions on the applicability of the doctrine to a case involving the resuscitation by the anesthesiologist of an infant who already had been damaged at birth.

In concurring opinion, one judge argued that the jury should have been told to consider the fact that the anesthesiologist had no time to adequately consider his response before acting. The emergency doctrine "is plainly applicable to medical malpractice actions," Justice **Vito Titone**, JD, wrote in his opinion.

He went on to explain that the physician's decision making "must be viewed in the context of the circumstances then faced by the physician. A 'careful examination' conducted in the jury room with the benefit of hindsight, cannot approximate a split-second decision in the face of an emergency."

Other New York medical malpractice cases have included debate over whether what might be an unforeseen emergency to others, shoulder dystocia for example, is not so for a professional trained to anticipate and react appropriately to that situation. Noting that first responders have been given leeway by the emergency doctrine when encountering an unusually serious situation, Lyddane and Goldberg say training should not always exclude use of the doctrine.

"Although it is conceivable that a doctor could be trained and experienced to the point where circumstances no longer present an emergency, a careful reading of the case precedent in New York as well as other states fails to support the position that because a medical practitioner is trained to deal with an emergency, she should not be allowed the same relaxation of the standard of care provided to trained first responders and others who routinely train for and face emergencies," they write.

Lyddane and Goldberg argue that the emergency doctrine can help prevent a jury from requiring malpractice defendants to perform at unrealistic levels of near-perfection, no matter the circumstances.

"Where a jury has spent several weeks analyzing a split-second decision made by a trained medical professional, whose patient faced serious consequences if action was not promptly taken, it is entirely appropriate for the trial court to allow the jury to determine whether the circumstances justify a modification of the standard to which the actor is held," they write. "Since the standard would only be relaxed to the point where the defendant is held to the standard expected of a similarly trained and experienced actor in the same circumstances, there could be little chance for prejudice to other parties." ■

Patient complaints can hold hidden liability risks

Patient satisfaction is more than just a touchy-feely goal for a healthcare institution. Keeping patients satisfied and acting on their complaints can have a direct impact on risk and liability exposure.

Evidence supports that happy patients don't complain, and patients who understand a complication of care is not an "unexpected" result don't sue, notes **Lee McMullin**, CPHRM, senior risk management and patient safety specialist with the Cooperative of American Physicians, a nonprofit in Los Angeles that represents the interests of healthcare providers in California. McMullin also is president of the Southern California Association of Healthcare Risk Management.

The root of patient complaints is the failure to recognize and manage patient expectations, he says. Many complaints and malpractice lawsuits are rooted in the patients' failure to understand the expected results and risks about their healthcare, he notes. For that reason, avoiding dissatisfied patients and lawsuits depends on assessing the patient's level of understanding and expectations for the proposed surgery or procedure.

When expectations are not met, the assumption is that the unexpected result is the product of error versus a realized risk and complication of treatment. This situation places the burden on the healthcare team to explain or "disclose" in a manner

consistent with the patient's level of comprehension why his or her expectations are unrealistic or why you are not negligent with your care. That's never an easy conversation, so eliminating that misunderstanding upfront is a better strategy.

Physician practices

The notions of patient satisfaction and expectations come into play more acutely with physician practices, McMullin says.

The reason is that the interchange is more personal and patients look to the physician as the captain of the ship when anything goes wrong, he says. With hospital systems integrating more physician practices, McMullin cautions that risk managers might be unfamiliar with the physician side of the equation when it comes to patient satisfaction and expectations.

"When you are acquiring a physician-based practice, it is key to evaluate whether there is a system in place there to pick up on patient satisfaction issues and complaints," he says. "Small little issues can smolder and become large problems. Remember that there are people out there who are very skilled at making mountains out of molehills. They're called attorneys, and they're very good at running the excavator and adding more dirt on top of the molehill."

McMullin suggests looking at these three potential problem areas in a physician practice:

- Does it have a system in place to identify and capture patient complaints?
- Is the staff encouraged to report problems and negative patient comments they observe or receive?
- Do staff have the necessary social skills and experience in complaint resolution?

McMullin notes that many staff members see their role as "running interference" between the doctor and the patient to protect them from unnecessary phone calls or "troublesome" patients.

"It is not uncommon to find staff members who are very well-intentioned, valuable members of the team, who think they are doing the right thing by being alert for unhappy or needy patients and steering them away from the boss," McMullin explains. "Such notions actually propel you into the fast lane for legal grief. Patients who learn their doctor will not listen will find an attorney who will," he says.

> "... THERE ARE PEOPLE OUT THERE WHO ARE VERY SKILLED AT MAKING MOUNTAINS OUT OF MOLEHILLS. THEY'RE CALLED ATTORNEYS..."

If managing patient expectations is the means of decreasing patient complaints, then consent is an important aspect of expectation management, McMullin says.

The consent discussion has evolved to being the most crucial event in managing a patient's care. An intelligent assessment of the patient's understanding of the expected results and its risks in the pretreatment phase is the foundation for managing any complaints that follow, he says. The failure to embrace this concept means an increased risk of facing a lawsuit.

Develop and encourage a patient-centered culture in which patient safety includes managing patient expectations and the preservation of patient satisfaction and customer service, McMullin advises. Consider using patient satisfaction surveys as a tool to measure the effectiveness of your efforts and identify ways to improve what you do.

Manage expectations from the outset, McMullin says. That process starts with determining whether your facility and professionals can provide what the patient is looking for. If the patient goes to a podiatrist complaining of a headache, the doctor should make clear right away that he or she is not the right person for the job. Similarly, patients who expect more than can be reasonably expected or promised should be counseled clearly from the start.

"If they walk in expecting something you can't do, or an

EXECUTIVE SUMMARY

Patient satisfaction can directly influence the risk of malpractice litigation. Expectations must be managed from the outset to avoid misunderstandings.

- Physician practices acquired by hospital systems should be assessed for satisfaction programs.
- Patients who feel ignored by physicians or hospitals will seek an attorney to listen to them.
- Determine a patient's expectations from the start, and ensure they are reasonable.

outcome you can't guarantee, stop everything and make that your only focus until they have a better understanding," McMullin says. "If you breeze by that and go on with your patient care, you're setting the patient up for disappointment and frustration that will be taken out on you." ■

Missouri hospitals could be liable for physicians and staff — Could other states follow?

In a ruling that could be followed by other states, a Missouri Court of Appeals has determined that hospitals could be liable for the acts or omissions of any physician on their medical staff, if such physician is considered an "employee" of the hospital according to common-law principles of agency.

Such principles focus on the amount of control the hospital has over the physician's work, according to an analysis provided by the law firm of Thompson Coburn, based in St. Louis, MO.

In *Jefferson et al. v. Missouri Baptist Medical Center et al.*, the plaintiffs filed a lawsuit agaainst Missouri Baptist Medical Center (MBMC) for the alleged negligence of a radiologist who was on the hospital's medical staff. The radiologist was not employed by the hospital but was instead employed by a radiology group. Under Missouri law, a healthcare provider is only liable for the actions or omissions of an employee of the healthcare provider, explains **Nicole K. Jobe**, JD, an attorney with the firm.

MBMC argued that it could not be held liable for the acts or omissions of the radiologist because the radiologist was not an "employee" of the hospital. It relied on a separate definition for "physician employee" within the definitions of Chapter 538 in state law. The trial court granted summary judgment in favor of MBMC.

On appeal, the Missouri Court of Appeals, Eastern District, discussed the fact that the term "employee" is not defined in Chapter 538 of the *Missouri Revised Statutes*. The term "physician employee" is defined in Chapter 538 as a person who works for the hospital and is covered under its insurance. The court held that the definition of "physician employee" does not apply to Section 538.210.2(3). Instead, the term "employee" should be defined using common-law principles of agency, which focus on the hospital's ability to control the physician. The appellate court remanded the decision back to the trial court with instructions to apply the definition of "employee" in accordance with common-law principles of agency, Jobe explains.

> … PRINCIPLES FOCUS ON THE AMOUNT OF CONTROL THE HOSPITAL HAS OVER THE PHYSICIAN'S WORK…

The hospital applied for transfer of the appellate court's decision to the Supreme Court of Missouri, but the Supreme Court of Missouri denied transfer. Because the Supreme Court of Missouri decided not to hear this case, the appellate court's definition of "employee" using common-law principles of agency for malpractice liability purposes is controlling for the jurisdiction.

"Hospitals may want to consider their contractual relationships with physician medical staff members, recognizing that these relationships will be evaluated under common-law principles of agency to determine whether the hospitals have malpractice liability for the acts or omissions of non-employed medical staff members," Jobe advises. "Hospitals should further consider that this decision returns us to a consideration of factors to determine if a medical staff physician is acting as an agent of the hospital for purposes of determining liability."

Jobe explains that in *Scott et al. v. SSM Healthcare St. Louis, et al.*,

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the Missouri Court of Appeals relied upon a number of factors from the *Restatement (Second) of Agency* Section 220 to determine if an agency relationship exists by referencing the following:

• the hospital's ability to control medical standards;

• the hospital's control over prices set for services;

• the hospital's requirement that the physicians maintain liability insurance with certain limits;

• the hospital's right to terminate individual physicians under the contract if dissatisfied with performance;

• the hospital's ownership of all of the equipment;

• the exclusivity of the contract (only physician group performing such services at the hospital).

Independent contrators

In contrast, the court referenced the following factors that could show that the relationship between the hospital and physician is one of independent contractors:

• The relationship is based upon a written contract in which the physician group agrees to provide services to the hospital.

• The physician group is the signatory to the contract, is a separate legal entity, and is the employer of the physician.

• The hospital does not employ or pay the physician.

• The hospital does not directly set the physician's work hours at the hospital.

• The hospital does not bill patients for the services of the physician.

Hospitals should study their state's case law and consider these factors for their contractual relationships with physician medical staff members, Jobe says. Hospitals should recognize that such factors might affect whether physicians will be considered agents of the hospital for malpractice liability purposes, she adds.

SOURCE

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Nursing group's campaign emphasizes that it's not acceptable to hit a nurse

National Nurses Organizing Committee (NNOC), an affiliate of National Nurses United, the largest U.S. organization of nurses, is sponsoring a campaign to reinforce that "It's not OK to hit a nurse." The campaign was inspired partly by recent incidents of violence against nurses.

NNOC — Florida, which represents thousands of Florida registered nurses, is sponsoring a national conference of NNOC nurses from Texas, California, Missouri, Kansas, and Nevada, all of whom are also calling for stepped-up action to reduce hospital violence. Model legislation on the issue was enacted in California in September 2014. Like the California law, proposed legislation in Florida would require hospitals to have comprehensive plans to assess and reduce factors that contribute to hospital violence, including inadequate staffing and security.

Such plans also would need to include personnel education and training programs to recognize and respond to potential violence, and improved reporting requirements.

U.S. Bureau of Labor Statistics demonstrates that healthcare workers are far more likely to be the victims of workplace violence than other workers. In 2007 a report commissioned by the National Institute of Occupational and Environmental Health found that nurses have the highest rate of victimization among occupations in the healthcare industry.

According to a study published in 2014 by the *Journal of Emergency Nursing*, 76% of nurses with 10 years of experience or more reported that within the last year they had been the victims of workplace violence, and 30% of that violence was physical violence. While the Occupational Safety and Health Administration has issued guidelines for workplace violence prevention programs in hospitals, there is no federal statute that mandates that hospitals follow them. ■

CNE OBJECTIVES

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

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

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CNE QUESTIONS

1. According to R. Stephen Trosty, JD, MHA, ARM, CPHRM, president of Risk Management Consulting and a past president of the American Society for Healthcare Risk Management in Chicago, what is the most likely explanation for the recent rise in malpractice awards of $5 million or more?

A. Risk management efforts have proven ineffective over recent years.
B. Hospitals and healthcare systems are increasingly viewed as large entities, which look and act more like a for-profit big business.
C. Medical schools have de-emphasized malpractice prevention programs.
D. Hospital mergers and practice acquisitions have created a larger pool of patients and caregivers.

2. The formation of a captive insurance company requires:

A. An investment of capital.
B. The formation of a consumer-oriented oversight board.
C. A divestment from any insurance-related funds.
D. A non-compete agreement with other captives.

3. The large deductible option is mostly likely to appeal to:

A. Younger, smaller organizations that must focus on immediate financial costs.
B. Older, more financially sound organizations with plenty of funds.
C. Small nonprofit hospitals or health systems.
D. Healthcare providers with a bad track record of malpractice payouts.

4. Which of the following is true of the emergency doctrine?

A. It is commonly used in some litigation, such as traffic-related cases.
B. It is most commonly used in medical malpractice cases involving birth-related injuries.
C. Courts have never shown any indication that it may apply in medical malpractice.
D. It holds the emergency physician to a higher standard than the caregivers.