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Prove patient's non-compliance: A defense verdict might result

But physician defendants need proof

If a patient failed to see a surgeon after you diagnosed a malignant tumor in her breast, should this bar her from recovering any damages? What about a patient's refusal to wear a medically prescribed orthotic device, or a patient falling while getting out of bed despite being repeatedly cautioned to call for assistance?[1,2,3]

These are actual cases in which juries have been allowed to consider the plaintiff's "contributory negligence" as a defense to the patient's claims, adds **Erin McNeil Young**, JD, a partner with Yates, McLamb & Weyher in Raleigh, NC.

In general, the defense of contributory negligence has been recognized in medical malpractice actions when the patient has failed to follow medical instruction; refused or neglected prescribed treatment; or intentionally given erroneous, incomplete, or misleading information, says Young.

In states that recognize the doctrine of contributory negligence in the context of medical malpractice claims, a plaintiff is completely barred from any recovery when his or her own negligence was a proximate or contributing cause of his or her injury, says Young. *(To view state-specific information, go to http://bit.ly/QkRSn6.)*

In other states, the principle of "comparative fault" has replaced the defense of contributory negligence. "Comparative fault is a system which provides for the reduction of a plaintiff's recovery, in proportion to the plaintiff's fault," says Young.

Good documentation of the physician's recommendations and the patient's non-compliance still can be used as evidence ...

When contributory negligence is used as a defense, the burden then shifts to the defendant to show that plaintiff's negligence contributed to his own injury and the defendant should not be held liable, says **Brandy Boone**, JD, a senior risk management consultant at ProAssurance Companies in Birmingham, AL.

Good documentation of the physician's recommendations and the patient's non-compliance still can be used as evidence, even if the defense doesn't use contributory negligence as an affirmative defense or is unable to prove all of the elements, adds Boone. *(See related stories on documentation, p. 51, refuting a patient's false claims, p. 52,*

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and whether obesity can be used to prove contributory negligence, p. 52.)

Philip R. Dupont, JD, a partner at Husch Blackwell in Kansas City, MO, says, "It's pretty rare that you find a case where you are assigning a percentage of fault between a patient and a physician. More often than not, if you've got a really strong situation where the patient is at fault, you just put that out there and hope to get a complete defense verdict."

Executive Summary

A patient's non-compliance can be used to support a defense of "contributory negligence," which might bar the patient from recovery, or "comparative fault" which might reduce the plaintiff's recovery in proportion to the patient's fault. Even if neither defense is used, the patient's non-compliance can be helpful to a physician defendant. Physicians should:

- ✦ Be specific in the chart about what they told the patient.
- ✦ Document admissions and even suspicion of non-compliance.
- ✦ Consistently chart recommendations every time they're given.

Physicians need proof

Bobbie S. Sprader, JD, an attorney with Bricker & Eckler in Columbus, OH, has seen several claims against primary care physicians by patients diagnosed with conditions such as colon cancer that arguably would have been picked up earlier had they undergone routine screening.

The issue was whether the physician recommended the screening at all, and whether they provided sufficient information to the patient about the need for the screening to shift responsibility for having the test to the patient, explains Sprader.

"Often, patients are not good about scheduling routine physical exams, so they only see their physician for sick visits," she says. "They still claim that they should have been advised to have the screening exams or, at a minimum, advised to schedule a routine physical where this could have been discussed in more detail."

The better a physician is able to prove that the recommendation was made, that the patient was told the risk of non-compliance with the recommendation and that the patient then did not comply, the more likely that the patient's own non-compliance will be successful in reducing or eliminating the liability, if any, on the part of the physician, says Sprader.

Delicate subject

A patient's non-compliance with a doctor's advice to quit smoking might well have contributed to complications with a subsequent orthopedic injury. However, making this an issue during litigation could easily backfire on a physician defendant.

"You have to be careful any time you point the finger at a patient for causing harm to themselves," says Dupont. "It's a delicate subject in front of a jury. The question is, to what extent do you push

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that?"

If there is no documentation of non-compliance, it might look like an afterthought. "The jury would say, 'Why didn't you tell the patient that in the first place? It's not in your notes.' Now it just looks like you are picking on them," Dupont says. Here are some opportunities before trial to raise this issue:

• During the patient's or physician's deposition.

"Both the physician and the physician's lawyer need to be careful," cautions Dupont, as poor treatment of the patient or a hostile-appearing physician can anger the jury.

• During the expert's deposition.

"Obviously, if the physician's expert is going to opine that the patient has some responsibility for his or her own injuries, that needs to come out in the deposition," says Dupont.

• During mediation.

"That is an excellent opportunity for the defense, through the mediator, to point out that the patient had some responsibility for their own injury or poor recovery," says Dupont.

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2. Faile v. Bycura, 297 S.C. 58, 374 S.E.2d 687 (1988).
3. Welker v. Scripps Clinic, et., Foundation, 196 Cal.App.2d 338, 16 Cal.Rptr. 538 (1961)

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Real-time charting tells compliance story

You can offer 'strong evidence' of recommendations

A note stating "routine screening discussed" might help a physician defendant prove a patient was non-compliant.

"You now have documented proof that a discussion did occur," says **Bobbie S. Sprader**, JD, an attorney with Bricker & Eckler in Columbus, OH.

However, she says it would be much better to have a note that says, "Patient advised that a colonoscopy is recommended for screening due to his age and family history of colon cancer. Patient understands risks and benefits of this test, including the risk that he may have polyps or pre-cancer that can be treated if found now before it progresses to colon cancer that may be fatal."

Here are risk-reducing strategies:

• Send a follow-up letter to the patient that outlines the recommendation and the basis for the recommendation.

"This would be strong evidence that the recommendation was made and that the patient understood the risks of ignoring the recommendation," says Sprader.

• Have patients initial something to acknowledge that they were advised and all their questions were answered.

"This would prevent any argument that they were unaware," says Sprader.

• Document any admission of non-compliance.

"Physicians are frequently asked in a deposition whether they consider their patient to be compliant in general," says Sprader. "It is hard to say no if there is no documentation of non-compliance anywhere in the chart."

• Document even suspicions of non-compliance.

For example, if diabetic patients report compliance with their diet and are checking their blood glucose levels regularly, but their HgbA1C is high, this situation is evidence that they are less compliant than they profess to be.

"If confronted, they may 'fess up, and this, too, should be documented," says Sprader.

• Be specific about what you told the patient.

Physicians often bring up the topic of non-compliant patients during risk management seminars, says **Brandy Boone**, JD, manager of risk resource at ProAssurance Companies in Birmingham, AL. Boone tells them that simply documenting "patient non-compliant" isn't enough for a defense. Physicians need to be very specific about what they recommended.

"Day after day, I see delay in diagnosis claims where the patient is alleging that the results of diagnostic tests weren't given to them in time to seek necessary treatment," says Boone. "It's a little harder to make those allegations when the physician record makes it clear that it's the patient who did not follow up."

• Document every time you give instructions.

Karen B. Everitt, JD, regional

vice president of risk management at ProAssurance Companies, recalls a claim involving a physician who had cared for an overweight diabetic patient with cardiac disease for many years. At the beginning of the relationship, the doctor always documented giving instructions regarding diet, smoking, and lab tests, and the patient's noncompliance.

"Over the years, the physician became less diligent about documenting those instructions at each visit and patient statements about noncompliance," says Everitt. "Eventually, the patient had a problem and sued the physician."

Although the defense attorney tried to show that the physician continually gave instructions and the patient did not comply, the medical record didn't appear that way. "In that situation, you are asking the jury to take the physician's word for it," Everitt says. "A physician cannot over-document their instructions and the fact that the patient did not comply." ✦

Patient might claim blood work not ordered

Most lawsuits involving contributory negligence relate to patients who fail to follow up with routine blood work and to return for scheduled appointments, according to **Molly L. Farrell**, vice president of operations for MGIS Underwriting Managers in Salt Lake City, UT.

"Only with very clear documentation of everything that the physician did and everything that the patient didn't do will a jury assign fault to the patient," Farrell adds.

In one case, a patient taking a daily dose of divalproex sodium alleged that the physician never ordered the required routine blood work, but the medical record clearly showed these weren't obtained by the patient despite being ordered over a two-year period. The prescriptions still were renewed on a monthly basis.

"The patient in this case developed aplastic anemia and sued. The case was settled for a small amount, due to the prescription issue," Farrell says. "While the case could have been defended, given that the physician ordered all the tests, the fact that he continued to order the refills was an issue of liability."

In another case, a patient was referred to his cardiologist for a cardiac work-up due to a strong family history of heart disease with recent complaints of intermittent chest pain. The patient did not make an appointment with the cardiologist, and the issue was discussed at the next visit.

At that point, the family practitioner had his office manager secure an appointment and advised the patient of the date. "The patient did not go to the appointment and died of a massive myocardial infarction seven days after the appointment," says Farrell. "The patient's family sued. However, the case was dismissed due to the clear documentation in the physician's chart."

The physician's charting needs to make the "story" of the appointment and the patient's lack of follow-through clear, including the fact that they told the patient the reason for a diagnostic test, says Farrell. "The physician has a much higher standard to prove that the patient was non-compliant, simply because juror expect that physicians have a better understanding of the situation," she says. ✦

Can patient's obesity be successful defense?

This contributory negligence defense might be 'difficult argument'

When it comes to using a patient's obesity as a contributory negligence defense, "there is a fine line," says **Philip R. Dupont**, JD, a partner at Husch Blackwell in Kansas City, MO. "I don't think you will find a court that allows you to base a percentage of fault on a patient being obese," Dupont says.

Obesity is a medical condition, and physicians are expected to take patients as they find them, he explains. "You can point out that the patient is obese and that it affects a number of medical issues in the care and treatment of the patient, but you're probably not going to be getting a comparison of fault on that," Dupont says.

A patient's obesity might be considered when evaluating a traumatic injury case such as a lacerated common bile duct, as surgery is made more difficult because the visual field available to the surgeon is smaller, but it's a "difficult argument," says **Molly L. Farrell**, vice president of operations for MGIS Underwriting Managers in Salt Lake City, UT. "Jurors tend to feel that the physician knew what he or she was getting into before they did the surgery."

"Lifestyle" factors relevant

"Lifestyle" factors such as drug use, obesity, and smoking often can be used as evidence of a patient's contributory negligence, says **Erin McNeil Young**,

JD, a partner with Yates, McLamb & Weyher in Raleigh, NC. However, contributory negligence is not applicable where a patient's conduct merely provides the occasion for care or treatment that later is the subject of a malpractice claim, or when the patient's conduct contributes to an illness or condition for which the patient seeks the care or treatment on which a subsequent malpractice claim is based, she says.

"For example, in a malpractice action for negligent treatment of a gunshot wound, one court has held that the patient's conduct in sustaining the gunshot wound in the first place is not a defense to the defendant's negligent or improper treatment," says Young.

Likewise, if a physician negligently performs a cardiac stent placement after an acute coronary syndrome, the physician cannot use the plaintiff's pre-existing obesity and dietary habits as a contributory negligence defense, says Young. "On the other hand, those lifestyle factors are certainly relevant to reduce the amount of recovery, as they directly relate to reduction in life expectancy and other elements of personal injury damages," says Young.

Substance abuse: admissible?

A person's use of alcohol cannot constitute contributory negligence in a malpractice action against a physician treating him for alcohol abuse, says Young. However, a person's use of alcohol could constitute contributory negligence in a malpractice action against a physician treating that person for a broken back, if the alcohol use contributed to the patient getting injured.

"Lifestyle" factors such as drug use, obesity, and smoking often can be used as evidence of a patient's contributory negligence.

"If a patient's negligent conduct occurs after the physician's negligent treatment instead of concurrently or simultaneously, recovery by the patient should be mitigated or reduced, and not completely barred," says Young.

A patient's drug abuse is possibly admissible in court, whether recreational or prescription, although plaintiff attorneys will try to keep it out, says **Molly L. Farrell**, vice president of operations for MGIS Underwriting Managers in Salt Lake City, UT. "The defendant must show that the specific drug abuse affected the outcome," she says.

One lawsuit involved a patient who lost his hands and feet due to an infection, and an allegation was made against the surgeon for failure to administer a vaccine following removal of the patient's spleen.

"What appeared to be an indefensible case changed significantly when it was discovered that the patient was an IV drug user," says Farrell. "While the case was settled, it was for a significantly lower amount." ✦

Is emailing patients truly legally risky?

It might make case more defensible

In one medical malpractice case, a psychiatrist emailed the husband of her patient, who had just been involuntarily committed by the psychiatrist. The psychiatrist set out the legal basis for doing so, which was an incorrect understanding of the law.

"It was the wrong standard, and the plaintiff had this email and could say, 'This is what the doctor said, and he was wrong,'" says **Steven Martin Aaron**, JD, a partner in the Kansas City, MO, office of Husch Blackwell.

If the physician's email communication is incorrect about any aspect of the patient's care, or contrary to the physician's notes, there is a memorialized record of it, says Aaron. "If the doctor says in a deposition, 'My notes say I did X, Y, and Z, and email communication to the patient provides conflicting information, the doctor has set himself up to be impeached and will lose all

Executive Summary

Liability risks of emailing patients include inconsistencies with the medical record that hurt the defense, a negligence claim involving inadequate evaluation, and violation of patient privacy regulations. On the other hand, some experts say legal risks are overstated and that emails can provide proof of a doctor's instructions.

✦ Obtain informed consent from the patient before using email.
✦ Keep emails even if these are not considered part of the official medical record.
✦ Be sure emails meet security requirements for electronic transmission of protected health information.

credibility with the jury," he says.

Less than 7% of office-based physicians routinely email back and forth with patients, in part because of worries over liability risks, according to a 2010 survey conducted by the Center for Studying Health System Change.

"While the percentage of physicians who do this today is still low, I believe it will increase rapidly in the near future," predicts **Deven McGraw**, director of the Center for Democracy & Technology's Health Privacy Project in Washington, DC.

As of 2014, the Centers for Medicare & Medicaid Services will require physicians to get at least 5% of their patients to engage in secure email communications with them in order to be eligible for a second round of electronic health record stimulus payments, adds McGraw.

"Physicians must adhere to professional standards of practice in emails with patients, just as they would do in any communication with patients over the phone or in person," says McGraw.

Risks exaggerated?

None of the experts interviewed by *Physician Risk Management* were aware of any medical malpractice lawsuit where email was a central issue in the case.

"I believe the risks are overblown," says McGraw. "The fact that the [American Medical Association] has put out best practices for this means they see the value, and do not believe it is inherently risky, or risky in a way that cannot be managed by physicians."[1] *(See Resource at end of this article to access the AMA's guidelines.)*

Emails actually might help a physician defendant if it can prove a doctor told a patient to do something to prevent a bad outcome. "Email correspondence could potentially make the case more defensible because the provider's advice, like a hospital discharge summary, provides the steps a patient should take in order to prevent an adverse event or worsening of a condition in a particular situation," says Rose.

"While the percentage of physicians who do this today is still low, I believe it will increase rapidly in the near future."

However, if an inaccurate response is given to a patient's query, it might lead to a negligence claim if an adverse event occurs and the patient hasn't been adequately evaluated, which is a state law cause of action, says **Rachel V. Rose**, JD, MBA, a Houston, TX-based attorney, focusing on health law. For example, if a physician has been treating a patient for Crohn's Disease and the patient emails the physician to report increased abdominal pain and cramping, fever, and pain, given the patient's history, the physician might provide advice solely based on that condition.

"However, appendicitis also has the many of the same symptoms," says Rose. "By potentially delaying treatment based on an email exchange without a physical exam, it could lead to a burst appendix, peritonitis, and additional complications." *(See related stories on risk-reducing practices, below, and liability risks involving patient privacy regulations, p. 55.)*

Reference

1. American Medical Association. Guidelines for physician-patient electronic communications. 2003.

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• To view the American Medical Association (AMA)'s "Guidelines for Patient-Physician Electronic Mail," go to bit.ly/QmLs9T. To view the AMA's ethical guidelines on the use of electronic mail based on its report "Ethical Guidelines for the Use of Electronic Mail Between Patients and Physicians," go to http://bit.ly/NMGd35. ✦

Reduce risks when emailing your patients

Many patients like to email their physicians. "There is a way for physicians to do so legally and in a manner that reduces risk," says **Kristen B. Rosati**, JD, an attorney with Coppersmith Schermer & Brockelman in Phoenix, AZ.

Rosati recommends these practices:

1. Have patients sign a consent form that sets the "rules of the road."

American Medical Association guidelines recommend physicians obtain informed consent before using email to communicate with patients.[1] "Some states require consent to communicate with patients by email," adds Rosati.

2. Send an automatic reply to all

patient emails, such as: "Thank you for your email. Any medical question, especially one of an urgent nature, will not be addressed via email communication. For other assistance, please call XXX-XXX-XXXX. If you have a medical emergency, please call 9-1-1."

3. Keep subject lines generic and nonspecific.

"Emails should not put patient information in the subject line or body of the email, such as a patient's name, date of birth or account number," says Rosati.

4. Check state laws to determine whether electronic communications with patients about treatment issues are considered part of the official medical record.

"Even if they are not treated as part of the medical record, keeping these communications is essential for risk management purposes, in the event there is a dispute with the patient later about the content of email communications," says Rosati. *(See related story on protected health information, below.)*

Reference

1. American Medical Association. Guidelines for physician-patient electronic communications. 2003. ✦

Emailing protected health information? Prevent lawsuits

If a physician emails a patient and doesn't meet security requirements for electronic transmission of protected health information (PHI), he or she could be held liable for a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, warns **Rachel V. Rose**, JD, MBA, a Houston, TX-based healthcare attorney.

A recent example is the Department of Health and Human Services (HHS), Office for Civil Rights' (OCR) enforcement action against Arizona-based Phoenix Cardiac Surgery in April 2012. According to HHS, "[t]he incident giving rise to OCR's investigation was a report that the physician practice was posting clinical and surgical appointments for its patients on an Internet-based calendar that was publicly accessible. On further investigation, OCR found that Phoenix Cardiac Surgery had implemented few policies and procedures to comply with the HIPAA Privacy and Security Rules, and had limited safeguards in place to protect patients' electronic protected health information (ePHI)."

Ultimately, the physician group was fined $100,000 and required to implement a corrective action plan. "This is one way physicians, as covered entities or business associates under HIPAA and the HITECH Act, will be held liable," say Rose. "Patients sign a HIPAA release form, and the entity agrees to protect their PHI."

If someone who has not been authorized by the patient sends a request for PHI to the physician, and the physician has not received a proper authorization and has not verified who is requesting the information, "it could open the doors to liability," adds Rose.

The HIPAA Privacy Rule sets parameters as to who can view and receive an individual's PHI, whether electronic, written, or verbal, says Rose. Without the proper safeguards in place, an entity that discloses that information to third parties without proper authorization might have breached its duty under the federal Privacy Rule.

Many state laws have patient privacy statutes that parallel federal HIPPA laws, notes Rose. "If the elements of a common-law negligence claim are considered — duty, breach, causation, and damage — then liability based on breaches of the Privacy and Security Rules is possible," she says. ✦

Warning! Patient might sue you for abandonment

Repeated missed appointments, non-compliance, or abusive behavior are some of the reasons a physician might seek to withdraw from providing further treatment to a patient, but what are the legal risks involved?

The primary liability risk is patient abandonment, according to **Robert Berg**, JD, an attorney with Epstein Becker Green in Atlanta.

"Essentially, the patient claims that the physician has an obligation to continue to treat the patient, or at least to assist the patient in obtaining alternate treatment, and that the failure of the physician to satisfy that obligation constitutes abandonment of the patient," he says.

While breach of an ethical obligation typically does not provide grounds for a private cause of action by a patient against a physician, it does provide evidence of the appropriate standard of care required of physicians — which, in turn, usually sets the bar for establishing a medical malpractice or patient abandonment case, says Berg.

In one case, a physician left a practice, and no notice was provided to the patients. **Joshua M. McCaig**, JD, an attorney with Polsinelli Shughart,

Kansas City, MO. "Both the practice and the physician had to deal with various complaints and litigation. If only a simple letter had been sent from the practice and the physician stating that the physician was leaving and that follow-up appointments can be made with other doctors, all of this would have likely been avoided."

Here are risk-reducing strategies:

• Avoid making late entries.

"A late, self-serving note on a reason for terminating a patient would be much more difficult to sell to a jury than a contemporaneous note simply stating what happened," says McCaig.

• The physician should offer to assist the patient in finding alternate care.

This offer is particularly needed in cases in which the patient's condition requires additional treatment, says Berg. *(See related stories on what makes a successful suit likely, below, and how to inform the patient, p. 57.)*

"It is usually appropriate to put a sentence in the termination notice along the following lines: 'Your condition requires additional treatment, and we would be happy to assist you in finding another treating physician,'" Berg advises.

• Provide a copy of the patient's medical record to the new treating physician without charge to the patient.

While most states allow a physician to charge the patient a reasonable amount for copying patient records, it is prudent for the physician to make the transition to the new physician as easy and painless as possible, Berg recommends.

"Little things like not charging for copying and sending the patient record can be the deciding factor in whether the patient sues the physician for abandonment," he says.

Executive Summary

If the physician terminates the physician/patient relationship due to non-compliance, abusive behavior, or missed appointments, the patient might have a successful suit for patient abandonment if his or her condition worsened because of failing to find another physician to provide treatment. To reduce risks:

✦ Offer to assist the patient in finding care.
✦ Provide medical records without charge.
✦ Allow the patient enough time to find another provider.

SOURCES

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Will abandonment lawsuit be successful?

"Bad facts" are the primary reason why patient abandonment claims succeed, according to **Robert Berg**, JD, an attorney with Epstein Becker Green in Atlanta. If the patient promptly finds another physician to provide treatment, a lawsuit is very unlikely, Berg explains, but a jury might go out of its way to find for a patient plaintiff in a case in which the patient's condition worsened following the termination.

"Other exacerbating factors include difficulty, or even failure, in finding another physician to treat the patient, or the additional cost incurred," he says.

Courts generally have allowed physicians broad latitude regarding terminating their patient relationships, says **Clinton R. Mikel**, JD, a partner at The Health Law Partners in Southfield, MI. "We have even seen instances where courts have allowed retaliatory physician-patient relationship terminations, such as group practice physician 1 terminating a patient based on the patient's lawsuit against group practice physician 2," he says.

Most states require a patient to prove that the physician ended the relationship at a critical stage of the treatment; that the physician did not provide the patient with sufficient notice and assistance in seeking other comparable medical care; and that the patient was injured as a result, adds Mikel.

A 2007 Wisconsin case involved allegations that a physician improperly abandoned a patient as a result of the patient filing a malpractice case against the physician.[1] "The physician successfully defended the suit by claiming the patient failed to obtain an expert affidavit supporting the claim," says Berg. "Similar allegations were made in a 2007 Washington, DC, case."[2]

A notorious 2011 Indiana case involved allegations of medical malpractice and patient abandonment, adds Berg.[3] "While it is not clear whether the plaintiff patient was awarded damages for one or both claims, the court did appear to sanction a claim for patient abandonment under appropriate circumstances," he says. "It should be noted that this was one of more than 350 malpractice cases filed against this physician, who had fled the country."

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2. Hill v.Medlantic Health Care Grp., 933 A.2d 314 (D.C. 2007).
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Take these 3 steps with termination

Termination of an acute patient in immediate need of surgery should not be handled in the same way as termination of a healthy patient not in need of specific care, advises **Robert Berg**, JD, an attorney with Epstein Becker Green in Atlanta.

"There is no "one size fits all" way to terminate the relationship," says Berg. Take these steps to reduce risks:

1. Provide notice and assistance in a way that is likely to allow the patient to make a smooth transition to another provider.

Christopher P. Dean, JD, an attorney at Ober Kaler in Baltimore, MD, says, "Don't terminate the relationship during an emotional encounter, and don't terminate the relationship 'effective immediately. An abrupt, or 'hard landing' for the patient makes it more likely that the patients will consider their legal options or complain to the state licensing board."

Shorter notice might be appropriate in a large metropolitan practice where there are many other options for the patient, whereas more notice might be needed if the physician is a subspecialist in a rural area, says Berg.

Dean says, "A patient requiring critical care would need a longer period of time to find another physician than a normal patient. A short letter can document that the physician addressed these needs before seeking to end the relationship."

"Reasonably" assist patient

Terminating physicians are not typically required to ensure that the patient finds alternative care, notes **Clinton R. Mikel**, JD, a partner at The Health Law Partners in Southfield, MI.

"In most cases, it is enough that the patient was given sufficient opportunity to seek alternative care and the physician reasonably assisted the patient in doing so," he says.

The physician's termination letter to the patient should clearly communicate where they stopped the patient's treatment in their continuum of care; if the patient requires ongoing medical care or has a particular issue that needs follow-up, and consequences for failure to do so; and instructions for how to handle medical emergencies, says Mikel.

2. During the notice period, the physician should continue to provide needed treatment if requested by the patient.

"This can be an awkward situation. But if handled properly, it can go a long way toward minimizing exposure to a claim for abandonment," says Berg.

3. Explain in writing, simply and concisely, why the physician/patient relationship is being terminated.

For example: "Please be advised that we are terminating our physician/patient relationship with you, as a result of your continued failure to follow our medical advice. This termination will be effective as of Oct. 31, 2012."

"It is not appropriate to go into extensive detail in terms of the reasons for termination, nor should the notice contain a litany of reasons," says Berg. "This may undermine the physician's defense, should an abandonment claim be made, if even one of the listed reasons is arguably false or not supported by the medical record." ✦

Want to prevent lawsuit? Chart decision-making

Physicians shouldn't rely on 'code of silence'

If patients pursue litigation simply to get answers about what happened, they might be relieved to learn that no malpractice occurred. One widow told **David R. Barry Jr.**, JD, an attorney with Corboy & Demetrio in Chicago, "I'm just glad to know my husband didn't die because someone was asleep at the switch."

"What people often don't realize is that firms like ours protect physicians whose care is reasonable from litigation way more than we sue people," says Barry. "For every lawsuit I file, I probably protect 25 doctors from getting sued."

If the plaintiff's expert sees a clear explanation documented contemporaneously with the event, he or she is much more likely to conclude that no malpractice occurred, Barry explains. "The cases that get litigated for a year or two before a plaintiff dismisses it are those where the records are misleading. There is no way for the attorney and his experts to know an explanation for the problem without discovery," he says. "If the doctor is forthcoming with the patient, all that can be avoided."

If a procedure goes awry or a problem occurs with a treatment modality, document why you did what you did, and why you thought what you

thought, advises Barry. "The audience you are writing that for is potentially a plaintiff attorney, who then sends it out to an expert," he explains. "Someone is going to be looking at those records to determine if a lawsuit ought to be filed."

Physicians also can add contemporaneous documentation to the chart if he or she subsequently speaks to the patient. "If you have a conversation, you can put in, 'Mrs. Smith called and asked for her records. She said XYZ,'" he says. "All you are describing is what happened that day."

Be forthcoming

If an unanticipated outcome occurs and physicians fail to communicate with the patient, they are "at the mercy of comments that subsequent treaters will make," Barry says. "While not actually meaning to stoke the fire, they will say something that translates to the patient that something was done wrong and it shouldn't have happened."

If a patient tells you he or she is going to consult a lawyer, Barry says not to give the impression you aren't being forthcoming. "The old code of silence that used to exist when things go wrong is the surest ticket to litigation," he warns. "The more candid you are, the less likely they will end up suing you to find out what happened."

Physicians might not be able to clearly explain why things didn't turn out well, however, because they aren't sure themselves. "There is nothing wrong with communicating that, as long as you do it in the context of, 'I did things the way I always do them, and we ended up with this outcome, and I don't know why,'" says Barry. If more information comes to light to explain the bad outcome, Barry says to call the patient and tell him or her what you learned.

"If you do end up getting sued, those types of statements bolster your defense," he adds. "When the plaintiff is deposed and says the doctor told them exactly the same thing the doctor is going to say in front of a jury, that type of consistency lends credibility to the doctor." *(See stories on responding to threatened litigation, below and discussing litigation with others, p. 59.)*

Executive Summary

Include an explanation for medical decision-making in the chart to increase the chances of a plaintiff's expert concluding that no malpractice occurred. Physicians should:

- ✦ Be forthcoming with patients if an unanticipated outcome occurs.
- ✦ Add contemporaneous documentation to the chart if they speak to the patient.
- ✦ Contact patients if new information is learned that explains a bad outcome.

SOURCES

For more information about how documentation can prevent litigation, contact:

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Is there a direct threat to sue? Take these steps

Chart accuracy of 'utmost importance'

"I'm going to sue you." If a physician hears words to this effect, "the patient or family should be advised that in light of this statement, which is a very direct threat, the physician-patient relationship and mutuality of trust and confidence has been breached," according to **Andrew S. Garson**, JD, a partner with Garson DeCorato & Cohen in New York, NY.

Accordingly, the patient should seek another caregiver, and the physician should offer names of several colleagues who are recognized specialists, says Garson.

"All of this must be accurately documented, with quotations," he says. "However, it should not contain self-serving remarks, which then can be depicted as a conspiratorial cover-up."

The chart and its accuracy is now "of the utmost importance," says Garson. He has seen situations in which the physician or the office sends a chart to a patient or attorney, or even an insurance provider, and does not make a complete and accurate copy for the physician's later reference. "Then a lawsuit is filed, and the version of the defendant physician's chart is at variance from the earlier copy given to the patient," says Garson. "This results in a multitude of problems for a physician."

If the physician intentionally is destroying or hiding evidence, there can be professional ethical or misconduct charges, the malpractice liability insurance carrier can disclaim coverage, and there can be consideration of a criminal prosecution, he says.

"The potential for a defense on the merits of the medical care rendered is nil," underscores Garson. "This has even occurred in cases where the medical care is proper, but the chart is tampered with." ✦

'Loose lips' will only help the other side

Don't discuss your legal case with others

It's not hard to understand why a physician defendant might complain about the case to a colleague in the privacy of the doctor's lounge. "But that doesn't make it a good idea," says **Joseph P. McMenamin**, MD, JD, FCLM, a partner at Richmond, VA-based McGuire Woods and a former practicing emergency physician.

Don't discuss the situation with anyone except individuals with whom you have a privileged relationship, which includes your attorney, your spouse, your doctor if it relates to your medical care, and your clergyman, he advises. "With the exception of those particular individuals, nothing else is privileged, generally speaking," says McMenamin.

If you engage in dialogue about the case with someone else and the plaintiff's attorney learns about it, that individual might be deposed. "The other party might suddenly find that he is a witness, which is not something he envisioned," he says. "You may not be doing your friend a favor by disclosing all this information about the case. You might convert him into a witness."

Even if you speak about the case at a support group for physicians named in lawsuits, this isn't necessarily privileged. "If it's run by a psychiatrist or a psychologist, maybe you could come up with a patient privilege theory to keep it out of the hands of the other side," he says. "While you might win, I would rather not have to fight that battle. The risk is smaller if your communication is solely with the treating professional."

You might add witness

When a physician gives the name of the person he or she spoke with about the case, that person is likely to be deposed, and the testimony unexpectedly could hurt the defense, says **George B. Breen**, JD, an attorney at Epstein Becker Green in Washington DC.

"You have now added a fact witness who may have a recollection that is different from yours," he says. "A colleague may say, 'I don't remember saying that.' It doesn't mean he didn't say it. It simply means he doesn't recall it, but you end up battling a negative."

After learning a patient has filed a claim, a physician probably will want to review the facts of the care provided. However, be sure that any investigation done of your care is done at the specific and express direction of your attorney, Breen advises, as "you can then have the comfort of knowing your efforts are going to be protected as privileged." ✦

COMING IN future MONths

- ✦ Avoid missed or delayed diagnosis lawsuit
- ✦ Why "hammer" clauses can affect lawsuit's outcome
- ✦ Legal risks of failing to disclose treatment risks
- ✦ Stop charting practices that can lead to litigation

CME OBJECTIVES

After reading *Physician Risk Management*, the participant will be able to:

- describe the legal, clinical, financial, and managerial issues pertinent to physician risk management;
- explain the impact of risk management issues on patients, physicians, legal counsel, and management;
- identify solutions to risk management problems for physicians, administrators, risk managers, and insurers to use in overcoming the challenges they face in daily practice.

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.

2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CME Questions

1. Which is true regarding a "contributory negligence" defense, according to Erin McNeil Young, JD, a partner with Yates, McLamb & Weyher?

A. The defense of contributory negligence is not recognized in medical malpractice actions in any state when the patient has refused or neglected prescribed treatment.

B. The defense of contributory negligence can be recognized only in cases in which the patient has intentionally given erroneous, incomplete, or misleading information.

C. In states that recognize the doctrine of contributory negligence in the context of medical malpractice claims, a plaintiff is completely barred from any recovery when his or her own negligence was a proximate or contributing cause of his or her injury.

2. Which is recommended to reduce risks of emailing patients, according to Kristen B. Rosati, JD, an attorney with Coppersmith Schermer & Brockelman?

A. It is not advisable for physicians to obtain informed consent before using email to communicate with patients.

B. The subject line of the email should include the patient's name, date of birth, or account number to avoid confusion about which patient is being discussed.

C. If emails are not treated as part of the medical record, it is not advisable to keep these communications.

D. Physicians should obtain informed consent before using email to communicate with patients.

3. Which is true regarding liability risks involving termination of the physician/patient relationship, according to Robert Berg, JD, an attorney with Epstein Becker Green?

A. While breach of an ethical obligation typically does not provide grounds for a private cause of action by a patient against a physician, it does provide evidence of the appropriate standard of care required of physicians.

B. Even in cases where continuing care is critical, a civil suit cannot be filed against the physician for patient abandonment or a negligent referral.

C. What happens to the patient following termination of the physician/patient relationship usually does not impact the likelihood of a successful suit for patient abandonment.

4. Which is recommended to increase the likelihood that an expert reviewing a claim will conclude that no malpractice occurred, according to David R. Barry Jr., JD, an attorney with Corboy & Demetrio?

A. Physicians should provide a clear explanation documented contemporaneously with the event.

B. If a procedure goes awry or a problem occurs with a treatment modality, physicians should avoid documenting their decision-making.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

$1.73 million was awarded against a defendant physician for the failure to properly perform a paraspinal injection

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News: A 24-year-old patient's estate was awarded $1.73 million against a physician for negligence in performing a paraspinal injection, medical malpractice, and wrongful death. The patient presented to the physician's family medicine practice for treatment of continuing pain in her neck and headaches following an automobile accident. The patient underwent a paraspinal injection in her neck, which was performed by the defendant physician, a part-time family practice osteopathic physician. The physician injected the patient's C4-C5 cervical nerve root with an anesthetic and steroid solution. Plaintiff's counsel contended that the patient died as a result of the injection.

Background: On March 17, 2005, the mother of the 24-year-old female patient accompanied her daughter to the practice of a part-time family practice osteopathic physician. The patient went for treatment of continuing pain in her neck and headaches following an automobile accident. The mother wanted to ask about the risks and potential side effects of the injection.

... after the physician injected the patient's neck and walked out of the room, she lost consciousness and stopped breathing.

According to the mother, the physician did not discuss any potentially harmful effects and, instead, assured the patient that he had performed the procedure many times with no adverse consequences.

The patient underwent a paraspinal injection in her neck, which was performed by the defendant physician. The physician injected the patient's C4-C5 cervical nerve root with an anesthetic and steroid solution.

Plaintiff's counsel contended that after the physician injected the patient's neck and walked out of the room, she lost consciousness and stopped breathing. The physician was summoned back to the room by the patient's mother. The physician found the patient unresponsive, which prompted him to call his nurse assistant to the room and direct his staff to call 911. The physician initiated CPR, but he could not establish a pulse or regular cardiac rhythm. Plaintiff's counsel also argued that the physician failed to properly monitor the patient's vital signs and did not have a crash cart available for the procedure.

After several minutes of CPR, medics arrived and determined the patient was in a state of cardiac arrest with no ascertainable blood pressure or pulse. Emergency resuscitative measures, including endotracheal intubation, were unsuccessful over the ensuing 30 to 45 minutes, prior to her arrival at the hospital. In the emergency department, providers determined that the patient was severely oxygen-deprived, and ventilation efforts were resumed, including reintubation of her trachea.

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Sandra L. Brown**, **Leanora Di Uglio**, and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Following reintubation, the patient's pulse spontaneously returned, followed by resumption of blood pressure. She then was placed on a ventilator with life support measures.

A neurological consultation later concluded that the patient had suffered a fatal loss of oxygen to her brain and remained neurologically unresponsive during the ensuing five days in the intensive care unit. Further tests confirmed the initial diagnosis, which prompted the hospital physicians to discontinue life support with agreement of the family. The patient was pronounced dead on March 22, 2005.

The patient's sister sued the physician on behalf of the deceased patient and alleged claims of medical malpractice and wrongful death. Plaintiff's counsel contended that the patient died as a result of the injection. Plaintiff's counsel argued that the physician's conduct was below the standard of care. Plaintiff's counsel also alleged the physician failed to obtain an informed consent from the patient. They also argued that the injection was performed in a "blind manner" as the physician failed to use guided fluoroscopy to ensure correct placement of the medication. Plaintiff's counsel further argued that the physician's placement of the injected solution pierced the spinal nerve root sleeve, where it intermixed with the cerebral spinal fluid and prompted an unintended paralysis of the patient's diaphragm and resulted in the patient's asphyxiating before artificial ventilation could be achieved.

Plaintiff's counsel contended that at the time of the injection, the patient was in good health other than having intermittent neck pain and headaches. Plaintiff contended that autopsy results later confirmed that the patient had suffered a fatal loss of oxygen to the brain as a consequence of complications arising from the defendant physician's nerve root injection. Ultimately, plaintiff argued, the physician lacked the proper training to perform the procedure and should have referred the patient to a specialist, such as a doctor in pain management.

Defense counsel argued that the injection was properly done and that the patient had an unexpected reaction to the injection. Defense counsel further argued that the paramedics were responsible for her death due to a problem with intubation.

The jury found the physician negligent and determined that damages totaled $1.73 million, apportioning $920,000 for the patient's sister and $810,000 for the patient's father.

What this means to you: It should be pointed out at the onset that patient safety protocols do not vanish when a procedure is being performed in an office-based setting. Instead, patient safety protocols should be consistent across the continuum of care regardless of the healthcare setting. In this case scenario, it is clear that the physician did not establish clinical or operational patient safety protocols and practices.

In a solo practitioner or group practice office setting, a review process should be in place to ensure there are appropriate clinical and operational policies and practices in effect that will support the safe performance of office-based procedures. In a single physician office setting. this process is particularly challenging. Absent any reimbursement constraints, solo practitioners are basically at liberty to determine what procedures can be done in their office setting. However, that liberty does not eliminate the solo practitioner's professional responsibility to establish clinical and operational policies and practices that support patient safety.

In the described scenario, the defendant physician did not provide evidence that he was competent to perform the paraspinal injection by background or training. When determining whether a procedure can be safely performed in an office-based setting, it is important to ensure that the provider performing the procedure has the required education, training, and competency to do so. For procedures being performed in an office setting, a retrospective review of clinical outcomes will provide information that can be used to identify and intervene in performance trends or system failures that might compromise patient safety. Although a retrospective review process is not ideal, it is a good strategy to use to monitor and mitigate performance issues, undesirable clinical outcomes, and unsafe conditions. For new procedures, a more thorough and rigorous review of peer-reviewed literature would help the physician determine the level of provider and staff training and competency needed to perform the procedure and to recognize and treat medical complications and emergencies.

In our case scenario, plaintiff's counsel contended that the paraspinal procedure was inappropriately performed using a blind method of injection and argued that the more appropriate method would be to perform the paraspinal injection using image-guided fluoroscopy. Obviously, the purchase of a fluoroscope for the physician would have a significant financial impact to his practice. However, this impact does not eliminate the physician's responsibility to use peer-reviewed literature to determine the safety and efficacy of performing the procedure in an office practice setting, while keeping in mind the financial and human resources available to the provider that might impact the purchase of necessary equipment or supplies, or staff training programs.

What is strikingly absent in the case scenario is the lack of nursing involvement before, during, and after the procedure. The physician failed to establish operational and nursing policies that support the provision

of clinical care in a safe manner. There was no evidence of a nursing pre-procedure screening, which is important on an operational as well as clinical level. Operationally, during the pre-procedure screening, nursing staff will confirm the presence of required lab tests, screening forms, as well as the important signed informed consent form. In this particular case, a well-crafted informed consent form with the patient's signature would have shown that the patient was made aware of the risks associated with the paraspinal injection.

Significantly absent in the case description is documented evidence that the physician established protocols that outlined the scope of intra- or post-procedure monitoring. It appears that the physician performed the procedure without nursing staff's involvement to monitor the patient's vital signs and oxygen saturation and that he left the patient unattended at the completion of the procedure. Implementation of minimal patient safety protocols for intra- and post-procedure monitoring in the office setting, combined with a trained and competent nursing staff, might have been sufficient to change this patient's outcome.

In terms of the post-procedure emergency medical treatment, plaintiff's counsel contends that the physician's office was not appropriately equipped to handle the medical emergency. Although the assertion that the physician's office was not equipped with a crash cart might be valid, the presence of a crash cart in and of itself is not salient unless it can be demonstrated that the physician and staff possess the skills and competence in emergency resuscitation efforts. Based on the initial clinical assessment of the emergency medical personnel, it appears that the resuscitative efforts performed by the physician were ineffective.

The described case scenario brings to light clinical and operational opportunities for improvement in this physician's office-based practice. Clinical improvements range from determining which procedures can be safely performed in an office setting to ensuring training and competency of physician and nursing staff to establishing protocols for required pre-, intra- and post-procedure monitoring. Operational improvements range from acquisition of equipment and supplies needed to perform the procedure to establishing an informed consent policy. Had the physician given due diligence to the clinical and operational practices in his office practice, perhaps the clinical outcome would have been different.

Reference

No. 06-5309CI-21, Pinellas County Sixth Circuit, Florida (2011). ✦

$3 million verdict awarded for failure to follow-up, warn of risk of exertion in light of cardiac condition

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News: In March 2009, a 31-year-old husband and father of two young sons was evaluated by a board-certified cardiologist with complaints of increasing episodes of chest pain radiating into his arm. The cardiologist, believing the condition was stable, ordered a nuclear stress test be performed within 1-2 weeks. The cardiologist did not advise plaintiff to avoid physical exertion until the stress test was performed. One day before the nuclear stress test was performed, the patient was found unconscious after a sexual encounter. He died at an area hospital an hour later of coronary artery disease. At trial, the jury found the cardiology group and cardiologist acted negligently in their treatment of the patient and awarded $5 million award to the patient's wife and two sons. The patient was found comparatively negligent, and the award was reduced by 40% to $3 million.

Background: On March 5, 2009, a 31-year-old husband father of two young sons presented to a board-certified cardiologist with a medical history significant for uncontrolled hypertension, hyperlipidemia, and sleep apnea. Plaintiff had complaints of increasing episodes of chest pain radiating into his arm. During the appointment, the cardiologist reviewed echocardiogram test results taken about a month earlier, which showed elevated calcium deposits in his coronaries, enlarged heart ventricles, and aortic regurgitation. The cardiologist's impression of the patient's conditions were:

- chest pain with an elevated calcium score, suspicious for underlying coronary artery disease;
- hypertension with left ventricular

hypertrophy with normal diastolic function and no evidence of congestive heart failure;

- hyperlipidemia with LDL of 140;
- hypertension.

The cardiologist believed that the patient's condition probably was due to his heart, but believed that it was stable. Accordingly, the cardiologist ordered the patient undergo a thallium stress test on the first available appointment and go to the emergency department if his symptoms lasted more than five minutes.

The patient scheduled an appointment for the Thallium stress test for March 13, 2009. On March 12, 2009, one day before the patient was supposed to undergo the stress test, plaintiff had a sexual encounter that included a friend and a woman who was not his wife. After having sexual intercourse multiple times, the woman found the patient unconscious. Emergency medical services were called and upon arrival found the patient unconscious, without pulse and with no spontaneous respiration. Resuscitative efforts were initiated, and the patient was transported to the hospital where he was pronounced dead. An autopsy that included toxicology screening revealed 90% occlusion of the left anterior descending and right coronary arteries, ventricular interstitial fibrosis biventricular hypertrophy, and mild cardiomegaly.

The patient's wife filed suit on behalf of the patient's estate against the cardiology group and cardiologist, and she asserted negligence and medical malpractice. At trial, plaintiff's expert testified that the patient's condition required an immediate and urgent workup. Plaintiff further claimed that the defendants did not instruct the patient to discontinue physical activity until the completion of his cardiac work-up. The defense contended at trial that the cardiologist did warn the patient not to physically exert himself until after the stress test.

The jury found that the cardiology group and cardiologist acted negligently in their treatment of the patient. Specifically, the jury found that the defendants should not have allowed the patient to go home after his last appointment and should have administered a cardiac workup and stress test immediately.

The jury awarded $5 million against the defendants, the cardiology group and cardiologist. The patient was found comparatively negligent, and the award was reduced by 40% to $3 million.

What this means to you: The case scenario describes the wrongful death of a 31-year-old man who was being treated for risk factors associated with coronary artery disease, i.e., hypertension and hyperlipidemia, while undergoing further diagnostic evaluation to determine the extent of his disease. Plaintiff's prevailed with their argument that the physician failed to meet the standard of care by not timely evaluating the decedent's new onset of exertional chest pain and through his failure to appropriately instruct the decedent not to participate in strenuous physical activity until his cardiac work up was completed.

A challenge many risk managers face is determining the best risk mitigation strategy to use when the alleged malpractice focuses on a physician's medical decision-making process. Reviewing compliance with clinical best practices might identify issues with a physician's clinical performance; however, in this case the diagnostic workup recommended by the defendant physician was in accordance with clinical protocols. Risk managers also can review physician documentation to determine whether the physician recorded the decision-making process. In this case, the medical record concisely reflected the defendant's thought process: need for further cardiac workup (i.e., Thallium stress test), treatment of identified risk factors (i.e., lipid-lowering medications, aspirin), and disease prevention strategies, (i.e., health, diet and weight).

Risk managers need to identify and mitigate other factors that might have contributed to this unfortunate outcome, specifically communication between the physician and office staff, and patient education. The defendant physician did advise the patient to schedule the Thallium stress test on the first available appointment, but were communication channels between the physician and office staff in place to notify the physician that the first-available appointment was eight days later? There might be opportunities through the appointment or scheduling programs to alert physicians when diagnostic or follow-up appointments have been made.

The other area that should be given attention as a risk mitigation strategy is the routine use of patient education literature. Although there was evidence that the defendant physician provided instructions to the decedent during their last office encounter, additional patient education literature would reinforce and perhaps expand the content of the information provided by the physician. Including patient education as part of any patient encounter process can assist with improving a patient's health behavior and status and would assist with minimizing the providers risk exposure.

Coronary artery disease does not discriminate among gender, ethnicity, or financial status, as evidenced by its status as the number one cause of death for men and women in the United States. The National Institutes of Health estimates approximately 400,000 people die from coronary artery disease per year. It is no wonder that comprehensive efforts are being made by the healthcare industry to improve the prevention and treatment of this deadly disease.

Reference

2010 WL 8705746 (Ga. State Ct. No. 10C-02212-4, 2010). ✦