PHYSICIAN Risk Management

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Patient harmed? Early compensation might prevent costlier malpractice suit

'Laying low' is not best approach

"Good or bad, we are going to be extraordinarily objective and transparent in our review of patient care, to the point that it's probably going to shock you." This is the first thing plaintiffs and their attorneys are told when meeting with representatives of Schumacher Group, a Lafayette, LA-based healthcare resource company.

Next, they're warned that the group expects the same degree of objectivity and transparency in return. "In discussing our review of the care, we do caution that we have and will mount a tough defense if at any point we find we are being taken advantage of," says **Ryan Domengeaux**, JD, the group's vice president of risk management and internal counsel.

"We tell patients or their families, 'We have carefully reviewed the patient care at issue. Here's what did well, and here's what we could have done better,'" he says. "People are sometimes flabbergasted by how candid we are in discussing our review of the care."

"People have to learn to talk to each other again face to face, and not always through their attorneys or mediators," says Domengeaux. "We have seen time and time again that face-to-face interaction is a catalyst to resolution and a rewarding experience for all involved."

"We have seen time and time again that face-to-face interaction is a catalyst to resolution and a rewarding experience for all involved."

The group has had a disclosure and offer program in place for seven years. "We believe strongly in a path to early resolution of any concerns, claims, or adverse events," says Domengeaux. "Early disclosure, honesty, and empathy are all critical factors in resulting claims quickly, which benefits the patients, their families, and the providers. No party wins by hiding the truth or prolonging resolution through protracted litigation."

While apologies aren't necessarily given for the care provided, providers routinely offer sincere apologies for the situation that the patient and family find themselves in. "I have never experienced a candid conversation or an apology being used against us or our providers in any case we've ever been involved in," says Domengeaux. "That is true even

INSIDE

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when the provider has admitted fault in writing."

The group's claims close in an average of 11 months for claims filed out of state and close in an average of 18 months for claims filed in Louisiana, he reports. Schumacher Group has also experienced a decrease in the frequency of claims filed and the severity of claims costs, despite a consistent increase in patients seen annually.

"Statistically, we are closing claims probably two to three times quicker than anyone else is experiencing," Domengeaux says. "Sure, our practice of managing disputes saves us money. But more importantly, we get to bring some peace and resolution to the patients and their families and the providers much quicker than usually everyone expects."

Resistance remains

Some plaintiff attorneys won't allow their client to meet face-to-face with the Schumacher Group and their providers, and they assume the group has ulterior motives. Even their own defense counsel are sometimes skeptical of this approach when first coming on board.

"We knew it would be somewhat of an uphill battle when we instituted this program. Frankly, we are still experiencing some resistance from other codefendants," Domengeaux acknowledges. "There are still many folks involved in the litigation process that don't believe in our approach. They just have a tough time believing that ours is the right path to take. Many still believe that discovery and litigation must precede any resolution — that is, until they give our approach a chance and see that results."

Individual providers or small practice groups might find it harder to take an open, candid approach when dealing with claims, he adds. "They might not have as much latitude as we have. They have to answer to an insurance company, and the majority are not yet at the point where they understand the benefits of early candid and transparent conversations about resolutions," says Domengeaux.

Malpractice liability carriers might fear that a physician group is setting a bad precedent with early offers or sending a message to plaintiff attorneys that they give in too easily. "I can tell you that we've been doing this for seven years, and we have not seen an adverse trend," Domengeaux says. "It's quite the opposite. We are receiving less claims

Executive Summary

Disclosure and early offer programs are becoming more commonplace due to increasing evidence that claims are resolved earlier and malpractice costs are less, but most defense attorneys and liability carriers still resist this approach.

- ✦ Individual providers or small practice groups might find it harder to take an open, candid approach when dealing with claims.
- ✦ Providers can apologize for the patient's situation without apologizing for their care.
- ✦ Some malpractice insurers offer real-time coaching in disclosure.

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than we received before, and others are starting to buy into the process."

Litigation is often avoided, but not always. "We have had discussions where people have not pursued claims, where we realized that we need to compensate people, and everything in between," he says. "What our patients and their families really want at the end of the day is an opportunity to be heard, so we give them that with an open mind and heart.'"

Approach spreading rapidly

Disclosure and resolution programs are becoming more the norm than the exception, according to **Thomas H. Gallagher**, MD, professor of medicine and professor of bioethics and humanities at the University of Washington in Seattle.

"We are seeing this take off on a large scale. This model is spreading rapidly," he reports. "The evidence is beginning to accumulate that this approach really does make sense."

After the University of Michigan Health System implemented a disclosure-with-offer program to patients for medical errors in 2001, the average monthly rate of new claims decreased from 7.03 to 4.52 per 100,000 patient encounters, the average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters, and median time from claim reporting to resolution decreased from 1.36 to 0.95 years, according to a study that analyzed claims occurring in 1995 to 2007.[1]

Many existing programs involve large self-insured academic health centers, but even smaller physician groups should be thinking about how they can implement a disclosure and offer program, according to Gallagher. "For a while now, it's been really clear that the absence of disclosure is something that fuels claims, and makes them more expensive and difficult to settle," he says.

Malpractice insurers across the country are adopting this approach, Gallagher adds, and some offer real-time coaching in disclosing errors. *(For information on training, see resources, this page.)* There is growing awareness that patients expect disclosure of even minor errors, he says.[2,3,4]

"We also know that the absence of disclosure makes patients unhappy in the clinical setting, and if it goes to court, leads to higher awards," Gallagher says. "It makes the jury angry that the doctor and hospital concealed what happened."

Disclosure and resolution programs are becoming more the norm than the exception.

Of the seven demonstration projects sponsored by the Agency for Healthcare Research and Quality in 2012 related to patient safety and medical liability reform, several involve disclosure and resolution. "But what is even more exciting is that the plaintiff attorneys, medical and hospital associations, and malpractice insurers, which typically fought against one another, are recognizing that this is something they can all come behind and support," says Gallagher.

Physicians need to recognize that reaching out to the patient is much more likely to help the situation than it is to hurt the situation, emphasizes Gallagher. "When something goes wrong, lots of physicians wonder whether the best approach is to sort of lay low and wait until the patient complains or a claim is filed," he says. "They worry that being proactive might lead to a claim when one wouldn't have happened in the first place."

"Laying low" has significant costs not only for the patient, but also the physician, he explains. "It not only makes the patient angry, it also keeps the physician from participating in efforts to understand what happened," says Gallagher.

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4. Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: a review of the literature. *Arch Intern Med* 2004; 164(15):1,690-1,697. ✦

SOURCES/RESOURCES

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• Seattle-based Physicians Insurance is collaborating with healthcare organizations on a demonstration project designed to improve communication, including a Disclosure and Resolution Program. It offers training to its providers in how to disclose errors. For more information, go to http://bit.ly/WaaZHc.

• An online disclosure training program for physicians and nurses and other front line staff in acute and long-term settings is offered by Sorry Works! The program teaches physicians and nurses how to empathize and stay connected with patients and families post-event without prematurely admitting fault. Cost is determined by the number of healthcare providers taking the class. To participate in a free webinar, send an email to doug@sorryworks.net. For more information, go to http://bit.ly/TLplnk. ✦

Higher coverage limits could make you a target

You might be seen by plaintiffs as a 'deep pocket'

Physicians carrying a high coverage limit can make themselves a target as a "deep pocket" for any incident or claim, warns **Elke Kirsten-Brauer**, Dipl-Kfm, executive vice president and chief underwriting officer for MGIS Underwriting Managers, a business unit of The MGIS Companies, based in Salt Lake City, UT.

"The selection of an appropriate limit of liability is a critical element of medical-professional liability coverage," says Kirsten-Brauer. "Your professional broker is there to assist you in this decision." She says to consider these items:

• With the trend of hospitals or health systems buying medical practices, some physicians will be covered by the hospital's captive or liability program.

"This may provide higher limits to the physician than what they may get on their own," says Kirsten-Brauer.

• If physicians practice in a state with joint and several liability laws, they might not want to carry higher limits so they do not become the target defendant.

• Coverage requirements not only depend on hospitals or preferred provider organizations the physician contracts with, but also state requirements.

Physicians operating in multiple states have to consider such state's unique limit and/or state fund requirements, Kirsten-Brauer says.

"Since the last malpractice availability crisis, the limit of 1 million/3 million is most common for a physician's professional liability coverage in most states, though states have different requirements," she says.

• Physicians who own or operate a surgery center or endoscopic center should require contracting providers to carry their own specific set of limits with a financially strong, rated carrier.

• Liability limits should bear a reasonable relationship to the physician's overall net worth.

"You want the limit high enough so the plaintiff is not eyeing your personal assets because your liability limits seem inadequate to cover the claimed loss," says Kirsten-Brauer.

• Physicians normally should keep coverage limits in line with what others in their profession are carrying.

"It is important that your limit of liability be perceived by actual and potential claimants as reasonable within the context of the broader professional community," she says.

SOURCE

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Executive Summary

Physicians carrying higher coverage limits might become a target defendant as a "deep pocket." Consider these items:

✦ Physicians operating in multiple states have to consider each state's requirements.

✦ Physicians owning or operating surgery or endoscopic centers should require contracting providers to carry their own specific set of limits with a financially strong, rated carrier.

✦ Physicians should normally keep coverage limits in line with what others in their profession are carrying.

Frustrated with a patient? Don't let it show in chart

Otherwise you might lose case that is otherwise defensible

While most physicians would think twice before using strong, unflattering language to describe a colleague in a patient's chart, they might not exercise the same degree of caution when documenting their impression of their patient.

"In my experience, inflammatory characterization of a patient is never helpful in defending a case. It should be avoided as a matter of practice," says **Joshua M. McCaig**, JD, an attorney with Polsinelli Shughart in Kansas City, MO.

McCaig handled two cases in which an upset patient acted rudely during an office visit and the physician documented the events. "In one case, the physician used words like 'immature' and 'babyish' to describe the patient, yet never described a reason for the patient's actions," he says.

"Instead of walking into the deposition confident about his care, the physician was immediately required to defend his choice of words and his characterization of the patient. Eventually,

he was backed into a corner and admitted his choice of words was poor," says McCaig. "More than just make him look bad, this called into question his ability to appropriately document information." Since the defense of the case hinged on the information in the records, the patient's attorney attempted to infer to the jury that the physician's records were untrustworthy.

Patient behaved violently

In the second case, the physician was called into a difficult situation in which a patient was behaving violently in the clinic and using inappropriate language toward the staff. After dealing with the situation, the physician wrote an objective note with no colorful language, documenting why the patient was upset and the steps that were taken to deal with the situation. "When it came time for deposition, this physician simply relied upon his note to describe the incident," says McCaig. "He came across as being professional and level-headed. This is a quality a jury looks for in a physician, and, needless to say, we were able to use this to our advantage."

The case with the good record eventually was dismissed without payment, and the case with the poor documentation was settled. "The bad note did play a part in our overall consideration for settling the case. It did not help the overall posture for defending the case," says McCaig.

Although the primary purpose of a medical record is to document patient care, during litigation a medical record provides the jury with insight into the character of the physician, says McCaig.

"The significance of medical records can never be overstated," he emphasizes. "Through the details within the notes, the juror forms an opinion about the physician's attention to detail and his or her professionalism."

> *... during litigation a medical record provides the jury with insight into the character of the physician.*

Regardless of the situation confronting a physician, medical record charting always should be objective, says McCaig. The average juror expects a physician to be a caring professional who is devoted to healing the sick, he explains, and once the juror forms a negative perception of the physician, it is difficult to undo.

"Whether or not the physician is liked by the jury often makes the difference in the verdict," says McCaig. "While a typical juror wants to believe and like a physician, he or she is also looking for a reason to give a sympathetic plaintiff money."

SOURCE

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Executive Summary

Physicians should avoid inflammatory characterization of patients when they are documenting, as this action can make an otherwise defensible case difficult to defend.

- ✦ Write objective notes with no colorful language.
- ✦ If patients are upset, document the steps taken to deal with the situation.
- ✦ Remember that inflammatory charting about a patient likely would give jurors a negative perception.

Conflicts in chart? Expect attack on your credibility

Explain discrepancies in the medical record in real time

A discrepancy in the patient's medical record is something that a physician defendant can expect a plaintiff's attorney to take full advantage of.

"Plaintiff attorneys routinely look for chart discrepancies and inconsistencies," says **John Davenport**, MD, JD, physician risk manager of a California-based health maintenance organization. "Even when they don't have a direct connection to the allegation, they can be used as evidence of general carelessness and, at worst, untruthfulness."

If two healthcare providers chart inconsistent information regarding the same patient, plaintiff's counsel will use those inconsistencies to show that either or both providers were negligent and not paying attention, warns **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas.

"When there is an obvious difference in the physician's findings, I would recommend he explicitly note, 'Though the nurse documented condition A, on re-examination the physician found

condition B,'" says Davenport.

A nurse's documentation might note something about the patient's color, temperature, or vital signs, for example, which a physician's charting done close in time doesn't mention or describes in a completely different way. "This type of inconsistency may cause a jury to think a physician did not perform a complete exam or assessment," says Stimmel. She advises physicians to review the nurse's notes, and if discrepancies are noted, to discuss them with the nurse prior to charting, with future charting clarifying the inconsistency.

"Different opinions by different physicians can occur," she says. "However, an effort to have a unified plan of treatment will make a strong defense in a lawsuit."

If you disagree with another provider's charting, resist the urge to criticize or correct the provider in the patient's chart. "In my experience, criticizing other healthcare providers in the chart hurts both sides," says Stimmel. "Use the chart to clarify your opinions so that you are protected, but chart objectively."

In one case Stimmel defended, the physician charted that a nurse did not tell him of a change in skin assessment during a phone call, and if the nurse had done so, the physician would have come in to see the patient. "In the subsequent lawsuit, the nurse was alleged to be negligent for failing to inform the physician of all pertinent changes in condition," says Stimmel. "In that same lawsuit, the physician was criticized for not asking the right questions of a nurse and accused of relying on nursing staff for medical diagnosis." *(See related story on avoiding inaccurate charting in EMRs, below.)*

SOURCES

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Executive Summary

Inconsistent information in the patient's chart can be used by plaintiff's counsel to depict physician defendants as negligent. Physicians should:

- ✦ Address conflicting information in the chart.
- ✦ Discuss discrepancies with nurses.
- ✦ Avoid criticizing or correcting providers in the patient's chart.

Your EMR charting might be provably false!

Physicians should not document impossibilities

Does your electronic medical record (EMR) indicate that you performed a full neurological examination for a patient who presented with a sore throat, cold, and headache?

Entering an overly complete history and examination on a patient presenting with a minor or simple complaint is one danger with EMRs, especially when time-stamping makes such a lengthy examination unlikely, warns **John Davenport**, MD, JD, physician risk manager of a California-based health maintenance organization.

Carelessly documented impossibilities can make a physician defendant appear untrustworthy. "In one recent case, a full preoperative clearance exam was entered and documented more than 20 minutes before the patient was documented to have arrived," reports Davenport.

Plaintiff attorneys have several goals in examining the patient's medical record, he explains. "The first is to find documentation that you acted below the standard of care," he says. "The second is to show that you are careless. The third, and one of the most powerful, is that you are not truthful."

EMRs "easy to abuse"

While EMRs are more efficient than paper charting, some of the factors that make them easy to use also make them "easy to abuse," says Davenport. "Such full and automated documentation sometimes leads to discrepancies in the chart."

For example, an automated phrase documenting a patient's pelvic exam with notation of a normal cervix is not credible in a patient who has had a full hysterectomy.

Davenport says he has seen an obviously incorrect finding entered into the chart become an issue many times in medical malpractice litigation, such as a male-specific exam performed on a female patient, and inappropriate responses to clearly abnormal laboratory or X-ray findings.

"A plaintiff attorney might ask both the plaintiff and the defense expert if the medical standard of care required accurate charting, followed up by a question if the defendant's charting was accurate," says Davenport.

Inaccurate charting makes the physician defendant's charting weaker and the case more likely to be settled, he adds. "When one or two keystrokes can populate a complete and thorough note, there is the risk of accidentally or carelessly entering false documentation into a patient's chart," Davenport says. "Such entries can lead to an attack on the physician's credibility." ✦

Defend non-compliance with guidelines in chart

The plaintiff's attorney will use it against you

If the reason you didn't comply with a clinical guideline isn't explained in the chart, a case alleging medical malpractice suddenly will become much harder to defend.

"It is important to show both your clinical reasoning and that there was an adequate reason to deviate from the guideline," says **Jonathan M. Fanaroff**, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

For example, some guidelines recommend when a sepsis evaluation should be performed on newborns, as well as when antibiotics should be started. "If antibiotics are not started and there is an adverse outcome as a result, there could be liability," says Fanaroff. While some physicians are simply unaware of guidelines, others disagree with the reasoning and elect a different course of treatment, he explains.

A relevant clinical case was decided by the Mississippi Court of Appeals in 2006 involving a patient who was injured in a car accident and sustained burns to 18% of his body, as well as a severe inhalation injury.[1] The patient developed a bedsore and sued for malpractice, claiming that the hospital was liable for failing to turn him once every two hours to prevent bedsores, as recommended in national guidelines as well as the hospital's own policy.

"The defense countered that guidelines are by definition suggestions and not strict requirements, and that nurses and physicians have discretion to deviate from the guidelines if such a departure is warranted by the patient's condition," says Fanaroff.

The physicians noted that every time the patient was turned to his side, his airway clearance was obstructed and his saturation would plummet. They decided that keeping the patient in the supine position gave him the best chance to stay alive.

The court agreed that this was not negligence, noting that "…it is clear that [the hospital's] decision to turn [the patient] less often than suggested by its internal guidelines was a product of reasoned medical analysis."

Fanaroff says a case such as this one could be more defensible with documentation such as, "Patient noted to have airway obstruction and desaturations whenever he is turned to the side. As a result, we are unable to turn him." It shows the rationale behind the decision-making, he says.

"If following the guideline doesn't make sense for a particular patient, the physician needs to document why they are choosing a different diagnosis or treatment option," he advises. *(See related stories on what items to document if you're intentionally deviating from guidelines, below, whether guidelines establish the legal standard of care, p. 8, and whether guidelines will be admitted into evidence, p. 9.)*

Reference

1. Vede v. Delta Regional Medical Center 933 So.2d 310 (Miss. Ct. App. 2006).

SOURCES

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Executive Summary

Intentional non-compliance with clinical guidelines should be explained in the chart, as otherwise this non-compliance can be used against physician defendants. Physicians should:

✦ Acknowledge their knowledge of a guideline.
✦ Explain that there was an adequate reason to deviate from the guideline.
✦ Include peer-reviewed journal articles and colleagues' agreement with their approach.

Deviating from guidelines? Take these steps

If you are intentionally deviating from nationally accepted guidelines, consider these risk-reducing practices given by **D. Clark Smith Jr.**, JD, an attorney at Smith Moore Leatherwood in Greensboro, NC:

• Make explicit notes in the chart as to why you are taking the course of action you are prescribing and why you

are deviating from the usual course.

"This should be explained sufficiently to answer any questions by anyone reviewing the chart, either simultaneously or in retrospect," says Smith. He advises including these items:

- objective findings;
- subjective findings;
- test results;
- diagnoses;
- the usual course of treatment, based on guidelines;
- the reason this case is different and calls for a different course;
- acknowledgement of guidelines and their source;
- a detailed explanation of the different course of treatment you are prescribing and why it is preferred;
- an explanation of the outcome you are trying to obtain with the different course of treatment.

Smith defended a physician in a medical malpractice case who had to explain why general guidelines weren't followed for a particular patient. "Unfortunately, he did not document this position in the chart," he says. "I believe the case could have been avoided if he had done so, because he won the case after he explained his position in court and had experts support him."

For this reason, it is important for physicians to acknowledge their knowledge of a guideline and then state why they are not following it, says Smith. "This will help tremendously to convince a jury that the physician was competent and was intentional about his course of treatment, and not that he inadvertently failed to follow a guideline of which he was unaware," he explains.

• If you are familiar with a peer-reviewed journal article that supports your position, reference it in the medical record.

• Obtain second opinions from other physicians, and document their agreement with the prescribed course.

Physicians should request a formal consultation, says Smith. They explain the potential conflict between the prescribed guideline and their alternate course of treatment and the reasons for consideration of the alternate treatment, he says. They specifically should ask the consultant's opinion as to which way to proceed, Smith says.

If an informal consult is given, physicians should explicitly describe any discussions they had with other physicians, the identity of the physicians, the facts discussed, and the conclusions reached, he advises. "It is quite possible the consultant may not want to go on record because of fear of liability," says Smith. "This should be a strong indication to the attending of the position experts will take against him if the matter ends up in litigation."

This approach should help to persuade the physician to follow the guidelines instead of an alternate course of treatment. "In other words, if the attending cannot get support from other physicians and/or consultants for his position to ignore the guidelines, he should abandon his position," he says. ✦

Can guidelines prove breach in standard of care?

Be warned: The plaintiff's experts might say that is so

Guidelines, per se, cannot be used to establish the standard of care, as this must be established by an expert, says **D. Clark Smith Jr.**, JD, an attorney at Smith Moore Leatherwood in Greensboro, NC.

However, if the expert incorporates the guidelines into his or her opinion of the standard of care, they then can be used to establish standard of care, he adds. For example, the American College of Obstetricians and Gynecologists (ACOG) has published guidelines and committee opinions for several years. Smith has seen many plaintiff experts testify that these guidelines and opinions are the same as the standard of care in a particular locality. This effectively allowed the ACOG guidelines and opinions to become a statement of standard of care in that particular case, he explains.

This action occurred in spite of the cautionary language in each guideline or opinion that the document reflects emerging clinical and scientific advances as of the date issued and is subject to change, and that the information should not be construed as dictating an exclusive course of treatment or procedure to be followed, notes Smith.

"I have likewise had defense experts who argued the ACOG guidelines were just that — guidelines — and they were not to be interpreted as standard of care because they cannot define the acceptable conduct in every case and must be interpreted under the specific facts of the particular case," he says.

Guidelines often are used against defendant physicians by getting them established by a plaintiff's expert as the standard of care, explains Smith. "The expert then will explain how the defendant deviated from following the guideline and will opine that the failure to follow the guideline is a deviation from the standard of care, which of course equals malpractice," he says.

Prove standard of care

Non-compliance with clinical guidelines "absolutely does not mean that the standard of care was breached," says **Jonathan M. Fanaroff,** MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

"It is important to remember that standard of care is a legal concept and must be proven in every individual

case," he underscores. In addition, many guidelines have specific disclaimers noting that they do not indicate an exclusive course of treatment or serve as a standard of medical care.

"Finally, there clearly are situations in clinical medicine where deviating from the recommendations of the guideline will be appropriate," Fanaroff says.

Physician defendant's response

Guidelines can be used against a physician if he or she failed to follow a guideline and the plaintiff's testifying expert opines that the standard of care required the physician to do so, says **Patricia Egan Daehnke**, JD, managing shareholder in the Las Vegas office and shareholder in the Los Angeles office of Bonne, Bridges, Mueller, O'Keefe & Nichols.

"The weight to be given to the guideline depends in great part on how the plaintiff's expert testifies," she says.

The physician defendant might respond by pointing out that guidelines do not replace a physician's clinical judgment, are not intended to be the action to be taken in every case, and that the guidelines were created for a different purpose.

The standard of care is generally defined as that level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful medical practitioners would possess and use in similar circumstances, not what an organizational checklist sets forth, adds Daehnke.

"And of course, the physician would present testimony as to his or her awareness of the guidelines and expert testimony as to the reason why the standard of care did not require such action be taken, whether set forth in a guideline or not," she says. ✦

Will guidelines be admissible?

They're both a 'sword and a shield'

Usually, it is the plaintiff who seeks to admit evidence of physician noncompliance with certain guidelines as evidence of malpractice, says **Patricia Egan Daehnke**, JD, managing shareholder in the Las Vegas office and shareholder in the Los Angeles office of Bonne, Bridges, Mueller, O'Keefe & Nichols. However, several states have allowed physicians to introduce evidence of compliance with relevant guidelines to show the physician met the standard of care.

Whether the jurors will be allowed to hear evidence of proffered guidelines depends to a large degree on the law the jurisdiction uses regarding the admissibility of expert opinions and the individual trial judge, Daehnke explains.

If the testifying expert attests that the guidelines are "reliable authority and relevant" or that the expert relied upon the guidelines in formulating his or her opinion as to the applicable standard of care, and the trial judge ultimately deems the guidelines relevant to the standard of care issues in the case, for example, the guidelines will be introduced into evidence.

Quality varies

Guidelines appear to be key to the U.S. government's efforts to enhance the quality of clinical care, as evidenced by the Agency for Healthcare Research and Quality's investment in the development of clinical practice guidelines, says Daehnke.

In addition, clinical practice guidelines have proliferated over the last decade from government agencies, professional medical societies, managed care groups, the insurance industry, other healthcare payers, and peer-review organizations.

"However, these guidelines vary in scope and quality," says Daehnke. "Most are designed to meet the needs of the promulgating organization, rather than defining the applicable standard of care for the clinician." For example, guidelines created for utilization review by payers or those promulgated by specialty societies sometimes conflict with other standards.

"Thus, there is a strong argument to be made that guidelines do not, nor should not, define the standard of care," says Daehnke. "Nonetheless, in litigation and at trial, guidelines may be used as both a sword and a shield." ✦

With electronic medical records, make these charting changes, and make the record defensible

An ear, nose, and throat examination might not be necessary for a patient presenting with right-sided chest pain, but if the electronic medical record's (EMR's) screen is left blank, this blank could become a pivotal issue during a malpractice suit.

"It's always better to put 'N/A.' If the record has to be defended, the physician can speak to the reason there was no need to do the exam," says **Karyn Finneron**, RN, BSN,

MA, HNB-BC, senior risk management representative for Boston-based Coverys, a provider of medical professional liability insurance. "Otherwise, it leaves physicians wide open for people to suspect they didn't take the time to address it."

With the section left blank, a plaintiff attorney typically would ask the physician a question such as, "Doctor, isn't it true that you didn't see the need to address the upper respiratory system because you were in a hurry that day?"

Physicians should consider their charting as part of the continuum of care, says Finneron. She suggest you ask this question, "If I am the next provider picking up the record, and I know nothing about this patient, is this going to be helpful to me going forward?" Finneron suggests these practices to reduce legal risks with EMRs:

• Indicate that specific examinations were done by another provider.

A woman might have had breast and pelvic examinations done by a gynecologist during her annual exam, for example. Primary care providers should ask for the date of these examinations and document the patient's response. "This gives the rationale for the provider not doing the exam, because it was done by another provider," she says.

• Specify that inaccurate information was corrected.

In one case, a patient's allergy to Dilantin was mistakenly entered as Dilaudid, due to the information being entered from an illegible handwritten form completed by the patient. "It was not picked up until they had an external review. It never became a claim, because fortunately it was picked up before the patient was prescribed either drug," Finneron says. This kind of correction should be specifically explained in the comment section of the EMR, she advises.

• Be sure a system is in place to alert you if patients fail to obtain diagnostic tests.

In one case, a patient diagnosed with bronchitis never went to receive the chest-X-ray the physician ordered, but the ordering physician didn't realize that it was never obtained.

"The patient was just given a requisition to go for the X-ray. No system was in place to say that several days had elapsed, and the X-ray report wasn't back,'" Finneron says. "The only way that the physician was put on notice for this was because the patient showed up in the ED and ended up being admitted for pneumonia."

• Identify the alerts that are most meaningful to you, which will depend on the needs of the patient and the clinical specialty.

While physicians should be alerted if a patient fails to show up for a diagnostic mammogram, they might not wish to be alerted to a patient's need for a routine mammogram.

"Physicians are turning off alerts because they are getting too many of them. If the plaintiff attorney can validate that alerts were ignored, that would not bode well for the physician," Finneron says.

SOURCE

For more information on liability risks of electronic medical records, contact:

• **Karyn Finneron**, RN, BSN, MA, HNB-BC, Senior Risk Management Representative, Coverys, Boston. Phone: (617) 526-0371. Email: kfinneron@coverys.com. ✦

Executive Summary

If physicians leave an electronic medical record screen blank, this blank could appear as though they didn't take the time to address it. To reduce risks:

- ✦ Chart "N/A" if an examination is not necessary.
- ✦ Document that examinations were done previously by another provider.
- ✦ Identify which alerts are most meaningful to your practice.

Neurosurgeons report practicing defensive medicine

To minimize malpractice risk, 45% of neurosurgeons have eliminated high-risk procedures, according to a recent survey of 1,028 neurosurgeons.[1]

"Our study captures the long-understood sentiment shared amongst physicians that malpractice liability results in defensive medicine practices, and ultimately, higher healthcare expenditure," says **Brian V. Nahed**, MD, the study's lead author and an attending neurosurgeon at Massachusetts General Hospital in Boston.

Nahed notes that this survey was the first national one of neurosurgeons on defensive medicine practices and that the findings echo those identified in previous research done on other specialties. "As concerns of medical liability grow, further defensive practices will result in increased costs in healthcare, fewer specialists taking on high-risk procedures, and ultimately limit patient access to care," he predicts.

Respondents engaged in defensive medicine practices by ordering additional imaging studies (72%), laboratory

tests (67%), referring patients to consultants (66%), or prescribing medications (40%). Malpractice premiums were considered a "major or extreme" burden by 64% of respondents.

"Meaningful healthcare reform must address the growing medical liability and malpractice risk physicians face, through tort reform," argues Nahed.

Reference

1. Nahed BV, Babu MA, Smith TR, et al. Malpractice liability and defensive medicine: a national survey of neurosurgeons. PLoS One 2012; 7(6):e39237. Epub 2012 Jun 22.

SOURCE

For more information on defensive medicine practices, contact:

• **Brian V. Nahed**, MD, Attending Neurosurgeon, Massachusetts General Hospital, Boston. Phone: (617) 726-2937. Fax: (617) 643-4113. Email: bnahed@partners.org. ✦

Malpractice payouts vary widely by state

Findings spotlight flawed system

The average medical malpractice payment nationally was $262,727 from 1990 to 2006, according to a study of payments made in and out of court, including jury awards and settlements.[1] Researchers queried surgery-related medical liability payments in the National Practitioner Data Bank.

Not surprisingly, the greatest factor when determining the size of surgical malpractice claims was patient outcome, according to study author **Ryan Orosco**, MD, an otolaryngology resident in the Department of Surgery at the University of California, San Diego Health System. "Payment size depends more on how the patient does than what actually led to that outcome," he says.

However, the degree of state-to-state variation in payment size did surprise researchers. The states with the highest predicted payments were Illinois ($243,000), Connecticut ($236,000), and Delaware ($188,000), and the states with the lowest predicted payments were Michigan ($155,000), Kansas ($152,000) and South Carolina ($130,000).

"Many people agree that these findings highlight the flawed nature of our malpractice system," says Orosco. "I hope that this research stimulates further investigation and brings an evidence-based perspective to the malpractice debate."

Reference

1. Orosco RK, Talamin J, Chang DC, et al. Surgical malpractice in the United States, 1990-2006. *J Am Coll Surg*. 2012; 215(4):480-488.

SOURCE

For more information on medical malpractice payouts, contact:

•**Ryan Orosco**, MD, Department of Surgery, University of California, San Diego Health System. Email: rorosco@ucsd.edu. ✦

COMING IN future MONths

✦ Liability risks of supervising residents, NPs, and PAs

✦ Legal risks of patients with psychiatric complaints

✦ Avoid lawsuits from non-English speaking patients

✦ What you must know about "hammer" clauses

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 of the following is true regarding Schumacher Group's experience with a disclosure and offer program?

A. Apologies given in writing have made claims more expensive to litigate.

B. Acknowledgement of substandard care has resulted in increased number of claims proceeding to litigation.

C. Litigation costs significantly increased due to candid admissions being used against physician defendants.

D. The group is receiving fewer claims, and they are being resolved in less time.

2. Which is true regarding the advisability of physicians obtaining higher coverage limits, according to Elke Kirsten-Brauer, Dipl-Kfm, executive vice president and chief underwriting officer for MGIS Underwriting Managers?

A. Physicians carrying a higher limit can make themselves a target as a "deep pocket" for any incident or claim.

B. There is no downside to physicians carrying higher coverage limits except for increased premiums.

C. Coverage requirements depend only on state requirements, not the hospitals or preferred provider organizations the physician contracts with.

D. If physicians own or operate a surgery center or endoscopic center, they should not require contracting providers to carry their own specific set of limits with a financially strong, rated carrier.

3. Which practice is recommended regarding discrepancies in the patient's chart, according to John Davenport, MD, JD, physician risk manager of a health maintenance organization?

A. Discrepancies cannot be used as evidence of carelessness or untruthfulness, unless they have a direct connection to the allegation.

B. When a discrepancy is noted, physicians should explicitly address it in the chart.

C. Physicians should avoid verbal discussions with nurses regarding discrepancies in the chart.

D. If a physician disagrees with another provider's charting, the physician should always correct the provider in the patient's chart.

4. Which is recommended if a physician is intentionally non-compliant with nationally accepted guidelines, according to D. Clark Smith Jr., JD, an attorney at Smith Moore Leatherwood?

A. Physicians should make explicit notes in the chart as to why they are taking the course of action they are prescribing and why they are deviating from the usual course.

B. Physicians should not explicitly acknowledge deviation from a nationally accepted guideline in the chart.

C. Physicians should avoid getting second opinions from other physicians to support their prescribed course.

D. Physicians should avoid referencing specific peer-reviewed journal articles which support their position in the medical record.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Failure to screen for cancer results in $5.4 million jury verdict

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News: A 65-year-old man was diagnosed with Stage IV colorectal cancer after exhibiting warning signs, including rectal bleeding, irregular bowel movements, and lethargy, while under the care of his internist for 16 years. Despite being at a higher risk for colorectal cancer after the age of 50, the internist never referred the man to a gastroenterologist or for a colonoscopy. The man died at the age of 69 after undergoing four years of aggressive chemotherapy treatment. In the wrongful death action that followed, a jury awarded the decedent's family $5.4 million after finding the internist negligent in failing to screen the decedent for colorectal cancer.

Background: For 16 years, a Washington, DC, adult male was under the medical care of his family care physician. According to the man's family, he presented to his physician with complaints of rectal bleeding, irregular bowel movements, and lethargy, which his family claimed were signs and symptoms of colorectal cancer. At no point during this time did the physician refer the man for a colonoscopy or to a gastroenterologist for further evaluation. In 2008, at the age of 65, the man was diagnosed with Stage IV colorectal cancer. The man underwent four years of aggressive chemotherapy treatment and died at the age of 69. He was survived by his wife and two adult children.

... failure to perform proper screenings resulted in a delay in diagnosis and treatment of colorectal cancer ...

In July 2010, the decedent's estate commenced a wrongful death action against the family care physician alleging that he was negligent and violated the standards of medical care by failing to order colorectal screenings after he was 50 years old, failing to refer the decedent to a gastroenterologist, failing to perform appropriate and complete physical examinations, and failing to timely diagnose colorectal cancer. The decedent's estate argued that the physician's failure to perform proper screenings resulted in a delay in diagnosis and treatment of colorectal cancer, which led to metastasis and death.

The physician denied liability and argued that he complied with the applicable standard of medical care at all times and that the decedent's death was the result of the progression of colorectal cancer. In addition, the physician argued that it was the decedent's failure to schedule a colonoscopy that contributed to his death.

At trial, the decedent's estate argued that during the 16 years before the decedent was diagnosed with colorectal cancer, the defendant-physician only performed limited testing/screening for colorectal cancer, despite the fact that the decedent was at a higher

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Betsy D. Baydala, Barbara K. Reding**, 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.

risk for developing cancer after he turned 50 years old. In addition, the estate argued that the physician failed to order a colonoscopy on several occasions, despite the decedent's complaints of rectal bleeding and other warning signs. In response, the defense argued that the decedent bore some of the responsibility to schedule a colonoscopy. However, the decedent's estate countered that the decedent had relied on the defendant-physician's claim that he already was screening him for cancer.

After one day of jury deliberations, the jury found the defendant-physician liable for the decedent's death due to his departure from acceptable standards of medical care in failing to screen the decedent for colorectal cancer. The jury awarded $5.4 million to the decedent's estate, of which $4 million was awarded for pain and suffering based on the evidence presented regarding the decedent's painful experience undergoing four years of aggressive chemotherapy.

What this means to you: The prevailing standard of medical care in a case such as this, in which a patient presents to his long-term internal medicine physician with concerns of a change in bowel pattern, rectal bleeding, and lethargy, warrants diagnostic screening and a referral to a gastroenterologist by the patient's primary care physician for further consideration and evaluation. Common signs and symptoms of colon cancer include a change in bowel habits or a change in the consistency of stool, rectal bleeding and/or the presence of blood in the stool, persistent abdominal discomfort (e.g., cramps, gas, or pain), unexplained weight loss, weakness or fatigue, or the sensation that the bowel has not fully emptied.

Colon cancer guidelines generally recommend colon cancer screenings beginning at age 50. Such screenings might include, but are not limited to, a physical exam and history, blood tests, fecal occult blood tests, digital rectal exam, a sigmoidoscopy, a colonoscopy, a biopsy, barium enema, or computerized tomography (CT) imaging. Thus it is apparent that a physician has a variety of methods available to "rule out" the presence of colon cancer or other disease processes that cause symptoms such as those experienced by the decedent in this case. Exactly why the decedent's physician opted not to recommend, order, or perform any of the screening methods to rule out colon cancer is unclear. Unfortunately, the physician's failure to act in a manner consistent with the prevailing standard of medical care led to a delay in diagnosis and treatment of colon cancer for the patient, which resulted in the progression of colon cancer and, ultimately, his death.

As soon as symptoms appear, it is imperative that healthcare providers listen to the patient concerns and act accordingly.

In the early stages of colon cancer, many patients experience no symptoms and do not complain of any warning signs to their physicians. Therefore, regular screenings for colon cancer aid in the detection of pre-cancerous conditions or early stages of the disease. Certain known risk factors for colon cancer, such as age, personal or family history of polyps or inflammatory intestinal conditions, a sedentary lifestyle, low fiber-high fat diet, diabetes, obesity, smoking, or heavy use of alcohol, must be discussed and reviewed with the physician and patient. As soon as symptoms appear, it is imperative that healthcare providers listen to the patient concerns and act accordingly. The earlier the diagnosis of colon cancer is made, the greater the opportunity for successful intervention and treatment. The best outcome for the patient must serve as a guide in determining the plan of care.

The patient in this case was not diagnosed with colon cancer until he had progressed to a stage IV status. A stage IV finding indicates the spread of cancer to distant sites, such as other organs. Based on the patient's expressed symptoms, a wise and prudent physician would have utilized some of the screening or diagnostic methods discussed above to care for his patient. Had the physician "ruled out" colon cancer, he would have seized the opportunity for early detection and treatment or a process of elimination as to causal factors. After a diagnosis is made, beginning any oncology intervention at a stage IV disease level drastically reduces the chance for a good or hopeful patient outcome.

The defendant-physician's arguments advanced at trial evidently were not supported by appropriate medical record documentation or physician action. At trial, the decedent's estate's arguments prevailed. The jury's large verdict in favor of the decedent's estate, which was based in large part due to the decedent's pain and suffering related to the delay in diagnosis and subsequent aggressive chemotherapy treatment, placed the decedent's outcome, responsibility, and liability solely on the defendant physician, the

decedent's internal medicine practitioner.

In today's healthcare environment, reimbursement issues and payment eligibility requirements often have led practitioners to reduce or eliminate screening tests that may be considered unnecessary or not justified by payment for services sources such as Medicare or other insurance providers. When omission of reasonable diagnostic testing for the sake of healthcare dollars leads to a negligent outcome, the punitive costs far outweigh the unreimbursed or unapproved costs of testing.

Moreover, today's medical environment consists of a team of experts in various medical disciplines. Gone are the days when "general practitioners" delivered babies; surgically removed tonsils, adenoids, and the appendix; and cared for patients who suffered strokes or developed heart disease or gastrointestinal problems. Indeed, today there are obstetricians, otolaryngologists, specialized surgeons, cardiologists, gastroenterologists, and oncologists, just to name a few. Accordingly, it is now the standard of medical care to consult with and refer patients to experts who specialize in the evaluation and treatment of specific conditions.

In this case, a wise and prudent physician, in lieu of or following diagnostic screening for colon cancer, would have chosen to refer this patient to an expert — a gastroenterologist — for additional follow-up. At the end of the trial, the jury provided the physician with a "wake-up call." Unfortunately, however, the call came too late for the patient and his loved ones.

Reference

Superior Court of the District of Columbia, Case No.: 2010-CA-005095-M ✦

Fatal heart attack yields $3.74 million jury verdict

News: A 59-year-old man suffered chest pains, and he was taken by ambulance to a nearby hospital. After the hospital staff determined that the man had not suffered a heart attack, the hospital staff discharged the man home. The man then subsequently presented to his primary care physician, who advised him to stop taking aspirin. The primary care physician did not refer the man to a cardiologist for further evaluation, despite his recent episode of chest pains. Four months later, the man suffered a fatal heart attack, and an autopsy showed coronary heart disease as well as prior heart damage. A jury awarded the decedent's family $3.74 million after finding that the primary care physician provided negligent medical care to the decedent.

Background: In February 2006, a 59-year-old Harvard, MA, man suffered chest pains while he was at work. The man called 911, and he was rushed by ambulance to a nearby hospital. The emergency medical technicians who responded to the call and transported him to the hospital provided cardiac intervention methods, including aspirin. At the hospital, the medical personnel determined that the man had not suffered a heart attack. He was discharged home. The hospital personnel did not rule out other possible coronary problems before discharging the man home. Thereafter, the man presented to his primary care physician and reported his recent episode of chest pains. In response, the primary physician advised the man to stop taking aspirin. The primary care physician did not refer the man to a cardiologist for a consultation or for further evaluation. Four months later, the man experienced another episode of chest pains, and he reported his complaints to his primary care physician. However, the primary care physician did not find any problems related to cardiac illness. Shortly thereafter, the man experienced more chest pain and called 911; however, the man went into cardiac arrest and died when he was transferred to a nearby hospital. According to the autopsy, the man suffered from coronary heart disease and had prior heart damage.

The hospital personnel did not rule out other possible coronary problems before discharging the man home.

In 2007, the decedent's estate commenced a wrongful death action against the primary care physician. The decedent's estate argued that the autopsy showed severe coronary artery disease that had started at least three months before the decedent died. After

more than a weeklong trial, the jury found that the physician was negligent in his care and treatment of the decedent and returned a verdict for $3.74 million.

What this means to you: Understandably, jurors are empathetic in cases in which patients have clearly made an effort to seek medical care and, therefore, have placed their trust in the physicians providing that care. Jurors find in favor of the plaintiff when the evidence presented demonstrates that the physician failed to comply with the applicable standards of medical care. Jurors typically award larger verdicts when they believe that the physician's "wrongdoing" led to a patient's death.

When evaluating and treating a patient, it is imperative that a physician fosters two-way, clear communication with the patient and his/her family members. Accurate documentation and meticulous recordkeeping serve as risk reduction strategies. Ultimately, the physician must decide the best treatment plan to address a patient's health concerns and problems that is within evidence-based practices and current standards of medical care. In this fatal heart attack case, it is difficult to fathom why the decedent's primary care physician did not refer him to a cardiologist in light of his recent medical history and multiple chest pain events. The primary care physician's failure to utilize the knowledge and expertise of a specialist — here, a cardiologist — evoked perceptions of negligence for the jurors and an eventual verdict against the physician.

The primary care physician's rationale for instructing the decedent to discontinue taking aspirin was presumed to be insufficient to support the defense of the physician's actions. It also appears that the primary care physician did not take sufficient measures in response to the decedent's complaints of chest pain. Were blood tests obtained prior to making the clinical decision to discontinue aspirin therapy? If so, did the blood test results indicate anticoagulation was not necessary? Where any tests done to rule out cardiac disease and/or damage based on the patient's recent chest pain episodes? Apparently there was no supportive documentation available to defend the primary care physician's actions.

... due to the failure to diagnose and treat by the primary care physician, a family lost a beloved one, and a man lost his life.

The autopsy confirmed the presence of severe coronary artery disease, which was determined to be present for at least three months prior to the patient's death. This timeframe indicates that the initial chest pain episode occurred in February 2006. Four months later, the patient was no longer taking aspirin therapy on the advice of his primary care physician, and he suffered another episode of chest pain. The primary care physician determined that the patient had no evidence of cardiac illness after this second episode of chest pain. However, what evidence did the physician use to determine that there was no cardiac illness? Without a referral to a cardiologist after the first chest pain episode, the second episode of chest pain would have been a prudent time to request a cardiology evaluation for follow-up. Shortly thereafter, a third chest pain episode claimed the life of the 59-year-old man.

It is interesting the hospital was not held liable for failure to rule out other possible coronary problems prior to discharging the patient during the first chest pain episode. It is likely that due to the coronary artery disease findings on the autopsy, the timeframe eliminated the hospital as a potential defendant.

Nonetheless, due to the failure to diagnose and treat by the primary care physician, a family lost a beloved one, and a man lost his life. The jury sympathized and acted accordingly in delivering their verdict. The physician's evidence was not able to warrant a defense verdict. This was another wakeup call that was too late.

This case demonstrates the risks for healthcare providers when they attempt to walk the line between appropriate medical care and reimbursement issues. All too often the request for diagnostic test approval is denied by parties who do not accept any responsibility for patient outcomes or safe practices. As a result, patients and practitioners are caught in the conflicted and confusing world of payment for services rendered. Who or what drives the final decision for services and payment? What is the best action in light of the most positive outcome for the patient? These regulating practices not only place the patient at risk, but they place the practitioner at risk as well.

Reference

State Court of Massachusetts, Middlesex County Superior Court, Index No.: 074416. ✦