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Just a 'curbside' consult? Court might decide otherwise — Both doctors face legal risks

A primary care physician might not want to take the time to initiate a formal consultation, but decides to quickly run something by a specialist to be sure nothing is missed.

These informal or "curbside" consultations, while common occurrences, pose significant liability risks for the referring physician and the specialist in the event of a medical malpractice lawsuit, warns **Sandeep Mangalmurti**, MD, JD, a lecturer in law and fellow at the University of Chicago's Section of Cardiology.

... Informal or "curbside" consultations, while common occurrences, pose significant liability risks ...

If a primary care physician takes action based on a consultant's recommendation and a bad outcome occurs, "the primary care physician is not going to necessarily get away with saying, 'I just did what the consultant wanted me to do, therefore, blame him,'" says Mangalmurti.

Informal verbal consults are inherently dangerous, he says, because the consultant is giving advice without knowing all the facts. The primary care physician can't divert malpractice responsibility without a formal, documented consultation, Mangalmurti explains, and the consultant faces the possibility of a court deciding a doctor/patient relationship was established even if he or she never saw the patient.

"The irony is that if you are just speaking very generally, you are fine. But the more information you get in an attempt to give good advice, the more likely it is that a court is going to find you are generating a relationship with the patient and exposing yourself to liability," Mangalmurti says.

If the consultant has any type of responsibility for the patient, then even an informal verbal conversation, such as an on-call cardiologist answering a general question from an emergency physician about a patient, is likely to be considered by the court as a formal consultation, adds Mangalmurti. "The warning sign that an informal consult is becoming formal from a legal perspective is that it moves from general medical advice to specific advice about a specific patient, including looking at actual labs or test results," Mangalmurti says. "If it smells like a formal consult, then you are better off just making it a formal consult and acting accordingly." Here are risk-reducing strategies:

- Consultants should be careful not to

INSIDE

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make recommendations on areas outside their expertise.

Document that a recommendation was made to address a particular question, advises Mangalmurti, and avoid making recommendations on other areas.

"You don't want to be held accountable for a decision being made that doesn't really deal with your specialty," he says.

For example, a cardiologist might be consulted to comment on an elevated troponin level on a critically ill intubated patient. Though ventilator management might have some effect on cardiac physiology, the consulting cardiologist should take care to not overstep his area of expertise by commenting too specifically on management of the ventilator, says Mangalmurti.

If the recommendation is based on limited information, the consultant should note this. "Certainly if there is some information that you think is essential that you don't have, you should document, 'I am making my decision in the absence of this information,'" says Mangalmurti.

Executive Summary

Informal "curbside" consultations pose significant liability risks for referring physicians and specialists, as the consultant is giving advice without knowing all the facts and there is no documentation.

✦ A court might determine that a doctor/patient relationship existed even if the consultant didn't see the patient.
✦ Consultants should avoid making recommendations outside their areas of expertise.
✦ Referring doctors should provide consultants with all necessary information.

• General practitioners should provide consultants with all necessary information.

Michael M. Wilson, MD, JD, a healthcare attorney with Michael M. Wilson & Associates in Washington, DC, recently handled a case of a patient who had a mechanical urinary sphincter implanted by a urologist, but the nephrologist did not take the time to review the chart and ordered a contraindicated catheterization.

The general physician did not warn the nephrologist of the presence of the mechanical urinary sphincter or review the nephrologist's catheterization order, because the general physician thought that these issues were determined by the nephrologist. "The patient had a catheterization pursuant to the nephrologist's order, and the urethra was permanently injured, rendering him incontinent," says Wilson.

If the consultant reviews the entire chart and discusses the recommendation with the general physician, it not only keeps the referring doctor out of trouble, but it also keeps the consultant out of trouble, since typically they would be jointly liable for any harm to the patient, says Wilson.

The most common reason for medical malpractice cases involving consultants is that the general physician fails

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to inform the specialist of the patient's particular problems, and the specialist fails to carefully review the chart, he says. When something goes wrong, such as administration of a contraindicated antibiotic, specialists typically claim they should have been warned by the general physician, while general physicians claim they relied on the specialist's recommendation.

"These cases would be more defensible for the general physician if he provided the specialist with all the necessary information, such as the entire chart, or specifically warned the specialist of the particular issues that the patient had," says Wilson.

SOURCES

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Avoid claim alleging missed cancer diagnosis

Laboratory or pathology results not sent to the proper physician or not sent at all. Receptionists incorrectly telling patients no follow-up is needed. Computer glitches causing erroneous cancellations of appointments.

Staff or administrative errors such as these often are the basis for successful malpractice lawsuits alleging a delayed cancer diagnosis, says **Kristin Zeender**, a claims consultant at Self-Insured Services Company, a subsidiary of RCM&D, a Baltimore, MD-based consulting company specializing in risk management and insurance.

"Staff should never communicate test results to a patient; nor should they be giving any kind of medical advice," Zeender advises.

In some states, a plaintiff must be able to prove that the claimant went from curable to incurable through the delay, while other states have a "loss of chance" statute that allows for the recovery of monies for the percentage of chance they lost even if they didn't have a greater than 50% chance of survival at the time of the missed diagnosis, adds Zeender. Here are risk-reducing strategies:

• Provide excellent communication with patients and their families, staff, and outside providers.

"Patient satisfaction is often predicated upon how much time the doctor spends in listening to and then discussing the patient's concerns," says Zeender. "Physicians are much less likely to be sued if the patient likes their doctor."

She recommends "drilling down" on a patient's reported symptoms to include onset, duration, frequency, and characterization of the symptoms; creating a timeframe for completion of diagnostic tests to create a sense urgency for the patient; and scheduling a follow-up appointment at the time of patient check out.

"This will give the physician a chance to re-examine the patient, review the test results, and counsel the patient further if needed," she says.

• Make your thought processes clear in the medical records.

"Poor documentation usually works in the claimant's favor if a claim or suit is brought," says Zeender. Creating a differential diagnosis in the patient chart and describing what you are doing to rule in or rule out what is on your list makes a chart much more defensible. In addition, subsequent changes to a chart might be seen as self-serving and could be counterproductive.

"Never go back and alter your records unless you clearly document the reason why you are doing so," says Zeender.

• Be proactive when obtaining test results.

"Seek out the information," says Zeender. "If a test, lab or consult is ordered, it is imperative that follow-up on the part of the ordering physician occurs."

By seeking out the information, not only do you ensure that you have received it, but you also can assure yourself that the patient has complied with your recommendations for follow-up, she explains.

• If you find that the patient has failed to follow your instructions, contact the patient and document it.

"In a handful of states, contributory negligence can bar a claimant from recovering damages," says Zeender. "In the remainder of the states, their recovery can be limited by their comparative negligence." *(For more information on this topic, see the* "Legal Review & Commentary" *supplement enclosed in this issue. Also see "Prove patient's non-compliance: A defense verdict might result,"* Physician Risk Management, *November 2012, p. 49.)*

Executive Summary

Malpractice suits alleging missed or delayed cancer diagnoses might result from administrative errors, such as staff incorrectly telling patients no follow-up is needed. To reduce risks:

- ✦ Give patients a timeframe for completion of diagnostic tests.
- ✦ Seek out results of tests, lab work, or consults.
- ✦ Review the patient's past medical history during visits.

• Review past visits and patient medical history during patient visits.

Often, it is the constellation of symptoms that leads a physician to a diagnosis, and this process might have occurred over several visits, says Zeender.

"Without a review of past visits and history, key information may be overlooked," she says. "Successful missed cancer cases often are won by the plaintiff when it is perceived that the treating physician had 'multiple bites at the apple.'" *(See related story on why missed diagnoses claims occur, below.)*

SOURCES

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Many claims involve failing to order test

Follow up is also factor in delayed or missed diagnosis

Many delayed or missed diagnosis claims come from failure to order the appropriate diagnostic test and/or failure to create a follow-up plan, says **Toni Brayer**, MD, FACP, vice president and chief medical officer of Sutter Health West Bay Region in San Francisco and chair of the underwriting committee of Medical Insurance Exchange of California, a medical malpractice insurer.

More than one-third of all claims against primary care physicians and radiologists are for missed or delayed diagnosis.[1,2,3] "Many of these lawsuits point to a delay in seeing the test result or a problem with handoff of the patient," Brayer says. "Because there can be so many physicians involved in the care of patients, it can lead to confusion about who is responsible for following up with a patient once the test is done," she explains.

These lawsuits can result from system errors or cognitive errors by the clinician, adds Brayer. "The majority of primary care physicians are not happy with their systems for test result follow-up," she says. "Patients go to varied labs and imaging centers. Unless there is a fail-safe mechanism for tracking all orders, some results will fall through the cracks."

EHR triggers alerts

"If all labs and diagnostic tests come to a physician's electronic 'in-basket' and cannot be filed without her signing off on it, the tracking of tests will be much simplified," says Brayer. The electronic health record (EHR) also can trigger alerts for routine screening that is considered standard of care, she adds.

For those physicians without a functional EHR, Brayer says that tracking mechanisms need to be put into place, such as a tickler file with all ordered tests that is followed up by the medical assistant to make sure the patient actually received the proper screening or diagnostic study.

> *More than one-third of all claims against primary care physicians and radiologists are for missed or delayed diagnosis.*

"Nothing should be filed in the chart without the doctor's signed initials on the study," adds Brayer. Patients should be instructed to call the office if they have not heard the test results, and no patient should be told, "If we don't call you, it means everything is normal," says Brayer.

Focus on these areas

"Cognitive errors can never be eliminated," says Brayer. "Clinicians should focus on areas where most mistakes are made and lawsuits are found for the plaintiff."

She recommends these practices:

• Make sure the date on the diagnostic exam is correct and you are looking at the most recent result.

• Make phone calls to referring physicians, and document the information in the medical record.

"This takes time, but is one of the most important steps in effective hand-offs that protect patients and prevent lawsuits," says Brayer.

• Keep an up-to-date problem list. "This can help with complicated patients who have many conditions. It helps the doctor follow up on past issues that may come back," says Brayer.

• Make sure every symptom a patient relates has a corresponding physical exam and follow-up documented in the chart.

• Be sure you have a plan for any clinical finding that has a negative pathology report or imaging study.

"The patient should be instructed to follow-up if the symptoms persist or change, and a time for follow-up should be clearly given," says Brayer. "Charting documentation of this follow-up recommendation is essential."

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Don't risk suit for failing to disclose surgery risks

Cover 'quality of life' risks as part of informed consent

Ninety percent of informed consent disputes involve disagreements about who said what and when, according to an analysis of 481 malpractice claims and patient complaints from Australia involving allegations of deficiencies in the process of obtaining informed consent.[1]

Of the cases studied, 45 involved disagreements over whether a particular risk ought to have been disclosed before treatment. "Many physicians express concern about the scope of their duty to disclose rare and remote risks," says **Marie Bismark**, MD, one of the study's authors and a senior research fellow at the University of Melbourne's Centre for Health Policy in Australia. "These sorts of cases are legally interesting and have given rise to some high profile medico-legal court decisions."

However, the study's findings suggest it is actually rare for a dispute to involve a head-to-head disagreement over whether a particular risk ought to have been disclosed. "It is much more common for informed consent cases to involve a failure to get the basics right: spending enough time with patients, communicating clearly, and talking about common risks," says Bismark. "This is where most disputes arise."

The cases where a doctor did not disclose a risk, and the patient alleged that they should have, mostly involved failure to disclose the risk of chronic pain, potential need for reoperation, possibility of a poor cosmetic outcome, risk of sexual dysfunction, and the risk of visual or hearing loss. "Remember to discuss risks with significant 'quality-of-life' implications, rather than just focusing on conventional clinical risks such as bleeding and infection," advises Bismark.

Document discussion

Anupam B. Jena, MD, PhD, an assistant professor of health care policy and medicine at Harvard Medical School and an assistant physician in the Department of Medicine at Massachusetts General Hospital, both in Boston, has analyzed claims in which patients were told about the risks of not agreeing to a procedure and ended up with a bad outcome after declining the procedure.

In one case, an elderly man presented to an emergency department (ED) with chest pain, and the ED physician and cardiologist recommended hospital admission. "The physicians were concerned that he was having an acute coronary syndrome and risked a heart attack in the near future," says Jena. "The patient felt better and decided to go home."

A week later the patient returned to the ED with a heart attack that he ultimately survived. He sued the ED physician and the cardiologist, and he claimed that he should not have been allowed to go home. "This example raises many issues about what should be expected for informed consent," says Jena. "If a physician informs a patient of the risks and benefits of an intervention, there is an assumption that this eliminates all further risk of malpractice."

That's situation is not always the case, however, says Jena, who adds that even if no malpractice occurred and the claim ultimately is dismissed, the physician defendant would likely incur significant defense costs. "The challenge of the current medical liability system is that even though the physician may not be held liable, there are important downstream costs that have to be incurred to reach that conclusion," he explains. He gives these risk-reducing practices.

- Physicians should specify, verbally and in writing, that the patient was informed of the risks of declining a physician's recommendation.
- Physicians should take the time to explain to the patient exactly why the procedure is necessary and what harm could occur if the patient chooses not to have it.
- To ensure that information is understood, physicians should ask patients to repeat the information back and document the conversation.

"At the end of the day, much of malpractice is about better communica-

Executive Summary

Many informed consent cases involve physicians' failure to spend enough time with patients, communicate clearly, and discuss common risks. To avoid lawsuits:

✦ Discuss risks with significant "quality-of-life" implications.
✦ Specify verbally and in writing that the patient was informed of the risks of declining an intervention or not being admitted.
✦ Discuss alternative treatments as well as the alternative not to treat.

tion between the physician and the patient," says Jena.

If a patient later claims he or she was never told of the risks, the attorney has to verify this information and might investigate the matter by first exploring whether there is documentation of the conversation.

"If not, the matter may boil down to 'he said, she said.' In that case, it is impossible to predict how the claim will evolve," says Jena. "Because defense costs are typically substantial, some insurers may choose to settle the case, rather than take it to court." *(See related story, below, on what physicians must disclose to obtain informed consent.)*

Reference

1. Bismark MM, Gogos AJ, Clark RB, et al. Legal disputes over duties to disclose treatment risks to patients: A review of negligence claims and complaints in Australia. *PLoS Med* 2012; 9(8):e1001283. Doi:10.1371/journal.pmed.1001283. ✦

Legally, what do you need to tell patients?

'Material risks' must be disclosed when discussing treatment with patient

Do you always document that you discussed the risks of treatment with the patient? This practice is a good one, but overly broad or highly detailed documentation of the discussion might work against you in a lawsuit, says **Tammi J. Lees**, Esq., an attorney with Roetzel & Andress in Cleveland, OH.

The general statement "I discussed all material risks with the patient" might not preclude a patient from claiming that he or she was not told about a particular risk that materialized, explains Lees.

"On the other hand, if the physician provides a detailed listing of the disclosed risks, it could be presumed that an omitted risk was never disclosed," says Lees. She advises physicians to use language such as, "the risks discussed with the patient included, but were not limited to…"

To obtain informed consent, the physician does not need to disclose every conceivable risk to the patient but must disclose the "material risks" that are inherently and potentially involved with respect to the treatment, says Lees. If a patient requests to have a benign mole removed, for example, it would be appropriate for the physician to disclose to the patient the risk of being left with an unsightly scar as a result of the removal.

Know scope of disclosure

A physician could be sued successfully for failing to disclose a material risk if that risk materializes and directly causes injury, and the judge or jury determines that a reasonable person would have decided against the treatment had the risk been disclosed prior to the treatment, says Lees.

In addition to disclosing the material risks of the proposed treatment, the physician should also disclose the benefits to be expected from the proposed treatment, any alternatives to the treatment, the associated risks and benefits of the alternatives, and the results likely if the patient remains untreated, says Lees.

Many states have adopted a "reasonable patient" standard, which means that the scope of the physician's disclosure is governed by the patient's informational needs, notes Lees. "A risk is considered material if a reasonable person, while in the condition that the physician knew or should have known the patient was in, would be likely to consider important the risk in deciding whether or not to refuse the proposed treatment," she says.

Roberta Carroll, RN, senior vice president at Aon Risk Solutions — National Health Care Practice in Odessa, FL, says that informed consent is "not a one-stop process. It doesn't have to occur in the hospital setting. It can start much earlier, in the physician's office."

Informed consent requirements vary by state, but in general, should typically include what the procedure is, why the treatment is recommended, reasonable risks, and likely benefits, says Carroll. "One thing people often tend to forget is to talk about alternative treatments, as well as the alternative not to treat," she adds. ✦

Avoid baseless claims of sexual misconduct

Patients might misinterpret examination and pursue legal action

Your examination might have been completely medically appropriate, but a patient might believe otherwise and contact an attorney at the first opportunity.

Erin L. Muellenberg, JD, an attorney at Arent Fox, Los Angeles, has seen several claims involving patients misinterpreting touching and comments.

"In a recent case a physician was doing a Pap smear. As part of the exam, he properly examined the clitoris. Because this was something that she had not experienced in the past, she believed that the doctor was improperly touching her and prolonging the exam unnecessarily," she says. "The same physician also performed a rectal exam that

she believed was outrageous."

Another lawsuit involved a patient with neck pain whose doctor examined her shoulders and chest area. "Because he went close to her breasts, she alleged that he was inappropriately touching her," says Muellenberg. "Always explain what you are doing. Don't assume that the patient knows what you are going to do."

A physician has a duty to treat patients respectfully and appropriately, and sexual misconduct breaches that duty, says **Sharona Hoffman**, JD, LLM, co-director of the Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH. "In addition, some patients go to the police and actually initiate criminal investigation if the misconduct involves improper touching," she warns.[1] Here are risk-reducing strategies:

• Maintain a professional demeanor, no matter how well you think you know the patient.

Avoid making suggestive or inappropriate remarks to patients even in a joking manner, such as commenting on the patient's attractiveness, says Hoffman. Physicians should be cautious with the last patient of the day and avoid suggesting to that patient that they meet after office hours for any social activity, says Muellenberg.

"Even if a physician believes he is helping the patient by offering a ride or anything similar, he needs to be aware that such could easily be used against him at a later time and could cost him his license," she advises.

• Have a chaperone present whenever you are examining the opposite sex.

Simply having a nurse or other clinician in the room when any intimate examination is conducted makes it far less likely that a patient will wrongly accuse a doctor, Hoffman says. If it is just the doctor and patient in the room, it is up to the jury to decide whom they want to believe, she explains.

"A witness will protect the physician more than anything else. When appropriate, have an exam performed by the same sex. The likelihood of accusation is much less," says Muellenberg. She recommends noting that the exam was done in the presence of a chaperone and recording the chaperone's initials, because it will assist the physician in recalling who was present in the event of a future question.

If a patient has a family member or friend present during the examination, this information also should be noted, adds Muellenberg. "Physicians need to realize that they are not just vulnerable during the physical examination, but at any time during the patient's presence in an exam room," she says. "If a physician is taking a history, leaving the door partially open until the examination is started may be a good prophylactic strategy."

• Never examine or interview a minor patient without an adult in the room.

"Asking a teen-age girl if she is sexually active and then having her lie down to exam her lower abdomen could lead to questions and unnecessary scrutiny," Muellenberg explains. *(See related story, below, on actions physicians should take if accused.)*

Executive Summary

Maintaining a professional demeanor and a chaperone's presence can decrease the chances of patients contacting an attorney due to misinterpreting a physician's comments or actions during a medical examination. Physicians learning of allegations should:

- ✦ Contact their insurer and obtain legal counsel.
- ✦ Carefully consider wording of apologies.
- ✦ Make notes only as part of attorney/client communication.

Reference

1. Dr. Shezad Malik Law Firm. Beaumont doctor sentenced for improperly touching two girls. Accessed at http://www.dallasfortworthinjury-lawyer.com.

SOURCES

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Hear rumors you were inappropriate?

Don't make matters worse wwhen facing allegations of inappropriate conduct

The vast majority of cases alleging inappropriate conduct settle, and malpractice insurers often will pay a modest settlement even for weak claims to avoid lengthy and expensive litigation proceedings, according to **Sharona Hoffman**, JD, LLM, co-director of the Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH

"Publicity regarding such allegations is very embarrassing and damaging for physicians. They are often eager to cut the process short," Hoffman says. "Also, the payments are actually made by the

medical malpractice insurers. They have a lot of influence on the timing and extent of settlement."

Immediately contact your insurer and obtain legal counsel if you hear rumors of allegations, recommends **Erin L. Muellenberg**, JD, an attorney at Arent Fox, Los Angeles. "Each accusation is very fact-specific. Any response must consider all the facts and be well-reasoned and thoughtful," she adds. Take these steps if you learn of allegations:

• Consider contacting the patient to explain that you believe firmly that you behaved appropriately and professionally, but that you are sorry if the patient was offended by anything said or done.

"There is some evidence that apologies work well and make patients less likely to sue," says Hoffman. If the patient has hired a lawyer, the claim generally will go to the insurer, and the doctor should consult a lawyer before reacting in any way, she advises. However, if the patient has merely made a phone call or written a letter or email, the doctor might want to contact the patient and have a conversation, Hoffman says.

"In all cases, however, the doctor would be wise to consult an attorney before speaking with the patient in order to avoid doing anything that could compromise his defense in case of litigation or criminal prosecution," says Hoffman.

An apology might be indicated, but careful consideration of how to proceed and what to say is where a lawyer can be of assistance, says Muellenberg. "It is automatic to vocalize a loud and immediate response. However, this may not be the physician's best interest," she says.

Many states have apology laws that prevent an apology from being entered into evidence against a physician in a civil professional liability action, notes Muellenberg. "However, this same exception may not apply if criminal charges are brought," she says.

• Do not alter the record.

"This may be perceived as an attempt to cover up guilt and certainly can be used at a later time to impeach credibility," says Muellenberg.

• If the accusation is not related to the patient's care and the physician feels compelled to make notes, he or she should call a lawyer and then write out the incident for the lawyer.

"That document will then become an attorney/client communication and be protected from discovery," Muellenberg says. ✦

Don't assume you know what's not discoverable

As a general rule, state courts allow a much broader range of privileges than federal courts, says **Michael E. Clark**, JD, LLM, special counsel at Duane Morris in Houston, TX.

For example, while state courts recognize the doctor-patient privilege to protect the information exchanged between a physician and his or her patient, federal courts have not done so yet, except for a Supreme Court decision in 1996 that recognized a psychotherapist-patient privilege, says Clark.

"This means that, for example, if a federal action is brought against a physician for alleged violations of the fraud and abuse laws, as compared to a malpractice action under state law, a physician may find that something he or she considered to be protected may not, in fact, be privileged," says Clark. For example, in a federal prosecution of a physician for dispensing controlled substances outside the realm of accepted medical practice, the various records related to these allegations such as patient charts, progress notes, and prescription records all are admissible as evidence.

Compliance review

Another important, broad privilege that only state courts have recognized is a privilege to protect efforts by physicians and health organizations to determine whether their compliance systems are properly functioning, says Clark.

"In some cases, the so-called self-evaluative or self-critical analysis privilege protects from discovery a compliance review conducted to ascertain or improve a company's or individual's compliance with laws, rules, regulations, or professional standards," he says.

Too often, a coding or compliance person is directly hired by a physician to review billings and coding without the involvement of an attorney, Clark says. "The problem in doing so is there is no way to bring these activities within the attorney-client relationship after the fact so that the person conducting the billing and coding review can be said to have acted as an agent of the attorney, whose

Executive Summary

As a general rule, state courts allow a much broader range of privileges than federal courts, including the doctor-patient privilege and privilege related to evaluating compliance systems.

✦ Courts provide absolute immunity from discovery of an attorney's subjective thoughts.
✦ Documents prepared by an attorney for litigation purposes receive only a qualified immunity from discovery.
✦ Information shared during peer review activities is privileged so long as certain basic due process rights are afforded during the process.

work arguably assists the attorney with formulating legal advice," he explains.

In light of constantly changing requirements, Clark says the question is not "if" but rather "when" big mistakes in coding and documentation will happen. "In the worst case scenario, if an outside billing or coding consultant who is working independently — that is, without reporting to an attorney who represents a physician — identifies and reports such problems so they can be fixed, perhaps by returning overpayments, then the consultant's underlying report is an unprivileged 'roadmap' and subject to discovery," says Clark.

Immunity not always absolute

The two major recognized privileges are the attorney-client privilege and the work product doctrine, says Clark. Although the work product doctrine requires there to be an "anticipation of litigation" before the privilege applies, its protection is broader than the attorney-client privilege, he explains.

This privilege was articulated by the Supreme Court in Hickman v. Taylor, 329 U.S. 495 (1947). It provides that any notes, working papers, memoranda, or similar materials prepared by an attorney in anticipation of litigation are protected from discovery, and it found that a "zone of privacy" is essential for the orderly working of the legal system, Clark adds.

"The 'anticipation of litigation' requirement must not be conjectural or hypothetical, meaning that it has to have some reasonable basis to support anticipating a potential claim or lawsuit," says Clark. For example, if a patient unexpectedly dies at a hospital, and the treating physician seeks advice from an attorney about his or her potential exposure, the discussions between them are covered by the attorney-client and work product doctrine, as are the attorneys' notes and research.

"To invade that privacy, a party must establish adequate reasons that justify the production of such materials through a subpoena or court order," says Clark.

Courts provide absolute immunity from discovery of an attorney's subjective thoughts, such as his or her mental impressions, legal theories, conclusions, and opinions, says Clark.

"Other documents prepared by an attorney for litigation purposes, such as written statements of witnesses, receive only a qualified immunity from discovery," he says. "This may be overcome if a party has a substantial need for the materials and equivalent materials are not available through other means. *(See related story, p. 70, on the peer review process.)*

SOURCE

For more information on what information is privileged, contact:

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Show plaintiff's lawyer claim not worth pursuing

Facts often weaker than expected , according to analysis of claims

Claims involving medical malpractice across specialties are dismissed by the court about 55% of the time, according to a study that analyzed claims litigated from 2002 to 2005 throughout the United States.[1]

"Even more interesting is that only 4.5% of the claims were decided by a trial verdict, [and those verdicts] favored the physician nearly 80% of the time," says **Traci L. Martinez**, JD, an attorney in the Columbus, OH, office of Squire Sanders (US). "About 40% of the cases are settled between the parties."

If 95% of cases against physicians never make it to trial, why do attorneys put so much work into filing them? "While there is no single answer, an attorney may simply pursue the claim because he or she only has one side of the facts or allegations," says Martinez.

An attorney might not realize the facts of the case aren't as strong as he or she thought without expending time and energy filing a claim and going through the discovery process. Attorneys understand that the defense also is incurring costs, adds Martinez. If there are enough facts to raise the possibility that the case will not be dismissed, attorneys might pursue it in the hopes of getting a settlement for their client, she says.

"Sometimes, when an attorney is far down that path, he or she may feel that too much time has been invested to simply voluntarily dismiss their case and will go forward hoping it will not

Executive Summary

More than half of medical malpractice claims are dismissed by the court, partly because attorneys often pursue claims without knowing all the facts of the case before the discovery process.

✦ Attorneys might pursue weak cases due to the amount of time invested.
✦ Defense attorneys can attempt to demonstrate that the amount of damages is insignificant.
✦ The defense should avoid revealing its strategy.

be dismissed by the court," she says.

Opportunity to respond

If the defense can show that the physician's method of treatment was not out of the ordinary and/or that the treatment done was specifically chosen by the patient with full knowledge of the risks, they might be able to demonstrate early to the plaintiff's attorney and the client that the claim is not worth pursuing, says Martinez.

"Sometimes an attorney will first send a demand letter to the physician outlining the alleged negligence and resulting harm prior to filing the lawsuit," she says.

The physician defendant, through his or her attorney, can show the opposing counsel that there is no basis to the claim by attaching the patient consent form, reputable medical articles regarding the same procedure, and/or case law with similar allegations in which the plaintiff's claims were dismissed by the court, says Martinez. "This is an opportunity for the physician to respond to the allegations and demonstrate that the plaintiff will have a difficult road ahead trying to demonstrate that the evidence will meet the legal standard," she says.

The defense also can put forth information showing that the degree of injury and amount of damages ultimately are insignificant. Unless the medical expenses are very high and the period of suffering long, it will not make economic sense for the attorney to purse the claim, says Martinez.

"There are some responses to demand letters where we send absolutely nothing, because we know the opposing counsel and sending over material will not make a difference," she says. Also, relaying too much information early in the litigation could be risky because it indicates the physician's defense strategy, adds Martinez.

"However, there are some cases where you just know the attorney does not have all the facts," she says. "A detailed response can cause him or her to rethink their representation of the case, or make the case ripe for a nominal settlement offer if that makes economic sense."

Reference

1. Jena AB, Chandra A, Lakdawalla D, et al. Outcomes of medical malpractice litigation against US physicians. Arch Intern Med 2012; 172(11):892-894. ✦

Is info discoverable from peer review?

The Health Care Quality Improvement Act and the Patient Safety and Quality Improvement Act provide statutory privileges under limited circumstances involving medical peer review and patient safety review procedures, says **Michael E. Clark**, JD, LLM, special counsel at Duane Morris in Houston, TX.

"If applicable, these are broadly construed statutory privileges and guarantee virtually absolute immunity from suit," he says.

Congress passed The Health Care Quality Improvement Act of 1986 to make privileged the information that is shared during peer review activities, so long as certain basic due process rights are afforded during the process, notes Clark. "It did so in part because the threat of private money damage liability under federal laws discourages physicians from participating in effective professional peer review," notes Clark.

However, if the peer review process is merely a "sham" that doesn't provide the physician with adequate notice, an opportunity to respond, or fair hearing procedures, then the statutory protections won't apply, he says. "Unfortunately, the process can be abused," says Clark. "For example, a financially motivated specialist physician may be able to get a hospital's staff to review a competitor's competency in treating patients and take advantage of these protections."

Congress enacted The Patient Safety and Quality Improvement Act of 2005 for similar reasons, Clark adds. "The goal is to encourage voluntary, confidential reporting of events that adversely affect patients," he says.

The legislation creates Patient Safety Organizations (PSOs) that collect, aggregate, and analyze confidential information provided by healthcare providers so that patient safety risks and hazards can be addressed. "If its provisions are satisfied, then there is a broad protection accorded to those who have shared information," says Clark. ✦

Insisting on your day in court? Think twice!

Settling might be a better option, according to attorney

Physicians might think that they have obtained a victory by being given the right to participate in the decision as to whether a case is settled or goes to a jury, or in some cases mandate that a case not be settled because they want their day in court. However, there are serious implications that most doctors are unaware

of, according to **David W. Spicer**, JD, a healthcare attorney in Palm Beach Gardens, FL.

Medical malpractice lawsuits are time-consuming, expensive, and jurors overwhelmingly rule in favor of the doctors on cases in which liability is not clear, says Spicer. "Jurors rule in favor of doctors on 80% of cases, but the worst cases almost never go to trial," he adds.

Insurance companies have the experience to evaluate cases and know which ones should be tried and which ones should be settled, says Spicer. However, a "defensible" case might mean one thing to the insurance company and something entirely different to the physician involved, he adds.

"Doctors accused of malpractice generally are in the worst position to determine whether or not the case should be settled or go to trial," says Spicer. "The unpredictability of a jury is certainly a factor."

When a doctor, who is intimately involved in patient care and angry over being accused of negligence becomes the decision maker in the lawsuit, "it is a recipe for disaster, both from a licensure standpoint and the potential financial ruin of the physician," says Spicer.

If a physician's insurance policy has low limits and the case has the potential for catastrophic damages, the doctor must evaluate whether to risk his or her entire financial future on the whims of a jury, he adds. "If the doctor tells the insurance company to settle, gives the insurance company full authority as to how to conduct the case, and the insurance company chooses to go to trial, they do so, arguably, with their own money at risk and not the doctor's," says Spicer.

Florida insurance law has been relatively straightforward that if a doctor wants to have the case settled and the insurance company takes it to trial, the insurance company is exposing itself to the excess verdict, not the doctor, he adds. This situation is not the case if a doctor wants to have the case tried and the insurance company simply follows his or her directions, however.

If a doctor demands to take a case to trial, the insurance company can go to trial, and all it has at risk is its policy limits, because any verdict greater than the policy limits is going to fall upon the physician "who, sometimes foolishly, wanted to have his or her day in court," says Spicer. ✦

Executive Summary

Physicians often are unaware of the serious implications of decisions to settle or defend a claim. Some items to consider:

✦ Jurors overwhelmingly rule in favor of doctors on cases in which liability is not clear.
✦ Insurers have experience in determining if cases should be settled.
✦ If insurance company chooses to go to trial, the doctor's funds generally are not at risk.

COMING IN future MONths

✦ When you should – and shouldn't – notify insurer

✦ Protect personal assets before suit is filed

✦ Pros and cons of obtaining higher coverage limits

✦ How early compensation can prevent suits

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 liability risks involved with informal "curbside" consultations, according to s andeep Mangalmurti, MD, JD, a lecturer in law and fellow at the u niversity of Chicago's s ection of Cardiology?**
   A. The primary care physician's ability to divert malpractice responsibility is not affected by whether a consultation is documented or informal.
   B. A court cannot determine a doctor-patient relationship was established by the consultant if the consultant did not examine the patient.
   C. If the consultant gives verbal advice on a patient without a formal consultation taking place, the court cannot determine that a doctor/patient relationship exists even if the consultant is the doctor on call for the department.
   D. If the consultant is the on-call doctor for a hospital department, even an informal verbal conversation is likely to be legally considered as a formal consultation.
2. **Which is recommended to reduce liability risks involving missed diagnosis, according to t oni Brayer, MD, f ACP, vice president and chief medical officer of s utter h ealth West Bay r egion?**
   A. It is not advisable to have a system for follow-up on all ordered tests to make sure the patient actually received the proper screening or diagnostic study.
   B. No screening or diagnostic study should be filed in the chart without the doctor's signed initials on the study.
   C. It is a good practice to routinely inform patients, "If we don't call you, it means everything is normal."
   D. It is not advisable to give patients a timeframe for follow-up with diagnostic studies.
3. **Which is true regarding liability risks involving informed consent, according to t ammi J. Lees, e sq., an attorney with r oetzel & Andress?**
   A. Physicians should focus solely on conventional clinical risks such as bleeding and infection, rather than discussing risks with significant "quality-of-life" implications.
   B. To obtain informed consent, the physician needs to disclose every conceivable risk to the patient.
   C. It is not advisable for physicians to ask patients to repeat instructions back.
   D. If the physician provides a detailed listing of the disclosed risks, it could be presumed that an omitted risk never was disclosed.
4. **Which action can a physician defendant take, through his or her attorney, to demonstrate to the opposing counsel that there is no basis to the claim, according to t raci L. Martinez, JD, an attorney with s quire s anders (u s)?**
   A. Provide reputable medical articles regarding the same procedure.
   B. Provide case law with similar allegations in which the plaintiff's claims were dismissed by the court.
   B. Provide information showing that the degree of injury and amount of damages ultimately are insignificant.
   C. All of the above.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Failure to diagnose herniated disk results in paralysis of male, $15 million jury award

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News: A 36-year-old male presented to the emergency department with complaints of severe neck pain and numbness in his arms and legs. He was discharged from the emergency department with a diagnosis of neck strain. Within a few hours after his discharge from the emergency department, he became completely paralyzed from the chest down. He then returned to the hospital and was subsequently left untreated for nearly two hours. Ultimately, it was determined that the patient's neck pain was the result of a herniated disk that was compressing his spinal cord and causing progressive neurological injury. The plaintiff commenced suit against the hospital and alleged negligent care and treatment. The jury returned an award of $15 million in favor of the plaintiff.

Background: A 36-year-old male arrived at the emergency department of a hospital in Colorado with severe neck pain and numbness in his arms and legs. He was examined by the emergency department attending physician and diagnosed with a neck strain. He was discharged to home. Following his discharge, the plaintiff returned home; however, within only a few hours, he suffered complete paralysis from the chest down. He then returned to the same hospital that previously had discharged him, and he was left untreated for nearly two hours. It later was determined that the plaintiff suffered complete permanent paralysis from the chest down caused by a herniated disc. Apparently, the herniated disc was compressing his spinal cord and causing progressive neurologic injury.

Within a few hours after his discharge from the emergency department, he became completely paralyzed from the chest down.

The plaintiff commenced a lawsuit against the hospital and emergency department physician. The plaintiff argued that the defendants failed to conduct a proper neurologic examination during his admission to the emergency department. Moreover, the plaintiff argued that the emergency department attending misdiagnosed his symptoms as a neck sprain, which the plaintiff argued resulted in a failure to timely and properly diagnose his true condition, namely the disc herniation causing spinal cord compression. The plaintiff also contended that a correct diagnosis was prolonged further as he was left untreated for an additional two hours after returning to the emergency department, even with complete paralysis.

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Tracey A. Reiser, Bruce Cohn, Christopher Warren,** and **Alvin Safran** 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.

The hospital settled with the plaintiff prior to commencement of the three-week trial for an undisclosed amount. Following the three-week jury trial, the jury returned a $15 million verdict. The jury awarded the plaintiff $10 million of the $15 million dollar award for pain and suffering. Due to Colorado's cap on non-economic damages, the award might be reduced, and the plaintiff might recover only $300,000 of the $10 million awarded for pain and suffering. The emergency department physician is now responsible for payment for his respective share of the jury's verdict. This was the largest medical malpractice verdict recorded in Colorado.

What this means to you: A 36-year-old man who does not appear to have any other issues appears in the emergency department with complaints of severe neck pain and numbness in his arms and legs. The physician's diagnosis of neck strain seems somewhat incongruous with the patient's significant complaints, but we always hesitate to "second guess" the physician, particularly in a busy emergency department. In this case, there was a clear misdiagnosis with an egregious result.

As is typical in many medical malpractice cases, the correct diagnosis is evident with 20-20 hindsight, but we need to look at what was going on at the time. It would be interesting to see the root cause analysis of this event. Was the emergency department extremely busy? Was it close to a shift change, or did the emergency department physician have an unusual amount of active patients at the time of his encounter with this patient? Physicians are trained to start with multiple differential diagnoses, eliminate the really unlikely possibilities, and narrow down to the most likely scenario. Did the physician eliminate the most dangerous potential before diagnosing probably the most common etiology of the complaint, the one that he most often diagnoses?

It is unclear in this case what testing was available, or if the doctor considered an MRI or a CT scan to eliminate a serious cause of the patient's complaints. Physicians are given the message by risk managers and malpractice insurance carriers to do everything to be sure of the diagnosis and prevent harm, but they are cautioned by their administrators and patient satisfaction not to order testing just to practice "defensive medicine." We don't have the ability to review the records in detail or look at their internal analysis that might reveal that the volume of patients was high or that the physician might have been dealing with critical patients, codes, or traumas at the same time. Many of the issues in this case hinge on the patient's actual complaints in the medical record and how those complaints progressed while he was in the care of the physician and the hospital.

The articles refer to the patient complaining of severe neck pain and numbness in his arms and legs, but is that the language of the plaintiff's complaint or the language of the medical record? Often in these situations, the patient's condition improves while in the emergency department, which can lead to the conclusion that because the patient is improving, the symptoms are indicative of a more minor condition.

This case has another fact that might have led to a successful result at trial for the plaintiff: The patient returns to the emergency department within hours of his discharge with worsening complaints and was not seen for two hours. Even if the diagnosis at the first encounter was incorrect, the second encounter creates the classical argument of failure to rescue. If the emergency department physician believed the patient to have neck strain initially, the return of any patient within hours to the emergency department should raise red flags and cause an immediate reevaluation of the patient's symptoms with additional testing, consultation, and intervention. We are not privy to the jury deliberations, but it can be safely assumed that the failure to respond timely to the patient's complaints on the return visit heavily influenced the jury in their verdict for the plaintiff.

As always, the emergency department is a dangerous place clinically and legally. The encounters are short, the doctors are under pressure to move patients through the system, and there is usually much less data available to make an appropriate and well-developed diagnosis. The two items that stand out in this case are that physicians in the emergency department must eliminate the most dangerous differential diagnosis before setting on a less serious diagnosis. Taking the facts as set out by the plaintiff, the complaints of numbness might have warranted a more comprehensive workup than the one that was done. The second major teaching point is that any patient who returns with the same or especially worsening conditions should be assumed to be seriously ill and seen immediately. The return of the patient that closely to the first discharge increases the likelihood of a serious condition being present. For this reason, many emergency departments have a protocol that mandates additional testing and the calling of a specialist in these situations.

Reference

Circuit Court for Baltimore City, Case No. 24C11001081 (Md.Cir.Ct. 2012). ✦

Prescriptions of several painkillers leads to overdose, death, and a $1.05 million settlement

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News: A woman presented to her ear, nose, and throat doctor seeking treatment for chronic sinusitis. For years, this defendant doctor had prescribed her painkillers such as oxycodone and methadone for headaches and facial pain. He continued to do so, despite having knowledge that she was receiving these pain medications from other providers. The plaintiff subsequently overdosed on methadone, and died; she was 40 years old. The woman's family brought a civil lawsuit against the ear, nose, and throat doctor, among others. Before trial, the plaintiff settled her claims against this defendant for $1.05 million; her claims against the other defendants settled earlier for $528,000.

Background: A woman presented to her ear, nose, and throat doctor to receive treatment for chronic sinusitis. For years, the defendant doctor treated her, and he had prescribed her oxycodone and methadone for headaches and facial pain.

In 2005, the defendant doctor received a letter from the woman's insurer advising him that she was receiving narcotic pain medications from multiple medical providers. Despite this notice, the defendant doctor testified in a deposition that he continued to prescribe the woman narcotic pain medications.

On Sept. 20, 2006, the woman died at age 40. An autopsy revealed that the cause of death was a methadone overdose. The woman's husband and her five children brought a civil lawsuit against the ear, nose, and throat doctor, among others, and claimed that they caused the woman's death by prescribing her narcotic pain medications despite knowing that she was abusing them.

On Dec. 6, 2011, the trial judge conducted a settlement conference. It resulted in a $1.05 million settlement between the plaintiffs and the ear, nose, and throat doctor. The other defendants resolved their claims with the plaintiffs earlier in the litigation for $528,000.

What this means to you: As the lyrics to the Kenny Rogers classic, "The Gambler," state, "You gotta know when to hold 'em; know when to fold 'em." In this case we find the physician being sued by a non-compliant patient. Complicating the matter is the fact that there appears to be culpable conduct on the part of the physician as well. This case gives us a great opportunity to discuss strategies when you know fairly well that your case is indefensible.

Before we delve into some defense and mitigation strategy, let's go over some risk management strategies in dealing with the non-compliant patient.

In the case at hand, the non-compliance resulted in the misuse and overdosing of pain medication. In most instances, the problem is the exact opposite. Patients are non-complaint in taking their medications according to schedule. The former U.S. Surgeon General C. Everett Koop once remarked, "Drugs don't work in patients who don't take them." With the growth of electronic tracking, more medical insurance companies are taking it upon themselves to proactively notify physicians that their patients are failing to comply with their treatment plans. Often the failure to comply pertains to patients who are not taking their medications or are under-medicating themselves. In this case, the physician was given a "heads up" by the insurance company that his patient was obtaining methadone at the same time from more than one source.

Physicians managing patients with long-term or chronic conditions requiring pain management should keep diligent documentation for any episodes of non-compliance. Careful monitoring of appropriate opiate and/or toxicology drug levels should be undertaken and documented as well. If the physician learns that the patient is receiving simultaneous medications from more than one source, he or she should immediately stop prescribing the medication and cancel any current order(s).

Another technique in dealing with patients who require long-term pain management is issuing of a pain treatment agreement, also called a pain management contract. In this agreement, the physician spells out the expected behavior of the patient with respect to the pain medication

as well as the patient's rights. Typically such contracts include the obligations of the patient to keep the pain medication in a safe place, not share prescriptions with anyone else, keep scheduled appointments, use only one pharmacy, accept prescriptions from only one physician, etc. Whether such contracts are legally binding is certainly debatable, but even if not legally binding, it is hoped that such contracts will deter patients from abusing pain medication.

Finally, and probably among the most difficult of decisions, the physician must decide whether to terminate the physician patient relationship. If the physician works in a hospital, he or she should contact the legal or risk management department for guidance. A physician who doesn't work in a hospital, or for some other reason prefers not to discuss the matter with risk management, might turn for advice to the company that insures him or her for professional liability. Most insurance companies have sample forms to guide the physician through the termination of physician patient relationship process. Before the physician embarks on the termination of the relationship, the patient should be given an opportunity to express any complaints or explanation as to why the patient is finding it difficult to comply with the physician's plan of care. The American Medical Association has guidelines as well at the following web address: http://1.usa.gov/S0mtXm. Although the guidelines might differ slightly, most of them will include a warning that unless the patient's non-compliant behavior changes, the physician will not be able to continue treating the patient. The guidelines will advise the physician to document non-compliance issues. The physician should document that he has informed the patient that failure to comply will result in termination of the relationship. The patient must be informed that you will continue to treat him or her for a certain amount of time, usually 30 days. The patient must be presented with a list of alternate options to receive the necessary treatment. The letter of termination should be sent to the patient's home address by certified mail, with return receipt requested. The physician must be careful to follow these steps in order to avoid any subsequent allegations of abandonment.

The issue of when to terminate the relationship with a non-compliant patient is likely to grow as a risk management issue as "pay for performance" initiatives are undertaken. Physicians might find themselves in the unfortunate position of having to decide whether to maintain a relationship with a non-compliant patient or suffer the economic penalties for a lower performance rating attributable to the non-compliant patient.

In a case in which a successful defense seems highly doubtful, there are still some techniques that can be used. One such technique that is used rarely but could be helpful is to consider conceding liability. The benefit of using such a technique is largely limited to cases in which you want the jury to decide only on a monetary amount of an award and not on liability. You don't wish to anger or unnecessarily inflame the jury by having the plaintiff bringing in medical experts to go through a laundry list of embarrassing departures. The obvious downside is that it guarantees that the plaintiff has won the case. To use this strategy, you have to be reasonably certain that the liability case against the defense is overwhelming.

Another strategy might be to take the case to mediation. A mediator that is acceptable to both sides is chosen. The mediator will try to bridge the gap between the two sides. This strategy will be most successful only if both sides are serious about settling the case and both sides are willing to compromise. There is virtually no point in going to mediation if the defense is taking a "no-pay" position on the case, particularly if there is only one defendant.

In some states, judges are taking a proactive approach and attempting to reach early resolutions in cases when it seems apparent that it is in both parties' interest to settle the case quickly without taking the case to trial. The rationale for this approach is that most cases settle out of court anyway. Why go through the additional time and expense of obtaining medical experts, incurring large legal fees, and making people lose time from work for depositions, if the case is going to settle out of court anyhow? In the above case, it appears that the judge helped the parties reach a settlement.

In the post-Michael Jackson world, we know that this type of case can be quite problematic and result in unpleasant consequences. Perhaps one of the strongest reasons for making every effort to settle this type of case as quickly and quietly as possible is to avoid the likely adverse publicity that this type of case is capable of generating. Knowing when to "fold 'em" might be a small price to pay in avoiding a shark-feeding frenzy by the media, charges of professional misconduct, or even criminal charges.

Reference

Superior Court of New Jersey, Morris Vicinage, Docket No.: MRS-L-2748-08. ✦

PHYSICIAN *Risk Management*

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When looking for information on a specific topic, back issues of Physician Risk Management *newsletter, published by AHC Media, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcmedia.com.*