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INSIDE

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Provider Relief Funds Require Strict Compliance Program

Healthcare organizations that received funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund, intended to reimburse eligible providers for healthcare-related expenses or lost revenue stemming from the COVID-19 pandemic, must use a strong compliance program to avoid severe penalties. Risk managers and compliance officers should act now to ensure compliance programs are consistent with the latest guidelines from the Department of Health and Human Services (HHS).

HHS has issued guidance indicating recipients who receive at least one payment of $10,000 or more must comply with reporting system requirements when it opens in early 2021. *(For details on the HHS guidance, visit: https://bit.ly/3p74NQT. See the story in this issue for a summary of the guidance.)*

> RISK MANAGERS AND COMPLIANCE OFFICERS SHOULD ACT NOW TO ENSURE COMPLIANCE PROGRAMS ARE CONSISTENT WITH THE LATEST GUIDELINES FROM HHS.

Risk managers and compliance officers should work closely with legal counsel to understand the guidance and requirements, says **Michael Buchanio**, senior principal with West Monroe, a business and technology consulting firm in Chicago. Focus on how HHS defines certain terms and conditions, and understand the deadlines, he says.

"Once you have a good understanding of the requirements, you can start developing robust policies and procedures," he notes. "Look for things like how your actions might affect any potential loan forgiveness,

Financial Disclosure: Author **Greg Freeman**, Editor **Jill Drachenberg**, Editor **Jonathan Springston**, Editorial Group Manager **Leslie Coplin**, Accreditations Director **Amy Johnson, MSN, RN, CPN**, 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. Consulting Editor **Arnold Mackles**, MD, MBA, LHRM, discloses that he is an author and advisory board member for The Sullivan Group and that he is owner, stockholder, presenter, author, and consultant for Innovative Healthcare Compliance Group.

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and what your document retention policies should be. Develop a plan to collect documents that will show you followed specific protocols."

Buchanio notes that, unlike some government funding, HHS sent Provider Relief Funds to healthcare organizations without first requiring an application. That does not make compliance any less important, he says. By cashing the check, the organization is accepting the terms required by the government.

"You can't always say you didn't know about some requirement, especially when there is this much guidance available. You are already knowingly culpable if there is guidance and you are accepting the money," Buchanio stresses. "Because you are taking the funds through Medicare, you could be jeopardizing your Medicare participation if you are not in compliance."

In addition, HHS notes in the guidance that any deliberate omission could be punishable by criminal penalties, forfeiture of funds, and civil liability, he notes.

Buchanio points to the aftereffects of the Troubled Asset Relief Program (TARP), which purchased toxic assets and equity from financial institutions to strengthen the economy in 2008. There were about 350 criminal convictions for fraudulently accepting money from TARP, he says. About $10 billion was recovered from recipients who obtained the funds fraudulently.

"Some of the larger organizations that already had a robust compliance program in place probably have responded well to this requirement, but that may not be the case for the smaller organizations that probably really needed the money and are strapped for cash. They may have made hiring cutbacks or let people go, so they may not have that strong compliance team in place," he explains. "They're asking people to wear many hats. If that's the case, some of these compliance requirements could slip through the cracks."

The changing nature of the conditions and guidance is troubling for some recipients, says **Mark J. Silberman**, JD, chair of the white collar, government investigations, and regulatory compliance practice group with Benesch in Chicago. Unlike most funding programs in which the requirements are laid out from the start and change little over time, the rules for the Provider Relief Fund have been changing with each guidance update, he notes.

"You may have gone from being

EXECUTIVE SUMMARY

Money from the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund comes with extensive requirements for compliance and reporting. The funds are intended to offset losses from COVID-19.

- Providers who received more than $10,000 in Provider Relief Funds remain subject to reporting requirements and HHS.
- Organizations receiving the funds should employ a grant or compliance manager to oversee the expenditures.
- Entities that received more than $750,000 in Provider Relief Fund payments are subject to audit requirements.

terrified that your hospital was going to go under just when the community needed you the most, but things changed, and you didn't get the rush you expected. Or you used the money in a way that was OK back then, but now it turns out that isn't OK," Silberman says. "You didn't return the money, so now you fear they're going to treat those as false claims, treble the damages, and put you out of business."

Silberman hopes government regulators have some sympathy for healthcare entities that tried to do the right thing, even if they come up short, and treat them differently from organizations that made no effort to comply.

"With that much government money going out, there is no doubt there are some people and organizations who took advantage," he says. "What I really hope is that the government focuses its attention on people who tried to game the system and evaluate the people who tried but came up short in a different way. Some of this is as clear as mud, so there should be some discretion."

Most assessments will rely on documentation, Silberman says. If an organization documents its efforts well, the government should see they made a good faith effort despite any shortcomings, he says.

In particular, Silberman says, be sure to document the decisions made at the times in which they were made. For instance, spending a lot of money on preparations for COVID-19 in March 2020 looks different than spending the same amount in September 2020 when the community was already deep into the pandemic response and past Phase I, he says.

"The rules and the government's expectations have been changing throughout. If there is any weakness in your documentation because expectations have changed, you should be able to show why you did something at a certain point," Silberman explains. "If you have to add documentation that is not contemporaneous to explain that, make it clear you are adding that documentation after the fact because the government standard changed."

The requirements are consistent with HHS' recent efforts to investigate where government funds are actually used, says **Maria D. Garcia**, JD, partner with Kozyak Tropin & Throckmorton in Miami. Providers must give detailed explanations of lost revenue from COVID-19 and where the Provider Relief Funds are used to cover those losses.

"They're asking providers to give detailed data on general and administrative expenses. The second major category is healthcare-related operating expenses," she explains. "Providers have to pay attention to how those funds are used and be prepared to give a detailed accounting. The regulators really want to see how the money was used and that it was used for the appropriate reasons."

It may be too late now, but Garcia says the Provider Relief Fund is a good example of how healthcare organizations should consider whether they can safely comply with the requirements before accepting any government largesse. Smaller organizations may be the most in need of such emergency funding, but they might be the least capable of meeting all the compliance requirements. Taking the money while unsure of compliance sets up the organization for big penalties down the road, she says.

"Compliance is at the top of the mind of the federal government. It really is the issue of the day," Garcia notes. "With this funding and other money provided in response to COVID, there is a lot of pressure for the government to detect fraud. Accepting funds like this without consideration of what will be required of you, and whether you really can accomplish that, is very risky."

Attestations Bring Obligations

As with any federal funds, there is a fiduciary responsibility of the distributor to ensure the funds were used in the proper manner, says **Anna Stevens**, CPA, CHFP, partner-in-charge of healthcare services in the Houston office of Weaver.

To ensure compliance, HHS has required audits for recipients who meet certain thresholds, such as expenditures of federal awards in a single fiscal year greater than $750,000, Stevens says. Noncompliance with the terms and conditions associated with these funds could require recipients to return all or a portion of the funds.

One of the most common pitfalls is lack of documentation, says **Rebecca Goldstein**, CPA, an accountant in partner assurance services in Weaver's Austin, TX, office.

Lack of established policies and procedures can result in internal control deficiencies and poor segregation of duties, Goldstein says. This often is amplified when there is decentralization throughout the organization or lack of management oversight as it relates to the grant.

"Having someone leading the charge who is familiar with the reporting and compliance requirement can help alleviate some of these traps," Goldstein says.

(See the story in this issue for elements of a good compliance program.)

Could Trigger False Claims Act

Compliance always is important when government money is at stake. The Provider Relief Fund is no different, says **Jonathan H. Ferry**, JD, partner with Bradley in Charlotte, NC.

Providers receiving $500,000 or more are required to report expense data with great specificity. The reporting requirements provide the specific categories of expenses such providers are required to report, Ferry says. Typical of government funding programs, the CARES Act Provider Relief Fund includes multiple attestations and representations providers made or were deemed to have made to keep the money. Failure to accurately report in accordance with the guidance could be deemed a breach of those attestations and representations, Ferry says.

"Inaccuracies in any report to the government can trigger serious consequences — administrative, civil, or even criminal. The main difference between the three is state of mind," Ferry explains. "A true mistake might be dealt with administratively, but if the mistake is blatant and unjustified, it might rise to the level of recklessness that triggers civil liability under the False Claims Act [FCA]."

Violation of the FCA requires a provider to pay the government three times the amount of the damage the false statement caused, plus additional penalties, Ferry notes. In addition, if an entity knowingly submits untrue data to a company, it may be looking at a criminal investigation of itself and its agents.

Healthcare compliance professionals will be familiar with the "seven elements" of a compliance program detailed in HHS Office of Inspector General guidance, Ferry says, but that is only a baseline. The Department of Justice recently published additional guidance on corporate compliance programs. Ferry notes these points are relevant to Provider Relief Fund compliance:

- Is the program well designed?
- Is the program adequately resourced?
- Does the program work in practice?

The first and third are relevant for the Provider Relief Fund, Ferry says. A company cannot rely on its old compliance program to ensure compliance with Provider Relief Funds.

"It must redesign elements of it to ensure business lines are properly tracking and accounting for the funds. It also must confirm that the system is working in practice for these new funds," Ferry says. "The government expects company compliance programs to be nimble and adjust to new realities and risks. Enforcement authorities won't give an organization a pass simply because Provider Relief Funds are new and subject to different requirements the company may not have seen before."

There are numerous pitfalls, Ferry says, the first of which is the regulations themselves. They change frequently and with little notice. Every few days, HHS releases new guidance on how to handle Provider Relief Fund money. The reporting

Recommended Elements of a Compliance Program

Provider Relief Fund compliance will require an extensive and far-reaching program, say **Anna Stevens**, CPA, CHFP, partner-in-charge of healthcare services in the Houston office of Weaver, and **Rebecca Goldstein**, CPA, an accountant in partner assurance services in the firm's Austin, TX, office.

Stevens and Goldstein suggest a good compliance program should include these elements:

- Established policies and procedures related to COVID-19 expenditure documentation, retention, and reporting.
- A grant or compliance manager to oversee the expenditures, reporting, and basic grant management cycle from start to finish, including communicating with HHS.
- Thorough backup documentation of all expenditures expected to be reimbursed with Provide Relief Funds.
- Payroll documentation, including timesheets, paystubs, and complete human resource files with positions listed for all individuals paid with grant funds.
- For significant nonpayroll expenditures, use of a procurement checklist showing history of bid solicitation, cost/price analysis, justification for noncompetitive procurement, and documentation that vendors are not suspended or debarred. ■

requirements issued on Sept. 19 were amended in significant ways on Oct. 22, Ferry notes. Further changes are expected.

"FAQs drop daily from HHS that can drastically affect how providers can use these funds. Stay up to date. Don't assume you know the latest just because you checked last week," Ferry says. "With regard to the reporting requirements and compliance, pay close attention to other money the organization may have received due to the pandemic. HHS has made it clear they are keenly interested in whether Provider Relief Fund money is being used to cover expenses or losses that in some way were already covered by other sources of funds."

A compliance officer should be plugged in to parts of the organization that may have received money, Ferry says. Were insurance payments received? Did the company also receive Paycheck Protection Program funds? There were many other government agencies providing funds to healthcare providers.

"Compliance needs to know where it all went so that the entity does not double-dip on government funds," Ferry says.

Compliance is essential, not optional, says **Edgar C. Morrison, Jr.**, JD, partner with Jackson Walker in San Antonio. The attestations that healthcare organizations signed when accepting the funds create legal obligations, and providers must take that obligation seriously, he says.

Providers should use their existing financial accounting systems to report their use of Provider Relief Fund payments using their normal method of accounting (cash or accrual basis), Morrison says. He explains providers will have to report Provider Relief Fund expenditures this way:

- Recipients who have expended funds in full prior to Dec. 31, 2020, may submit a single final report at any time during the window that began Oct. 1, 2020, but no later than Feb. 15, 2021.
- Recipients with funds unexpended after Dec. 31 must submit a second and final report no later than July 31, 2021.

"The most obvious pitfall is late reporting or failure to report. The second is simply financial records that are not detailed enough, or are internally inconsistent," Morrison says. "The Provider Relief Fund definitions are broad and generous enough that most providers should have no trouble reporting in compliance with the law. Those who ignore or pay scant attention to the reporting requirements, however, risk investigations by the HHS Inspector General, and potential refunds of amounts received." ■

SOURCES

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Summary of HHS Guidance on Provider Relief Fund Compliance

The reporting requirements for the Provider Relief Fund should not be a surprise to healthcare organizations, says **Heather Macre**, JD, director with Fennemore Craig in Phoenix. "Free" money usually comes with a lot of strings attached.

When providers took the funds, they promised the funds would only be used to prevent, prepare for, and respond to COVID-19 and will reimburse the recipient only for healthcare-related expenses or lost revenues that are attributable to COVID-19, she says.

Providers also agreed to comply with reporting requirements as specified by the Department of Health and Human Services (HHS) in program instructions. *(The guidance is available at this link: https://bit.ly/3p74NQT.)*

"This was a condition of funding, so failure to report could lead to an enforcement action and the inability to use other government funds programs," Macre says.

Macre points out these noteworthy elements in the HHS guidance:

- HHS modified the calculation of "lost revenues" attributable to the COVID-19 emergency, defining "lost

revenues" as a year-over-year change in net patient care operating income, which is equal to patient care revenue for the year minus patient care-related expenses for the same year. This is a significant change from the previous FAQ, which was less definite, referring to "lost revenues" as any revenue a healthcare provider loses due to COVID-19, without incorporating expenses. Recipients who relied on this prior guidance need to review and evaluate the effect of the modified definition.

• Eligible expenses should be reported, but only to the extent the expense is not reimbursed or obligated to be reimbursed by other sources.

• Recipients of between $10,000 and $499,999 in aggregated Provider Relief Fund payments will report healthcare-related expenses attributable to coronavirus in two aggregated categories: General and administrative expenses, and other healthcare-related expenses. Those who received $500,000 or more in payments need to provide more detailed information.

• Entities that received more than $750,000 in Provider Relief Fund payments are subject to audit requirements.

"Any sort of reporting program needs to take all of this into account. Providers may need to recalculate their lost revenues and need to be sure to document everything," Macre says. "Audits are likely, especially if a larger amount of funds was taken. Accounting needs to be done carefully and in a well-documented manner." ■

SOURCE

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What to Do When Malpractice Allegations Become Defamation

Medical malpractice litigation can get ugly, with passionate plaintiffs and indignant clinicians or hospital administrators firing off heated accusations and insults. But where is the line where a malpractice allegation becomes defamation? What can be done when that happens?

TV star Terry Dubrow, MD, filed a defamation lawsuit after a patient sued him for $10 million. The suit alleges a former patient's lawyer made defaming comments about Dubrow to a newspaper. The attorney called the surgeon's work "incredibly incompetent," among other accusations. *(More information is available at: https://pge.sx/2Il2w4i.)*

Proving defamation in such a case can be difficult, says **Carol Michel**, JD, partner with Weinberg Wheeler Hudgins Gunn & Dial in Atlanta. Courts generally give broad leeway regarding statements connected to a legal filing, she says. It can be less clear when these are statements made before the initiation of legal action or they are made outside the broad scope of the litigation itself.

Court Statements Hard to Challenge

"If the statements are made publicly and sufficiently outside what the court sees as being part and parcel of the malpractice case, the court could see the defamatory statements as actionable," Michel explains. "Trying to find that line is difficult. I would say that if these types of statements are not something necessary for the litigation, then an attorney should be hesitant about making statements like that."

If that line is crossed, Michel says the healthcare organization should be cautious in responding. A defamation lawsuit may give greater public awareness to the original comments, she notes.

Defamation is especially difficult to prove with statements made in court. There usually is a privilege for statements in court, including pleadings, because society wants people not to be afraid to speak truthfully, says **John A. Lynch, Jr.**, JD, professor of law at the University of Baltimore. However, there may be a civil remedy for abuse of process or malicious prosecution if the lawyer maintains a groundless suit, he says.

The standard for when a lawyer should tell a client that he or she has no case is quite high, Lynch notes. The judgment that a lawyer has acted tortiously in alleging malpractice is made in hindsight, so the lawyer is given considerable margin for error.

The definition of "defamation" encompasses false statements of fact that may injure someone's occupational or professional reputation, explains **Eric Easton**, JD, professor of law emeritus at the University of Baltimore.

"In my view, any allegation of medical malpractice may be

actionable in a libel suit by the practitioner. Of course, the fact that a statement is defamatory in no way guarantees the plaintiff's success," Easton says. "Indeed, defamation is only one of several elements that a plaintiff must prove even to make a prima facie case."

The others are publication to a third party and identification of the plaintiff, falsity, fault, and injury, Easton says. Even then, there is a shield for the defendant. When a lawyer is the defendant, the obvious defense is privilege, although that typically applies to statements made in court, not to the media, Easton explains.

Many Forms of Defamation

There are many potential areas in healthcare where defamation claims can arise, says **Elizabeth L.B. Greene**, JD, partner with Mirick O'Connell in Worcester, MA.

Defamation by a patient or their representative relative to the care received or not received from a doctor or hospital is commonly understood to be a false statement of fact, published to a third party. This is harmful to the reputation of the doctor or hospital, Greene says.

"Notably, there are many nuances to defamation claims, as most states have defamation statutes, which vary in how they define the elements, defenses, potentially recoverable damages, and filing limitations," Greene explains. "As the law of defamation varies by state, understanding your state's defamation statutes is important to evaluating the merits of a potential claim for defamation."

Typically, opinions and factually accurate statements are not actionable as defamation, Greene explains. Opinions are protected when they cannot reasonably be interpreted as a statement of fact and cannot be determined to be true or false, she adds.

Although truth often is a defense to a defamation claim, under some state laws, truth may not be a defense to written defamation where actual malice is proven, Greene says. When public figures, which may include some doctors, claim defamation, they must prove actual malice to recover damages. "Actual malice" often is defined as knowledge of falsity or reckless disregard for the truth.

"When a defamation claim is related to allegations of medical malpractice, the assessment of the merits of the defamation claim may be tied to the fact-finder's determination on the malpractice claim," she says. "For example, when the defamation is about the quality of medical care, the truth of that statement may be established by the jury's finding as to whether the doctor met the applicable standard of care in caring for the patient in the malpractice case."

When a defendant individual or organization seems to be the victim of defamation, responding with a lawsuit may not be the best option, Greene says. Clinicians and hospitals should consider filing defamation suits against patients only as a last resort.

Can Be Hard to Prove

Proof of the elements necessary to recover for a defamation claim can be complicated by HIPAA and state patient confidentiality laws, and litigation can be expensive, Greene explains. If a clinician or hospital believes a patient or their representative's statement is defamatory, it is advisable to consult with counsel experienced to assist with assessing all potential options, including the merits and risks of filing suit for defamation.

"It is best to exercise caution in responding to allegedly defamatory statements, consult with counsel regarding whether the statements are considered opinion or defamation under your state's law, and the best approach for responding if the statements are considered defamation," Greene says. "Prior to filing suit against a patient for defamation, a physician or hospital will want to consider whether a meeting or other communication with the dissatisfied patient could lead to resolution of a potential misunderstanding and, potentially,

EXECUTIVE SUMMARY

Some claims made regarding a medical malpractice allegation could amount to defamation. It can be a difficult choice whether to pursue a defamation lawsuit.

- Many statements from attorneys regarding malpractice claims are protected and do not amount to defamation.
- Statements made to the media generally are less protected than statements made in court or as part of court filings.
- Unfounded statements posted online by patients can be defamatory. It is possible to pursue litigation and request the statements be removed.

a retraction of the defamatory statement."

In many instances, evaluating the harm that is or may be caused by the defamatory statement is important, as pursuing a claim for defamation potentially will inflame the dissatisfied patient and can increase the public's awareness of the allegedly defamatory statement, Greene explains.

Providers and hospitals also should be mindful of the statute of limitations for defamation claims in their state. "However, at times, after consultation with counsel and analysis of the issues, the only way for a physician or hospital to defend their reputation is to bring a claim for defamation," Greene says. "If the defamatory statements are sufficiently egregious, depending on the applicable state statute, the doctor or hospital may also recover for punitive damages."

Good Faith Can Protect Statements

Greene notes some hospitals and medical groups post all government-required satisfaction survey responses patients fill out once a certain number of reviews are received for a provider. Providing a place for patients to submit feedback and voice any concerns close in time to their visit may create opportunities to address the patient's care-related concerns and prevent some patients from making allegedly defamatory statements, she says.

A malpractice claim has to be based in good faith, meaning the plaintiff believes he or she was harmed by the negligence of the physician or the hospital, notes **Marc H. Kallish**, JD, shareholder with Roetzel & Andress in Chicago. Before filing a malpractice lawsuit in Illinois, the plaintiff must submit a certificate stating the matter was reviewed by a licensed physician and the physician has certified the "potential" for malpractice exists, he says.

Typically, if a plaintiff files the allegations in a court pleading in compliance with the requirement of Illinois state law, he or she likely will be immune from a defamation action, Kallish says.

In general, a well-pled malpractice case in a civil action immunizes the plaintiff from a defamation act, Kallish says. Furthermore, otherwise defamatory statements may be shielded from suit if they are "conditionally privileged," which applies to situations in which some interest of the person who publishes the defamatory matter is involved; situations in which some interest of the person to whom the matter is published or of some other third person is involved; or situations in which a recognized interest of the public is concerned.

"Nevertheless, public statements of malpractice that are patently false can be the basis of a defamation action," Kallish says. "For example, we have represented many physicians whose patients have publicly posted completely false allegations on the internet, such as an orthopedic surgeon who was accused of operating on the wrong leg of a patient, as well as a physician who was accused of misdiagnosing a patient's cancer, leading to the patient's death. In those cases, the allegations were completely false and nonprivileged, so we sued the patients for defamation, and took legal action to get the postings taken down."

Just as individuals can bring defamation suits, so can corporation or other entities, Kallish notes.

Damages Assessed by Court

If claims prevail, showing the statements are false, proving the clinician or hospital sustained reputational harm, damages are assumed, says **Andrew Clott**, JD, associate with Roetzel & Andress in Chicago. However, a court still must assess damages in some monetary amount so loss of business or reputation is considered when formulating a monetary award, he says.

For example, Illinois recognizes two types of defamation claims: per se and per quod. In a per se action, the statement's defamatory character is considered so "obvious and apparent on its face" that "injury to the plaintiff's reputation may be presumed," Clott explains. This means the plaintiff does not have to prove damages because they are assumed.

Under Illinois law, "words that impute an inability to perform or a want of integrity in the discharge of duties of office or employment" fall under the per se category of defamation. False statements by a patient against a doctor relating to his medical treatment would be those which "impute an inability to perform" his duties as a doctor, meaning they would be considered defamation per se, Clott says.

"We have handled several situations where patients or competitors have posted false claims of malpractice and bad care on healthcare websites where the physician had a reasonable basis to believe the statement was false and it was hurting their inflow of patients. We pursued defamation action or sent cease and desist letters. We have won these cases and gotten damage awards or settlements," Clott explains. "We also have had success getting the false, damaging materials pulled from rating websites. Often, postings on rating websites are anonymous, which complicates pursuing redress against false posters."

In those cases, Clott's firm has used the court's subpoena powers to obtain URL identification information of posters from websites and other means of identifying a potential defamer.

"In some scenarios, it is worth pursuing, and in other instances, it is better to ignore," Clott says. "These situations must be dealt with on a case-by-case basis."

Difficult with Attorneys

Pursuing a defamation claim against an attorney may be more difficult than the same claim against a former patient, says **David Richman**, JD, partner with Rivkin Radler in Uniondale, NY. Attorneys' stock and trade are their words, he says. They are consequently afforded more latitude to use those words when commenting on another individual than someone not representing a client in matters that tend to be adversarial in nature, Richman says.

THIS LIMITED IMMUNITY GENERALLY WILL COME INTO PLAY WHEN THE ATTORNEY MAKES COMMENTS ABOUT A CLIENT'S ADVERSARY TO A LISTENER, LIKE THE MEDIA, OUTSIDE OF THE COURTROOM.

In the context of words spoken before the court or in a judicial or quasi-judicial proceeding, attorneys are accorded absolute immunity against a suit for defamation even if those statements are proven to be false, malicious, or made with ill will, Richman explains. Many states have codified this protection. The only test these statements must survive is whether the statements are pertinent and material to the litigation.

In New York, that protection appears in Sec. 74 of the New York Civil Rights Law and reads, in part, "A civil action cannot be maintained against any person, firm, or corporation, for the publication of a fair and true report of any judicial proceeding, legislative proceeding, or other official proceeding, or for any heading of the report which is a fair and true headnote of the statement published. This section does not apply to a libel contained in any other matter added by any person concerned in the publication; or in the report of anything said or done at the time and place of such a proceeding which was not a part thereof." *(The code is available at: https://bit.ly/3lDgJrL.)*

"The reasoning behind this protection is a policy recognizing the need for vigorous representation of one's client and the assumption that, as officers of the court, counsel will act in a manner consistent with that responsibility, even if those actions and words are not true and sound personal in nature," Richman explains.

This protection is available to attorneys for words spoken outside of an actual legal proceeding, although it is generally regarded as less absolute and therefore subject to some conditions. This limited immunity generally will come into play when the attorney makes comments about a client's adversary to a listener, like the media, outside of the courtroom, Richman says.

The question of propriety will first turn on whether the context of the statement was central or ancillary to the litigation, he explains. If ancillary, as it usually is when an attorney speaks with the media, the question of propriety will turn on whether the statement was made with

"actual malice." But even there the question of whether the statement was defamatory has to clear several hurdles that examine the context of the statement.

"If, for example, the statement was made in response to a comment by or on behalf of the adversary, the response, though sounding defamatory, will likely be given greater leeway," Richman says. "If a statement was made by one party about the circumstances of the underlying litigation, the response, calling the adversary a liar and defending oneself against the perceived lie, would generally not be viewed as defamatory."

The question becomes even more complicated when the allegedly defamed party is a public figure. In the Dubrow case, the plastic surgeon is a well-known TV personality and therefore would be viewed as a public figure, Richman says.

Actual Malice a Big Hurdle

Consequently, while the statements by counsel to the media would seem to be clearly harmful to the doctor's reputation, the standard of proof to be met must establish the defendant/defamer acted with "actual malice" — that is, that he or she knew or should have known the statements were untruthful, Richman says.

"Where the lines become blurred for attorneys and the courts weighing defamation claims against attorneys in this context is whether and/or to what extent the statements relate to allegations made in the complaint," he says. "If claims, using the Dubrow situation, are simply echoes of the allegations of malpractice — such as 'he ruined my client's life,' 'he was grossly incompetent,' 'he turned my client's life upside down' — it is more likely than not that the plaintiff in an ensuing defamation claim will not prevail."

Should the public figure protection be lost, the court's analysis of the attorney's statements will be based on a more traditional standard of proof for defamation, including whether the statement was false and whether the statement was an unprivileged communication to third parties, Richman says. What sets these types of claims apart from most other litigable claims is the burden of proof shifts from the person who was defamed to the person making the statement. The one made the remark will bear the burden of proving the statement was not defamatory, provided the plaintiff has met his or her burden in the initial pleading.

"If the statement is not previously stated in a pleading or filing with the court, claims against non-public figures that the other party was incompetent or unfit will be deemed to be defamatory per se, meaning that the statement is presumed to be harmful to the person about whom the statement is made," Richman explains.

This analysis applies whether the attorney is commenting about a layperson or one connected with the healthcare industry, be it a physician, nurse, hospital, or medical office or clinic, he says. For hospitals or medical care providers on the receiving end of what might be viewed as defamatory statements, the decision of what to do in response, if anything, should rest, in part, on a balance between the benefit to be gained by pursuing a claim vs. refraining from a response, Richman says.

As always, the context is important. If the statement is untethered to a court or quasi-judicial proceeding, the grounds for pursuing a claim may be more justified, Richman says. But again, context is everything, as is the question of the perceived harm.

"Has the statement or is the statement likely to impact business or reputation? If so, is the damage short- or long-lived?" Richman asks. "The analysis should also consider the chances of success at trial, as the vast majority of defamation suits wind up in favor of the alleged defaming party, particular if the one making

the statement is an attorney and the comments are arguably related to actual or anticipated litigation arising out of a failed doctor-patient relationship." ■

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Online Ratings Pose Risk of Defamation, May Need Response

The risk of defamation increases with the proliferation of online rating services in the medical industry, says **Marc H. Kallish**, JD, shareholder with Roetzel & Andress in Chicago.

"There is a significant distinction between defamation and opinion. For example, if a patient of a hospital posts or makes a public statement that they believe the care at a particular hospital or clinic is 'sub-standard,' 'impersonal,' or 'not the best,' this would likely be construed as opinion and not actionable as defamation," Kallish explains. "However, if the patient says, 'I went to particular hospital and they operated on the wrong leg' when this never happened, or the hospital 'misdiagnosed my appendicitis,' but the patient never went to the hospital for this condition, the hospital could have a defamation action against the patient."

Another scenario is where the patient actually went to the hospital and received treatment but ultimately experienced a bad outcome. The patient's public statements about this may be protected if made in a legal pleading, Kallish says.

In these scenarios, truth is an absolute defense to a defamation action, Kallish says. Consider a patient who presents to a hospital emergency department complaining about symptoms that sound like a heart attack. However, the patient is discharged without treatment, and suffers a massive heart attack at home. This patient may publicly accuse the hospital of malpractice and post this story on the internet, Kallish says.

The hospital could dispute that they did anything wrong and pursue a defamation action against the patient. In defense, the patient may claim it was true the hospital committed malpractice in its treatment. If proven in a defamation action brought by the hospital, the patient would prevail, Kallish says.

"If the patient proves malpractice occurred, truth is a total defense to defamation action," he says. "On the other hand, if it is proven that the hospital met the standard of care, even though the facts posted by the patient were substantially true, the patient may be subject to damages for defamation." ■

HEALTHCARE RISK MANAGEMENT™

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CME/CE QUESTIONS

1. **Physicians and organizations who received Provider Relief Funds are subject to reporting requirements if they received more than:**

   a. $10,000.
   b. $100,000.
   c. $250,000.
   d. $750,000.

2. **For recipients who have expended all their allocated funds, when must they report on their expenditures through the period ending Dec. 31, 2020?**

   a. By the end of calendar year 2020.
   b. Within 45 days of the end of calendar year 2020.
   c. Within 90 days of the end of calendar year 2020.
   d. By the end of calendar year 2021.

3. **Which is true regarding defamation and malpractice litigation?**

   a. Generally, statements made to the media are less protected than statements made in court or as part of court filings.
   b. Statements made to the media are protected as much as statements made in court or as part of court filings.
   c. Attorneys cannot be held liable for defamation related to malpractice litigation, but plaintiffs can.
   d. Courts generally will not consider a defamation allegation until the related malpractice litigation is resolved.

4. **Why is it sometimes more difficult for public figures, including prominent physicians, to prove a defamation claim?**

   a. Juries are less sympathetic to public figures.
   b. They must prove "actual malice."
   c. Courts are more likely to dismiss the claim as frivolous.
   d. Attorneys are less likely to accept such cases.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Surviving Spouse Awarded $1.1 Million for Patient's Delayed Cancer Diagnosis

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News: A 26-six-year-old woman visited a federally funded clinic three times, complaining of breast pain and lumps. However, the clinic's employee failed to follow up and did not order an ultrasound. The patient subsequently was diagnosed with an aggressive form of breast cancer. She later died. A court determined an ultrasound would have revealed the suspicious mass, enabling an earlier diagnosis, and the clinic was negligent for failing to perform an ultrasound. The court awarded the patient's surviving spouse $1.1 million.

Background: In December 2014, a 26-year-old patient sought treatment at a federally funded clinic for a sore throat and a non-tender nodule in her right breast. The nodule had been present for approximately three days. The records of the examination did not indicate whether the clinical staff attempted to perform a physical examination of the lump, and the exact location of the lump was not noted in the patient's records. The patient was told the lump was most likely a cyst associated with her menstrual cycle. She was instructed to follow up with the gynecological department in two to three weeks.

In late February 2015, the patient attended the follow-up visit at the clinic, complaining of lumps and pain in her right breast. The clinic employee performed a manual examination, but could not locate any masses the patient felt. After the visit, the clinic mailed the patient a referral for an ultrasound; however, the patient alleged she never received the mailing. She also alleged she requested an MRI but was denied based on her young age.

A COURT DETERMINED AN ULTRASOUND WOULD HAVE REVEALED THE SUSPICIOUS MASS, ENABLING AN EARLIER DIAGNOSIS, AND THE CLINIC WAS NEGLIGENT FOR FAILING TO PERFORM AN ULTRASOUND.

Over several months, the patient failed to follow up, and missed scheduled ultrasound appointments. In May 2015, after complaining of pops and pain in her right breast, the patient arrived at a different hospital's emergency department. After an ultrasound and a chest X-ray revealing no cysts or abnormalities, the patient was sent home and instructed to follow up with a breast specialist the next day. However, she again failed to do so. A few weeks later, she returned to the hospital for an unrelated condition. During this visit, she did not report any chest pain or breast tenderness.

At the end of June 2015, the surgical specialist conducted an exam, which revealed a 3-4 cm mass in the patient's right breast. Despite the discovery, the patient did not return for diagnostic testing of the lump until Aug. 19, 2015. An ultrasound was performed and, for the first time, the patient revealed she had suffered traumatic injury to her right breast caused by her son's elbow. Consequently, the radiologist who identified the mass in her right breast classified it as likely benign and consistent with trauma.

At the end of August 2015, before receiving the results of the ultrasound, the patient returned to the clinic for an annual gynecological visit. She did not report any tenderness or pain in her chest, and the nurse practitioner did not conduct a breast examination, noting that one had been performed less than six months prior. During the next several months, the patient underwent several tests, although it was unclear from the records whether the patient missed additional appointments. In April 2017, the patient finally underwent a surgical double mastectomy to remove the mass, which had grown to 10 cm. The mass was consistent with angiosarcoma, an extremely aggressive type of cancer that often is metastatic. Despite the double mastectomy, further testing confirmed the angiosarcoma had spread to the patient's pulmonary nodules, ribs, sternum, and spine. Following her surgery and until her death in April 2019, the patient received radiation five days per week and was administered morphine and oxycodone for pain management. During the final months of her life, the patient was bedbound and extremely weak.

The patient's surviving spouse filed a medical malpractice lawsuit against the clinic, alleging the delay in diagnosis prevented timely treatment and caused the patient's death. The court concurred, noting if the ultrasound had been performed in September 2015, the cancer would have been detected and treated sooner. At that time, the mass was only approximately 3 cm in diameter, and the chances of recovering from this aggressive form of cancer was significantly greater for a mass smaller than 5 cm. While the court recognized the clinic was negligent for the delayed diagnosis, the court also confirmed the patient was partially responsible for her injuries. This finding was based on the patient's repeated missed appointments and failure to follow up. As a result, the court reduced the initial recovery award of $2.2 million to $1.12 million.

What this means to you: Although the parties disputed several essential facts in this case, one important, incontrovertible fact was the patient missed several follow-up appointments, failed to schedule tests recommended by the care providers, and thus contributed to her injuries. Physicians and care providers only have so much ability to compel patients to seek treatment. Even with the most urgent recommendations, a patient always can refuse treatment, expressly by denying such treatment or implicitly by simply failing to follow up on recommendations. Under such circumstances, it is proper for a physician or care provider to draw attention to the patient's own shortcomings and fault. A jury may even determine that the patient, not the care provider, was solely responsible for the injuries suffered, and the care provider cannot be found liable for any damages.

In this matter, the defendant care providers did raise the patient's failure to attend follow-up appointments and schedule recommended testing. The court concurred, reducing the plaintiff's recovery to almost half the verdict rendered. Under these circumstances, the care providers were not completely absolved of liability. If medical personnel at the clinic paid closer attention to the patient's symptoms, conducted more detailed analysis, and performed an ultrasound, they would have identified the tumor at an earlier stage, preventing it from metastasizing and potentially saving the patient's life.

To determine whether a breach of the standard of care occurred, the court analyzed each of the patient's visits to the federally funded clinic, and reviewed the expert witness' testimony concerning the evolution of the patient's condition. The plaintiff's expert testified the care provider who examined the patient on the first visit breached his duty of care by recommending a follow-up visit weeks later, rather than immediately referring the patient to a specialist. However, the defendants' expert successfully established three key facts qualified the patient's situation as non-urgent, thus justifying the recommendation. First, the patient was only 26 years old at the time, and cysts and chest pain are more common in women of that age group. Second, the patient reported no family history of breast or ovarian cancer. Third, the patient reported the mass had only been present for three days.

Given these circumstances, a non-urgent follow-up visit was appropriate. The court agreed with the defendant care providers on this issue and found that during the first visit, no breach of duty had occurred. Similarly, during the patient's second visit, the judge ruled the appropriate standard of care would have required a referral for an ultrasound. The referral was actually mailed by the examining nurse practitioner to the patient's address. Therefore, the second visit also satisfied the required standard of care.

However, during the third visit, the court ruled the patient presented more substantial evidence for heightened scrutiny and action by the care providers. In fact, the plaintiff's expert opined that, given the patient's history of pain, the nurse practitioner who examined her should have followed up on the previous referral

of an ultrasound (which the patient never scheduled) and immediately provided a new referral and instructed the patient to schedule the test. Both parties agreed an ultrasound performed at this time would have revealed the mass, likely resulting in further testing. The court also ruled the patient's tumor would have been detectable by manual examination in August 2015. If the nurse practitioner had performed a routine breast exam, the tumor would have been detected.

This case reveals the necessity of increasing scrutiny when a patient returns with a continuing complaint. Additional resources should be used to investigate the cause, especially when it may be life-threatening. It is inevitable that patients do not comply with follow-up appointments and instructions, or even deny or ignore their symptoms. Care providers should provide immediate access to diagnostic resources when warranted, even if a patient is resistant. More often than not, breast lumps prove to be benign, transient manifestations caused by multiple factors like hormonal changes during the menstrual cycle. However, ignoring a lump that persists can be life-threatening, as in this case. Additionally, some of these tumors can be more aggressive in younger women. It is crucial to obtain an accurate history and timeline of events, such as the dates of first appearance, frequency, dates of follow-up care, and changes in size, location, and firmness. Leaving potentially cancerous tumors unidentified poses a significant risk for the tumor to grow or for the cancer to metastasize, increasing the patient's risk of harm. Unfortunately, in this case, those risks materialized and the delayed diagnosis was a significant factor in the patient's death. ■

REFERENCE

Decided on Oct. 5, 2020, in the United States District Court for the Southern District of New York, Case Number 1:18-cv-09270.

Court Vacates $911,000 Malpractice Verdict on Expert Testimony Rule

News: An appellate court vacated a jury verdict of $911,000 in a medical malpractice suit. The plaintiff alleged a physician botched the patient's back surgery, causing the patient's death. The appellate court ruled the plaintiff did not prove her expert complied with the state court's rule barring testimony from medical experts who allocate more than 20% of their time serving as experts.

The appellate court ruled the plaintiff failed to present records establishing how much of the expert's professional activities were dedicated to serving as an expert. Once the court excluded the expert's testimony, the patient had no evidence supporting a claim against the physician.

Background: An adult male patient underwent back surgery to treat an underlying condition. Complications caused directly by the surgery led to the patient's death, and the patient's wife filed a medical malpractice action. The plaintiff alleged the physicians breached their duty of care by failing to identify the patient as high-risk when determining the appropriate course of treatment. Furthermore, the plaintiff argued that if the physicians considered the patient's physical condition, a less invasive alternative would have been chosen. Such less invasive alternatives were readily available, but were not discussed with the patient. However, the physicians proceeded in performing a highly invasive back surgery, which caused the patient's death.

During the trial, the plaintiff presented expert witness testimony from an orthopedic surgeon. The defendants objected, claiming the expert was not qualified to testify based on a state rule precluding experts who dedicate more than 20% of their time serving as experts. The trial court permitted the expert testimony, a necessary element of the plaintiff's case. The plaintiff was awarded $911,227.02.

The defendants raised a procedural challenge, again arguing the plaintiff's expert should have been disqualified for failing to provide sufficient evidence concerning the 20% activity rule. Although the trial court initially permitted the testimony, it subsequently acknowledged its error and granted the defendants' challenge, entering judgment for the defendants notwithstanding the adverse verdict.

The plaintiff appealed the trial court's decision, arguing the trial court's initial determination was correct and the trial court exceeded its discretion in subsequently disqualifying the expert. Regarding satisfying her burden of production, the plaintiff alleged the trial court erroneously granted the defendant physicians' motion to compel the

expert to produce his financial records without a subpoena. However, the appellate court did not find this argument compelling because the records were identified in the deposition notice for the expert. Also, it is the burden of the party who proffers the expert to produce sufficient financial records for the court to determine whether the expert meets the requirements of the 20% rule.

Accordingly, the appellate court determined the trial court did not abuse its discretion because based on the expert's own testimony, at least 70% of his income was derived from serving as an expert witness in medical malpractice trials. The plaintiff failed to satisfy her burden and to produce evidence showing the expert complied with the state's rule. The appellate court upheld the trial court's decision and affirmed the judgment for the physicians.

What this means to you: This case provides another example of how trial strategy and preparation is essential to the positive outcome of a case, with particular focus on the selection and retention of expert witnesses. Expert witnesses often can make or break a case, and that is true for either party in a medical malpractice action. If a plaintiff presents a credible, unchallenged expert the jury believes, it may be difficult for a defendant care provider to overcome such compelling expert testimony. Fortunately for defendant care providers, there are many ways to challenge an opposing party's proffered expert witness, whether such a challenge goes to if the expert can opine at all in the matter or if the challenge undermines the expert's credibility and findings if permitted to opine.

In this case, the particular challenge went to the heart of the expert's ability to testify: This particular state uses a bright-line 20% rule precluding individuals who devote more than 20% of their professional activities to those directly involving testimony in personal injury claims. (Note that such rules vary by state, so it always is important to consult with well-informed local counsel on such matters.) According to the court, the rule is straightforward and mathematical, identifying the offered expert's activities and calculating those pertaining to personal injury litigation compared to those that do not; for example, those pertaining to providing direct medical services or otherwise. Courts applying the rule look to the activities and the value of the activities to determine the expert's compliance. The burden of providing sufficient evidence for the court to conduct this analysis rests on the party who has retained and seeks to offer the expert's testimony. If that party fails to provide evidence, then the expert is unable to testify.

During this litigation, the defendant care providers requested documents during discovery detailing the expert physician's professional activities as well as a list of cases where he had served as an expert witness. However, the plaintiff and expert did not produce any responsive documents. Furthermore, while testifying, the expert claimed he did not keep a record of how much time he spent testifying, preparing to testify, and reviewing court records. When asked what percentage of his income was generated by court testimonies, the expert provided contradicting estimates ranging from 70% to 83%.

The defendant care providers rightly seized on this percentage, which vastly exceeds the 20% rule permitted for experts in the jurisdiction. Although the trial court initially incorrectly determined the issue, the care providers again properly persisted with their procedural challenge to the opposing expert. The court ruled the plaintiff did not met her burden and that based on the evidence presented, the testimony of her only expert witness should have been excluded based on the 20% rule violation. Because the plaintiff offered no other evidence establishing a breach of any duty by the care providers, once the expert's testimony was excluded, the entire case had to be decided in favor of the defendant care providers. This dramatic reversal — a defense judgment after a jury verdict of nearly $1 million — confirms the importance of selecting the right expert, and the importance of challenging an opposing party's improper expert.

Another quick but important lesson comes from the trial court's actions in this case. Courts and judges are fallible, and make incorrect rulings on occasion, even against the weight of the evidence. But when such an incorrect ruling occurs, there are avenues for seeking reconsideration of the decision and politely informing the court of its mistake. The defendant care providers took such timely remedial action, even after an adverse verdict, and were successful in pointing out to the court its error — which the court then corrected and entered judgment in favor of the defendants. It is important to be persistent but polite in the face of an adverse ruling, and to recognize there are legal mechanisms and procedures for remedying incorrect rulings. In the end, the trial court and appellate court confirmed the plaintiff's expert was properly excluded, and the care providers succeeded in defending against the action. ■

REFERENCE

Decided on Oct. 5, 2020, in the Court of Special Appeals of Maryland, Case Number 3377.