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Never even saw the patient? You still might be liable, if supervising

Physicians can be held liable for actions of others

If you never saw a patient, you can't held be liable for a bad outcome resulting from the negligence of a resident or nurse practitioner you're supervising, correct? That's a dangerous assumption, warns **Lori Meyerhoffer**, MD, JD, a partner with Yates, McLamb & Weyher in Raleigh, NC.

Supervising physicians often assume that liability cannot attach if they don't personally evaluate the patient, but often, this is not the case, she says.

A Georgia attending physician was sued for the actions of a physician assistant who performed vein harvest on patient's leg during cardiac bypass surgery and injured the saphenous nerve, which caused permanent damage. The Court of Appeals, which addressed only whether or not the physician could be liable for the actions of the physician assistant, stated that physicians do not have "carte blanche to delegate any and all tasks to an assistant," and "to hold otherwise would allow a brain surgeon to delegate brain surgery, or a neurosurgeon to delegate a spinal fusion, or a plastic surgeon to delegate rhinoplasty, all with impunity."[1]

Some states will extend the doctor-patient relationship and, therefore, physician liability to supervising physicians who have no actual contact with the patient when those they supervise are negligent, explains Meyerhoffer. "Furthermore, some medical boards will also take action against a supervising physician for the negligence of those they supervise," she says.

> *"The law has always been that a physician owes no duty of care to a patient that he does not treat."*

Expansion of responsibility

Attendings and on-call physicians often assume they have no potential legal exposure if they never treat the patient, says **Lisa Lepow Turboff**, JD, a shareholder with Munsch Hardt Kopf & Harr in Houston, TX.

"A physician's belief that he cannot be sued for medical negligence if he has no professional relationship with the patient is certainly well-founded," she says. "The law has always been that a physician owes no duty of care to a patient that he does not treat."

INSIDE

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While the existence of a physician/patient relationship is still the law, many states have expanded the manner in which such a relationship can be formed in order to allow patients to sue attending and/or on-call physicians for the medical negligence of others such as resident physicians, nurse practitioners, and physician assistants, explains Turboff. "The most common example is in teaching hospitals, where units are staffed by residents with on-call or attending physicians available for consultation," she says.

In this scenario, courts have allowed medical negligence lawsuits to proceed against on-call physicians who have no knowledge of the patient/plaintiff and no interaction with the treating resident(s) about the patient/plaintiff, notes Turboff. "These courts rely on the wording contained in the contract between the attending and the teaching hospital, and the agreement to be treated by a physician in training signed by the patient, to establish a physician/patient relationship sufficient to allow the patient to sue the attending," says Turboff.

Executive Summary

Physicians can be held liable for the actions of residents, nurse practitioners, and physician's assistants they are supervising, even if they don't personally evaluate the patient, and can be sued under the legal theories of vicarious liability, or negligent supervision. Supervising physicians should do the following:

- ✦ Ensure that providers don't perform acts outside the scope of their practice.
- ✦ Periodically check the provider's work habits.
- ✦ Keep the lines of communication open.

Judges don't answer questions about the duties and requirements of an attending physician, says Turboff, such as whether an onsite attending should proactively review the charts of every patient on his unit every day, or whether an off-site on call physician should routinely call the emergency department to be informed about all patients being treated. "Rather, once a judge allows a such a lawsuit to proceed against a physician who has never laid eyes on a patient, it's the jury who evaluates the evidence presented by medical experts and answers the questions about the duties and requirements of an attending or on-call physician," says Turboff.

Increased scrutiny

While physicians aren't responsible for all actions of those they supervise, the current trend is to expand the responsibility of supervising physicians, says Turboff.

"In the last 10 years, there has been increased scrutiny of residency programs, born from medical errors made by sleep-deprived residents," she notes.

Congress requested a study on the state of medical residencies nationwide, in an effort to encourage institutions to implement measurable standards such as policies and procedures about when and

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how to contact supervising physicians, notes Turboff. The resulting December 2008 Institute of Medicine report recommended new regulation of resident duty hours, supervision, and training.

"Despite this growing interest, the legal theories under which a supervising physician may be sued has remained constant," says Turboff. A supervising physician can be sued under the legal theory of vicarious liability, which means a physician is liable for the acts of another physician based solely on the relationship between the two physicians, she explains, or under the legal theory of negligent supervision, which is based on the supervising physician's own actions, or lack thereof, in supervising another.

"This area of the law is expanding, as plaintiffs' attorneys look for novel ways to create a physician/patient relationship," says Turboff. *(See related stories on legal obligations of supervising physicians, below, and litigation involving supervising physicians, p. 88.)*

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Supervising MDs have these legal obligations

Supervising physicians have an obligation to ensure that patient care is within the standard of care when delegating that care to others, says **Lori Meyerhoffer**, MD, JD, a partner with Yates, McLamb & Weyher in Raleigh, NC.

"It is difficult to determine how much supervision is required, but ensuring the supervising physician is readily available for any concerns is paramount," she says.

Liability varies according to state law, but in general, a supervising physician should consider all healthcare providers they supervise as extensions of themselves, Meyerhoffer says. "There are multiple examples of supervising attending liability, and multiple suits have been brought against physicians for the alleged negligence of those they supervise," she adds. "Attending physicians supervising interns and residents are obvious examples."

In most instances, attending physicians are liable for the actions of their residents under a theory of negligent supervision, explains Meyerhoffer. "The reach of this liability can be broad and can extend liability to supervising physicians for the care provided to patients they did not personally examine," she adds.

Physicians might be legally liable for the failure of providers they're supervising to act appropriately even if the physician acted appropriately, warns **Harriett T. Smalls**, JD, an attorney with Smith Moore Leatherwood in Greensboro, NC.[1,2,3] "If the [provider] commits a negligent act and was under the physician's control, the physician may be liable," she says. "Failure to properly supervise a [provider] can also lead to liability."

Smalls says that supervising physicians have these obligations:

• Check the credentials of any providers you supervise to make sure they have the proper training and certification.

Physicians should not require or allow a provider to perform acts that are outside the scope of their practice, advises Smalls, adding that a nurse practitioner or physician assistant's scope of practice might vary depending on the setting. For example, a nurse practitioner in an emergency department setting would have considerably more responsibility and independence than a nurse practitioner in an office setting.

"If a [provider] does an act that is outside the scope of their practice that is not at the direction of the [supervising] physician, then the physician will, most likely, not be held liable for the [provider's] actions," says Smalls. Generally, a physician is not responsible for the actions of a resident if the resident exercised independent medical judgment, she adds.

• Make sure you have clear written protocols in place.

Include language relating to lines of communication, how communication is to be done with supervising physicians, the provider's scope of practice, and where the provider is to practice, says Smalls.

• Periodically check the provider's work habits.

• Make sure the lines of communication are open and that the provider has reliable contact information for the supervising physician.

"The supervising physician should foster a collaborative relationship. Make sure the PE understands that it is OK to call any time without fear of reprisal," says Smalls.

• Require signature of the provider being supervised and the supervising physician on medical records.

"Remember that by signing, the physician is implying that he or she understands and agrees with the diagnosis and plan of treatment," says Smalls. "Although the [provider] is responsible for the care of the patient, the supervising physician is still liable."

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1. Ross v. Mandeville, 45 AD3d 755 (2d Dept. 2007).

2. Quirk v. Zuckerman, 196 Misc. 2d 496 (Sup. Ct. Nassau Co. 2003).

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Can supervising MD be liable? Courts say yes

In a North Carolina case, an obstetrician was supervising residents from home, never personally evaluated the patient prior to the alleged negligence, was not present during the allegedly negligent delivery, and arrived shortly after the residents delivered the baby. Nonetheless, the court found the attending physician could be liable.[1]

"The court extended the traditional notion of the physician-patient relationship to the supervising physician in that circumstance and held there could be supervising attending liability for the negligent acts of the residents he supervised, even without direct patient contact," notes **Lori Meyerhoffer**, MD, JD, a partner with Yates, McLamb & Weyher in Raleigh, NC. " It was reversed at the Supreme Court level because the lower court dismissed the claim."

In another case, the court found a surgeon was in a supervisory role over a nurse anesthetist, where there was no anesthesiologist onsite, when the nurse anesthetist failed to notify the surgeon of the patient's deteriorating condition.[2]

"That court held supervising physicians can be liable to patients, even when supervising skilled healthcare professionals," she says.

Other suits have been filed against the supervising physician when a physician's assistant or nurse practitioner failed to contact the supervising physician or failed to communicate the circumstances to the supervising physician. "Although the law in each state varies, it's safe to assume that the physician, the practice, and the allegedly negligent healthcare provider supervised by the physician will all become defendants if there are allegations of negligence," says Meyerhoffer.

Some state courts hold that an attending physician is not responsible for the actions of a resident physician in those instances in which the resident should be independently capable, such has suturing a wound or closing an operative site, says **Lisa Lepow Turboff,** JD, a shareholder with Munsch Hardt Kopf & Harr in Houston, TX. "In these instances, the fact that the attending physician has provided medical care to the patient was irrelevant," she says.

A 2001 case involved a 4-year-old girl brought to the emergency department of a teaching hospital to be evaluated for chicken pox and lethargy.[3]

"A first-year and third-year resident treated the child. Neither resident contacted the off-site on-call physician," says Turboff. "The residents missed a pulmonary condition, hydrated the child, and discharged her."

"Physicians should be aware of state laws in order to formulate a strategic plan to lower the risk of being sued for the actions of others."

The child later died from the undiagnosed pulmonary condition. The Virginia court would not allow the case to proceed against the on-call physician because the plaintiff did not establish a physician-patient relationship. "The court clearly stated that it was amenable to establishing this relationship via less traditional means, such as the language in the contract between [the on-call physician] and the hospital, however, but plaintiff did not present any such evidence," notes Turboff.

In a 2002 case, obstetrics/gynecology residents negligently treated a pregnant patient resulting in the birth of a brain-damaged baby. The plaintiff sued the obstetrics/gynecology attending physician, who played no role in the care of the patient.[4]

"The trial and appellate courts dismissed the lawsuit because of a lack of a physician-patient relationship," says Turboff. The Ohio Supreme Court reversed the lower courts' rulings, rejected prior Ohio law, and held that "[a] physician patient relationship can be established between a physician who contracts, agrees, undertakes, or otherwise assumes the obligation to provide resident supervision at a teaching hospital and a hospital patient with whom the physician has no direct or indirect contact," she says.

"The court based its decision on the language in [the attending physician's] contract with the hospital and the language in the plaintiff's consent to be treated by resident physicians," says Turboff.

Physicians should be aware of state laws in order to formulate a strategic plan to lower the risk of being sued for the actions of others, she says.

"Supervising physicians and teaching institutions should examine the language used in their contracts to see if there are revisions to be made to avoid these scenarios," Turboff advises.

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4. Lowensbury v. Van Buren, 762 N.E. 2d 354 (Ohio 2002). ✦

Patient suicide? You'd likely be named in suit

If one of your patients commits suicide, you're likely to be named in any subsequent lawsuit, says **Martin G. Tracy,** JD, ARM, president and CEO of Professional Risk Management Services, an Arlington, VA-based firm that manages professional liability insurance programs covering psychiatrists and neurologists.

"They may get dropped from the case as the case progresses, but it wouldn't surprise me that any doctor who has seen the patient in the month or two leading up to a suicide would be named in the suit," he says.

Tracy occasionally sees psychiatrists named in claims alleging failure to diagnosis cancer. "It's not that anyone expected the doctor to treat the cancer, but sometimes a patient's psychiatric condition can be due to a brain tumor," he explains. "Other doctors would be held to that same standard." For example, a primary care physician treating a patient who suffers from depression has to deal with the patient's mental health issue in some way.

Fifty-nine percent of mental health drug prescriptions are written by family doctors, not psychiatrists, according to a 2009 study.[1] "That certainly indicates that doctors of all specialties are aware that psychiatric conditions can have an impact on a person's overall health. Somehow, those psychiatric conditions should be addressed," Tracy says.

Courts generally are disinclined to hold non-mental health professionals liable for a mentally-ill patient's self-harm when such parties lack special training and expertise enabling them to detect mental illness and/or the potential for self-harm, says **Neah L. Mitchell**, JD, an attorney with Balch & Bingham in Montgomery, AL.[2] In addition, courts have recognized that physicians do not have a duty to treat each of their patients for every conceivable medical condition that they might have, she adds.[3] "However, a primary care physician with a long-standing relationship with a mentally ill patient could be at risk if he fails to at least attempt to refer his patient for treatment of an apparent mental health condition," says Mitchell.

Different standard of care

In general, non-specialists in a given area of medicine are held to a lower standard of care than are specialists treating the same disorders, according to **Paul S. Appelbaum**, MD, Dollard Professor of Psychiatry, Medicine, & Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University's College of Physicians & Surgeons in New York City.

> *"... any physician dealing with patients who have psychiatric disorders should be inquiring about suicidal and homicidal thoughts."*

However, in circumstances in which non-specialists would ordinarily refer patients to a specialist but elect not to do so, or when non-specialists hold themselves out as providing a specialist level of care, they might be held to the standard expected of a specialist, he adds. "Since the majority of patients with depression and anxiety are treated by non-psychiatrists, a physician undertaking such treatment will likely be held only to that level of care expected of someone with similar training," says Appelbaum. However, non-psychiatric physicians who decide to treat patients with schizophrenia, bipolar disorder, and other conditions that usually are managed by psychiatrists might be held to the same standard as psychiatrists, he says.

"Hence, before undertaking such treatment, they should ensure that they are thoroughly familiar with applicable standards of care," says Applebaum. A primary care physician, for example, could be held liable for failing to properly assess or manage suicidal or homicidal ideation.

At a minimum, any physician dealing with patients who have psychiatric disorders should be inquiring about suicidal and homicidal thoughts, Applebaum says. "If such thoughts are present and the physician is uncertain how to handle them, consultation with or referral of the patient to a psychiatrist is indicated," he says. *(See related stories on non-compliance and involuntary commitment, p. 90, and unique legal risks posed by patients with psychiatric conditions, p. 90.)*

Executive Summary

Physicians treating a medical condition of a patient with a mental health issue who commits suicide might be named in a lawsuit for failure to properly assess or manage suicidal or homicidal ideation. Physicians should consider:

- ✦ referring the patient to a mental health professional for treatment;
- ✦ talking with the patient or family members about the importance of treatment;
- ✦ exploring whether compliance is more likely with alternative treatments.

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Non-compliant patient with mental illness?

Involuntary commitment requires burden of proof

If you are aware your patient is not receiving treatment for his mental illness and that this lack of treatment will prevent him from complying with your prescribed treatment of a physical condition, could you be held liable for a resulting bad outcome? It is possible, says **Neah L. Mitchell**, JD, an attorney with Balch & Bingham in Montgomery, AL.

"Thus, under such circumstances, a physician should first consider referring the patient to a mental health professional for treatment," she says.

If this action is unsuccessful, the physician might be faced with the difficult decision of whether to initiate involuntary commitment proceedings to ensure the treatment of the patient's physical condition. Procedures for involuntary commitment of mentally ill patients typically are governed by state statutory procedures, says Mitchell. Whether a physician can meet the burden of proof based solely upon a patient's refusal to comply with treatment of a physical condition might depend upon the severity of the physical condition necessitating treatment, she says.

"Most state statutes allow involuntary inpatient treatment only upon showing that a patient has threatened to inflict serious bodily harm upon himself or others, has exhibited or threatened violent behavior, or is unable to avoid severe injury," Mitchell says.[1,2]

A physician requesting involuntary commitment of patient for the patient's inability to comply with a necessary treatment regimen must be able to show that this inability could lead to severe injury, explains Mitchell. "If the inability to comply with treatment would not lead to a severe injury, a physician may still be able to initiate involuntary commitment proceedings for outpatient treatment, as such proceedings may require only proof of some harm to the patient without treatment of the patient's medical condition," she says.[3]

Respond appropriately

Where non-compliance interferes with treatment, the question in any subsequent litigation will be whether the physician behaved appropriately, according to **Paul S. Appelbaum**, MD, Dollard Professor of Psychiatry, Medicine, and Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University's College of Physicians & Surgeons in New York City.

"That is, did he or she inquire about or otherwise monitor compliance? If non-compliance was anticipated or actually occurred, did he or she respond appropriately?" Appelbaum says.

Suitable responses could include talking with the patient or family members about the importance of treatment, exploring whether compliance is more likely with alternative treatments, and considering the availability of resources that might aid in compliance, he says.

"Realistically, however, there is a limit to the degree of control that a physician has over any patient's behavior," says Appelbaum. "Non-compliance does not necessarily indicate that a physician has performed inadequately or that liability should be imposed."

References

1. Ala. Code § 22-52-10.4(a).
2. Tenn. Code § 33-5-403.
3. Ala. Code § 22-52-10.2. ✦

Psych condition? There are unique legal risks

Are you caring for a patient with a psychiatric condition? Be aware of these specific legal risks, advises **Gerald E. DeLoss**, JD, an attorney with Popovits & Robinson in Frankfort, IL:

• There is an increased likelihood that patients will harm themselves or others.

"The failure to prevent the psychiatric patient from harming herself or himself or others is a known legal risk for therapists," says DeLoss. "It is less well-known and less common for the primary care provider."

The physician needs to be aware of the possibility, monitor patient comments or warnings, and report or disclose the information to protect the patient or others, as may be allowable under federal and state laws, he says. Primary care physicians have a duty to refer patients with a psychiatric condition in some cases, adds DeLoss. "Just as a medical condition may require a referral to specialist, so may a psychiatric patient need to see a psychiatrist or other professional," he says.

If the physician is aware that the patient intends to harm a specific third party, the physician may be under a duty to warn or to take steps to protect others, says DeLoss. The Health Insurance Portability and Accountability Act (HIPAA) recognizes the need to disclose information to protect third parties, and it specifically allows a physician to disclose health information without an authorization to carry out the notice needed.[1]

To sustain a cause of action in tort predicated on a therapist's alleged duty to warn third parties of the potential violent acts of a patient, the plaintiff must demonstrate that the patient made specific threats of violence, that the threats of violence were directed against a specific and readily identifiable victim, and that there is a direct physician-patient relationship between the defendant and the victim or a special relationship between the patient and the victim, says DeLoss.

California, Michigan, Minnesota, New Jersey, Pennsylvania, and New York similarly hold that a cause of action against a therapist exists when the patient has communicated to the therapist serious threats of physical violence against reasonably identifiable victim(s), says DeLoss.[2-8]

• There are specific state laws governing mental health information in most states that differ from what HIPAA generally requires.

If there is substance abuse treatment information involved, federal law under 42 Code of Federal Regulations Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," may govern, adds DeLoss. *(To view the regulations, go to http://bit.ly/WUyNQ5.)*

The physician must understand that these laws function differently from HIPAA and generally are more restrictive about what mental health data a physician may disclose, and when, he explains.

• The provider should not assume that the patient understands the consent form or the standard explanation utilized by the provider during the consent process.

"State laws provide additional protections and rights in this area that may govern," says DeLoss. "The physician should comply with state law and document the consent process."

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8. NY CLS Men. Hyg. § 33.13. ✦

Translation shortcuts might get you sued

Untrained interpreters pose legal risks

The biggest liability risk physicians face when caring for limited English-proficient (LEP) patients requiring interpreters is using untrained bilingual people such as staff, family members, or friends of the patient to interpret, instead of professional interpreters, according to **Lisa Diamond**, MD, MPH, an assistant attending at Memorial Sloan-Kettering Cancer Center in New York City.

"Professional interpreters have proficiency in both English and the target language that has been assessed," Diamond explains. "They go through many hours of training, including medical terminology and ethics, and are now certified under a national examination process."

In 32 of 35 cases analyzed by researchers at the University of California at Berkeley School of Public Health, healthcare providers did not use competent interpreters, according to a 2010 study that analyzed medical malpractice claims related to failure to provide appropriate language services.[1]

"Untrained bilingual people may not be proficient in either English or the target language. They may not know medical terminology or its nuances, and they may add, edit, or omit important parts of the information being relayed," says Diamond. Here are some legal risks faced by physicians treating LEP patients:

• Allegations of breach of the standard of care.

The physician's risk of breaching the standard of care in treating LEP patients does not differ from the risk posed when treating any other patient, so long as the physician did what a "prudent physician" would do to facilitate effective communication with the patient, says **John W. Miller II**, principal of Sterling Risk Advisors in Marietta, GA.

Though it doesn't directly bear

on determining the standard of care, a 2003 guidance issued by the Department of Health and Human Services (HHS) provides a framework of what the government expects of physicians treating LEP patients, notes Miller. *(To view the guidance, go to: http://1.usa.gov/pvbiE9.)*

"This is certainly a fact a jury will take into consideration, should there be any questions of whether the physician should have more effectively acquired additional information or disseminated a treatment plan through the use of an interpreter," says Miller.

• Allegations of failure to obtain "informed consent."

"As many attorneys and risk managers will concur, physicians obtaining informed consent from patients is more than their signature on a form," says Miller. "Relying upon the signature on the form as proof that effective informed consent took place is potentially dangerous for physicians in some venues."

Informed consent is the process by which a physician explains the risks and benefits of a procedure, and decides with the patient what course of care the patient desires once those risks and benefits are weighed, says Miller. "This sort of communication warrants a higher level of certain communication by the physician and the patient," he advises. "The litigation risk associated with allegations that the patient did not understand the risks of the planned procedure can be significant."

Miller recommends physicians use a professional interpreter who is adept at explaining complicated medical terminology for the informed consent process whenever an invasive procedure is planned. "Further, it is good practice to have the patient repeat back through the interpreter the physician's instructions and their understanding of all information they have received," he says.

• Allegations of violating Title VI.

Title VI of the Civil Rights Act of 1964 prohibits healthcare providers who receive federal money from Medicaid, Medicare, or any other government program from discriminating on the basis of national origin, which the courts have determined includes language discrimination, says Miller.

Under Title VI, according to the HHS guidelines, physicians and other HHS recipients must take "reasonable steps" to ensure meaningful access to their LEP patients. Failure for physicians to comply with these requirements usually means an investigation by the HHS Office of Civil Rights (OCR), warns Miller.

"I've had several practices investigated by the OCR for LEP violations and for violations relative to deaf or hearing-impaired patients," he reports. "The compliance costs alone after a visit have resulted in many of my clients wishing they had paid for interpreters for their patients all along."

Executive Summary

Use of untrained bilingual individuals when caring for limited English proficient patients can result in medical malpractice claims. Physicians should consider:

✦ Using professional interpreters who understand medical terminology.
✦ Having informed consent communication done by a professional interpreter for invasive procedures.
✦ Having the patient repeat the physician's instructions back.

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Suspect lawsuit is coming? Know how to report it

Too-late notice to your insurer might negate coverage

Most medical malpractice policies have a clause that requires physicians to notify the company of all claims in a timely fashion, advises **Karen Kelly**, vice president of claims operations for The Doctors Co., a Napa, CA-based medical malpractice insurer.

While the defensibility of a claim is primarily driven by the facts of a case, late notice might preclude the carrier from providing physicians with direction and advice that will ensure their interests are protected, she adds.

"Late notification may limit the carrier's ability to retain the best defense attorney and experts for a particular case, as they may already be retained by another involved party to the claim," warns Kelly. "A delayed response may also result in a default judgment being rendered against the physician."

Ensure coverage

If an insured has provided written notice of a potential covered claim during the active policy period, The Doctors Co. will accept that as notice under the policy, says Kelly.

"Even if the insured is no longer with

the company when the claim is formally made, coverage may still be available," she adds.

When reporting a claim, physicians need to know whether they have a claims-made or an occurrence-based policy, says Kelly. A claims-made policy covers claims made during the time the policy is in force, and a claim that is made after the expiration of the policy period might prevent the claim from being covered, she explains. "Therefore, physicians must timely report the claim and follow all policy conditions in order for the coverage to apply," she says.

An occurrence policy provides coverage for a claim when it occurs, no matter when it was reported. "As long as there was coverage under an occurrence policy at the time of the claim, the claim can be reported years later, and coverage for the claim will be provided," says Kelly.

Review carefully

How and when reporting is required varies by carrier, emphasizes **Roberta Carroll**, RN, MBA, CPCU, senior vice president at Aon Risk Solutions — National Health Care Practice in Odessa, FL.

Carriers might require physicians to report claims by telephone instead of email or fax, or only through a specified form on the insurer's encrypted website. "I've seen some carriers that consider a claim for payment purposes as a demand for compensation or lawsuit," adds Carroll. "On the other hand, the provider has an obligation to report potential compensatory events that could give rise to a claim."

In this case, there could be a gap in coverage if the provider changes carriers and the reported claim hasn't become a lawsuit yet, but does become a lawsuit after the new coverage takes effect, she explains.

In this scenario, the first carrier wouldn't cover the reported claim because no one was asking for payment until after the coverage lapsed, and the second carrier wouldn't cover it because the provider was aware of a possible claim, she explains.

If this is the case, the provider might wish to negotiate a coverage change or find a different insurer who will cover a previously reported potential claim, she says. "Most carriers say, 'Once you've reported it as adverse event, I will cover it regardless of when it comes in,'" says Carroll. *(See related story, below, on how early investigations can prevent suits.)*

Executive Summary

Physicians typically are required to notify insurance carriers about claims in a timely fashion, and late notification can make a claim less defensible.

- ✦ How and when reporting is required varies by carrier
- ✦ Early reporting allows the insurer to perform an investigation and binds insurance coverage.
- ✦ Misleading or incomplete documentation can be appropriately amended.

SOURCES

For more information on notifying carriers about possible claims, contact:

• **Roberta Carroll**, RN, MBA, CPCU, Senior Vice President, Aon Risk Solutions – National Health Care Practice, Odessa, FL. Phone: (813) 926-8069. Email: roberta.carroll@aon.com.

• **Karen Kelly**, Vice President, Claims Operations, The Doctors Co., Napa, CA. Phone: (707) 226-0346. Email: kkelly@thedoctors.com. ✦

Early investigation might prevent suit

Was there an unexpected result that resulted in an angry, upset patient? If so, you should notify your carrier without hesitation, advises **Karen Kelly**, vice president of claims operations for The Doctors Co., a Napa, CA-based medical malpractice insurer.

"It is always advisable to report incidents in a timely manner," she emphasizes. Physicians should do this step as soon as they receive any indication that they might be sued, such as receiving a subpoena, a request for medical records, requests for money from a patient, or being contacted by phone or letter to discuss a patient's care, says Kelly.

"After a physician contacts the carrier, patient safety and/or claims experts may then be able to provide further assistance or guidance. This may reduce the severity of a loss, and possibly prevent a lawsuit," says Kelly.

Reluctant to report

There are several ways carriers might weigh reported claims as part of their internal review process, according to Kelly. The Doctors Co. encourages early reporting of potential claims, but only considers actual claims with a written demand for compensation when evaluating an insured's claims history, she says.

Too often, physicians fail to report potential claims because they don't want it to affect their experience rating, says **Roberta Carroll**, RN, MBA, CPCU, senior vice president at Aon Risk Solutions — National Health Care Practice in Odessa, FL. "They don't want to be known as a physician with a lot of claims, but I'm hoping that misconception is getting dispelled," she says. "There are benefits to reporting early."

This reporting allows the insurer to conduct an investigation and have a file prepared, in the event a lawsuit is later filed months or years later, says Carroll. "By that time, it's hard to get a report of what occurred. Often, witnesses you really want to talk to are no longer there,"

she explains. "All you really have is the medical record to go on."

An early investigation might uncover misleading or incomplete documentation that can be amended appropriately, for example. "Insurance companies aren't just looking at the claims piece anymore," says Carroll. "Many have robust risk management services." ✦

Patient didn't follow up? Be sure chart is clear

Was patient's lack of follow-up the real reason a bad outcome occurred? This quickly can become a "he said/she said" situation during litigation.

"I am always worried when a provider tells me that there was a bad outcome because the patient was 'non-compliant.'" says **Kathryn Wire**, JD, MBA, president and principal consultant at Kathryn Wire Risk Strategies, a St. Louis, MO, firm specializing in healthcare risk management, and former director of risk and claims for two St. Louis health systems. "That is a judgmental word that covers lots of circumstances."

When reviewing a chart, Wire looks at what was ordered for the patient, what discussion there was with the patient about it, whether there was adequate education about the suggested care and the risks and benefits it offers, hurdles or obstacles that might interfere with the patient's ability to participate in that care, and if the patient is simply refusing to do what's asked, whether there is a moral or philosophical issue and an alternative approach.

"I would look for all that information before I evaluated the case for liability," Wire says.

The liability standard is what a "reasonably prudent" physician having the competency and professionalism consistent with the specialized training, experience, and care of the defendant would have done under the same or similar circumstances, says **Michael E. Clark**, JD, LLM, special counsel at Duane Morris in Houston, TX. However, says Clark, "it's always best never to be put into such a position in the first place." To avoid suits, he recommends these practices:

• Have "ticklers" in place.

This ensures appropriate follow-up within a reasonable time if a patient fails to follow through as the physician has instructed, says Clark. *(See related story on what systems should be in place, p. 95.)*

• Consider the type of patient involved.

"Are we dealing with someone who is emotionally or intellectually compromised?" asks Clark. "Is there any suggestion that the patient has been less than candid with the physician?" If so, he advises even more oversight by the physician or staff with following up with the patient, and documenting these efforts.

Document nonadherence

Physicians and patients have responsibility to pursue a shared goal of maintaining or restoring the patient's health, emphasizes **Ben A. Rich**, JD, PhD, professor and an Alumni Association Endowed Chair of Bioethics at the University of California — Davis Health System's School of Medicine.

Juries are unlikely to ignore or discount a patient's failure or refusal to actively participate in his or her own care, he explains. "It is no longer the case, if it ever was, that the physician bears the sole responsibility for health outcomes and the patient none at all," says Rich. "Of course, sound risk management requires that the physician document what the patient was told and when." To reduce risks, do the following:

• Document that you've educated of the patient about the reason for the follow-up, the process for accomplishing it, and the risk of failing to follow through.

"Patient indicated that they attended the joint replacement class and also accurately recited the key total hip precautions" is better than "patient advised of restrictions," Wire says. "Patient given brochure and discussed anti-coagulation safety and regulation; understands plan for testing" is better than "patient advised to go to lab for test," she says.

"The more detail in the documentation, the better," Wire emphasizes.

• Document that you inquired, directly or indirectly, about the patient's ability to follow through.

For example, a physician might chart, "Discussed need for home health vs. appointments for outpatient testing and physical therapy," says Wire.

• Document that you facilitated contact if a patient has to make an appointment with another provider.

"Sometimes, it is hard to get an appointment with another physician in the prescribed timeframe, or there may not be insurance coverage without a tussle with the carrier," says Wire. "Acknowledging those issues and providing assistance is helpful."

• Document that obstacles were addressed.

"If a simple referral to a transportation agency will solve the patient's inability to go to follow-up therapy, then a jury might expect the physician to have that information and share it, or at least have a number for social service assistance," says Wire.

Executive Summary

Physicians must document a patient's non-compliance in the medical record and must have systems in place to ensure they're notified if follow-up doesn't occur.

- ✦ Document details regarding patient education.
- ✦ Facilitate contact with another provider.
- ✦ Address obstacles to obtaining follow-up.

SOURCES

For more information on liability risks involving non-compliance, contact;

• **Lizabeth Brott**, JD, Regional Vice President, Risk Management, ProAssurance, Okemos, MI. Phone: (800) 292-1036 or (205) 877-4400. Fax: (205) 414-2806. Email: lbrott@proassurance.com.

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• **Kathryn Wire**, JD, MBA, Kathryn Wire Risk Strategies, St. Louis, MO. Phone: (314) 540-4910. Email: kathy@wireriskstrategies.com. ✦

Do you know if patient followed up?

Did you order a diagnostic or laboratory test, or recommend a patient see a consultant? If so, you need a system that indicates that the patient did or didn't have a reported result, advises **Kathryn Wire**, JD, MBA, president and principal consultant at Kathryn Wire Risk Strategies, a St. Louis, MO, firm specializing in healthcare risk management and former director of risk and claims for two St. Louis health systems.

"If the physician has ordered something involving another provider, they should almost always get some feedback," she says.

If a physician orders a drug that is critically important and either new or complicated, phone follow-up to make sure the patient understands the new regimen would be a good step, says Wire.

To reduce risks, physicians should establish and maintain systems to trigger follow-up communications with patients so that nothing is left to chance, says **Ben A. Rich**, JD, PhD, professor and an Alumni Association Endowed Chair of Bioethics at the University of California -- Davis Health System's School of Medicine. "These mechanisms will generate documentation in the medical records that follow-up information was transmitted to the patient," he says.

If these basic measures are taken and documented, but the patient still fails to respond appropriately, then the physician's duty will have been met, and the patient will have assumed the risk of adverse consequences, says Rich. "If patients who suffer such consequences file malpractice claims, it is unlikely that they will be able to recover damages," he says. "Most juries would conclude that the negligence, if any, is their own."

All jurisdictions have legal provisions allowing the assertion of contributory negligence or contributory fault when a patient's action or inaction is a major factor in an adverse outcome, notes Rich.

Physicians need good tracking systems to be sure reports were received from consultants, laboratories, or radiologists, advises **Lizabeth Brott**, JD, regional vice president of risk management in the Okemos, MI, office of ProAssurance. "The good news is that with many practices converting to EHRs [electronic health records], they have another tool for tracking reports," she says.

However, Brott notes that EHRs pose a different kind of risk if they provide too many alerts regarding test results and drug interactions.

"Physicians may develop 'alert fatigue' and may not pay as close attention as they should," she says. "We have had cases where practices have turned off the alerts because they became overwhelming." ✦

COMING IN future MONths

✦ Liability risks of off-label prescribing

✦ How to prove standard of care wasn't breached

✦ Strategies to avoid successful misdiagnosis suits

✦ When and how you should apologize to patients

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 of supervising physicians, according to Lisa Lepow Turboff, JD, a shareholder with Munsch Hardt Kopf & Harr?
   A. Liability cannot attach to supervising physicians under any circumstances if they don't personally evaluate the patient.
   B. No state has extended the doctor-patient relationship and, therefore, physician liability to supervising physicians who have no actual contact with the patient when those they supervise are negligent.
   C. Many states have expanded the manner in which a patient/physician relationship can be formed in order to allow patients to sue supervising physicians for the medical negligence of others.
2. Which is true regarding liability of physicians who are treating medical conditions of patients with psychiatric conditions, according to Paul S. Appelbaum, MD, at Columbia University's College of Physicians & Surgeons?
   A. Courts are very likely to hold non-mental health professionals liable for a mentally ill patient's self-harm, even after they have referred the patient to mental health specialists for treatment.
   B. A primary care physician cannot be held liable under any circumstances for failing to properly assess or manage suicidal or homicidal ideation.
   C. Because most patients with depression and anxiety are treated by non-psychiatrists, a physician undertaking such treatment likely will be held only to the level of care expected of someone with similar training.
3. Which is recommended to reduce legal risks when caring for limited English proficient patients, according to John W. Miller II, at Sterling Risk Advisors?
   A. Physicians should routinely utilize untrained bilingual people such as staff, family members, or friends of the patient to interpret, rather than professional interpreters.
   B. Physicians should have the patient repeat back through the interpreter the physician's instructions and their understanding of all information they have received.
4. Which is recommended to reduce legal risks involving a non-compliant patient, according to Kathryn Wire, JD, MBA, at Kathryn Wire Risk Strategies?
   A. Physicians should avoid documenting specifics about a patient's obstacles to compliance.
   B. Physicians have no legal obligation to provide assistance if a patient has difficulty obtaining follow-up.
   D. Physicians should facilitate contact if a patient has difficulty making an appointment with another provider.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Appeals court lowers award for pain and suffering in negligent nephrectomy case to $1 million

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News: A New York State appellate court ordered a reduction of damages after an Erie County jury awarded $1.75 million in past and future pain and suffering damages against a hospital and physicians for negligence and medical malpractice in performing a nephrectomy. In March 2005, a healthy 43-year-old collections agent underwent a donor nephrectomy. Preoperatively, the hospital conveyed that the nephrectomy would be performed within three hours with limited recovery time. However, the operation spanned nearly eight hours and resulted in significant postoperative discomfort and difficulty ambulating. Ultimately, the patient required an emergency spinal fusion surgery that included removal of a vertebra to relieve the postoperative symptoms. At trial, an Erie County jury found negligence on behalf of the hospital and surgeons and awarded $4.1 million in damages. On appeal, the New York State Appellate Division, Fourth Department, held that the pain and suffering damages were excessive and ordered a reduction of pain and suffering damages by $750,000. No appeals are pending.

...The outcome of what initially was intended as an altruistic act on the part of the plaintiff ultimately changed the course of his life.

Background: On March 23, 2005, a patient underwent a donor nephrectomy at a hospital whereby his right kidney was harvested and transplanted to his mother. Before the transplant, his mother was suffering from kidney failure and, without the transplant, would have required a lifetime of dialysis. Typically, this type of surgery is performed within two to three hours. However, the surgery took nearly eight hours to perform due to the alleged delay of one of the physicians performing the procedure. During this eight-hour span, the patient was positioned in a flexed spinal position, on his left side, and his head and lower body were angled downward to facilitate the removal and harvesting of his right kidney.

Upon waking postoperatively, the patient complained of pain down his left side and an inability to walk without limping. The patient suffered from a painful condition known as rhabdomyolosis, the breakdown of muscle fibers that leads to the release of muscle fiber contents [myoglobin] into the bloodstream. This condition can be potentially dangerous as research shows that it can lead to kidney damage. However, in this case, the rhabdomyolosis resulted in permanent muscle damage of his left flank.

The patient's symptoms worsened and on May 3, 2005, the patient underwent emergency spinal fusion surgery at C3-4 and C4-5 in which

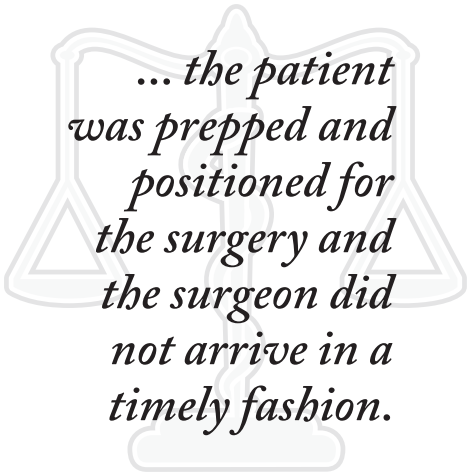
Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq., **Alyssa M. Panaro, Carol Gulinello**, and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

one whole vertebra and neighboring discs were removed to release pressure from the spinal cord.

The patient sued the physicians and the hospital that performed the transplant surgery. In his suit, the patient argued that his injuries resulted from the pressure of remaining in a surgically flexed position for an extended time. At trial, the patient testified that he has experienced excruciating, permanent pain in his back, neck and left side; antalgic gait due to a dropped foot from weakness; and an inability to resume leisure activities or home repair. Additionally, at trial, the patient alleged that he will likely necessitate additional surgical interventions to correct his injuries. Furthermore, the patient presented evidence that the physician performing the kidney transplantation was responsible for delaying the surgery for a substantial time. Moreover, the patient contended that the doctrine of res ipsa loquitor was applicable to account for the physicians' negligent performance of the nephrectomy and to account for the delay in performing the procedure. Res ipsa loquitor (Latin for "the thing speaks for itself") is a legal doctrine that presumes that an alleged wrongdoer is negligent if he had exclusive control of whatever caused the injury even though there is no specific evidence of an act of negligence, and without negligence the accident would not have happened.

In response, the defendants' argued that the patient's injuries were attributable to an infarct of his congenitally narrowed spinal cord during a 5-minute episode of low blood pressure during the surgery. An infarct refers to a localized area of dead tissue (necrosis) resulting from obstruction of the blood supply to that part, especially by an embolus.

However, in October 2010, an Erie County jury found the defendant physicians and hospital's arguments to be non-compelling and awarded damages totaling $4.1 million, including, $2 million for future lost earnings, $500,000 for past pain and suffering, and $1.3 million for future pain and suffering. On appeal, the hospital and physicians successfully argued that the jury's awards of damages for future lost earnings and past and future pain were excessive. Accordingly, the Appellate Division, Fourth Department lowered the jury award to $1.1 million for future lost earnings, $250,000 for past pain and suffering, and $750,000 for future pain and suffering.



What this means to you:
Unfortunately, the outcome of what initially was intended as an altruistic act on the part of the plaintiff ultimately changed the course of his life.

A surgery that would normally last approximately three hours took more than eight hours to perform. During that time the plaintiff was positioned in an unnaturally flexed position allegedly causing permanent damages to his neck and back.

During this procedure, the surgeon is operating in the lumbar area of the spinal cord and is responsible for the positioning of the patient to optimize access to the operative area. However, the anesthesiologist is responsible for positioning the patients head and neck to ensure proper alignment of the spine and maximize proper airway management. In surgical cases lasting many hours, much care is taken to avoid the injuries alleged in this case. Whether the positioning is for a surgery lasting one hour or 10 hours, the anesthesiologist maintains the position of the cervical area and airway. It is of note that the anesthesiologist's role in positioning the patient and maintaining vital signs was not mentioned in this claim, and this role appears not only to be to be the crux of the case, but the etiology of the plaintiff's longstanding injury.

The other equally important issue in this case is the delay of the surgeon arriving to perform the surgery, while the patient was waiting on the operating room table. Although not explained in the summary, the reader can assume that the patient was prepped and positioned for the surgery and the surgeon did not arrive in a timely fashion. This case occurred in 2005 when, in fact, The Joint Commission had issued its list of National Patient Safety Goals (NPSGs) one year earlier, in 2004. One of these goals, the Universal Protocol or "time out" procedure, was created to prevent wrong-site, wrong-procedure, and wrong-patient surgery. The intent of this goal is to ensure patient safety by requiring that all immediate members of the procedure team including the surgeon, anesthesia provider, circulating nurse, operating room technician, and other participants in the procedure be present for the verification of the patient's identity, type of procedure to be performed, verification that an informed consent exists for the procedure, and verification of the laterality of the surgery or procedure if required for the particular procedure. The time out is done even before the patient is positioned and draped. At that point, the "captain

of the ship," in this case the surgeon, ensures that everyone is aware of the overall plan of care for the patient, and everyone agrees to begin. The surgeon and anesthesiologist also agree on the anatomical positioning of the patient to ensure a good outcome. Clearly, this time out did not occur in this case. Had the Universal Protocol standard, in the form of a time out, been performed, the surgeon would have been in the room and ready to operate. The members of the operating room staff that allowed this patient to arrive in the OR, prepped and positioned, without the surgeon on hand are equally responsible for deviation in the standard of care and the overall outcome of the patient. This breech would be considered a sentinel event reportable to The Joint Commission.

Clearing a re-education and reinforcement of the NPSG regarding Universal Precaution accompanied by a concurrent observation of time-out procedures is recommended as a corrective action in this case.

Reference

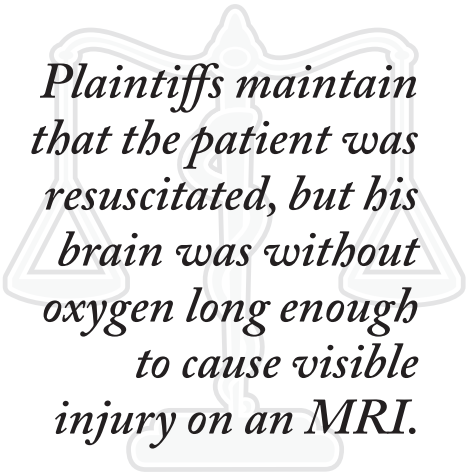
Backus v. Kaleida Health, et al., 91 A.D.3d 1284 (App. Div. 4th Dept., 2012). ✦

$1.2 million verdict to parents of a 5-year-old boy who suffered anoxic brain injury during tonsillectomy

News: A Dauphin County jury awarded the parents of a 5-year-old boy $1.2 million in damages against a physician for failing to appreciate the then 11-month-old patient's enhanced risk for respiratory failure that resulted in anoxic brain injury subsequent to the performance of a tonsillectomy. The patient presented to the physician's otolaryngology practice for tonsillectomy and adenoidectomy after preoperative testing determined that sleep apnea, a condition that interferes with breathing during sleep, was causing respiratory problems. Postoperatively, the patient experienced breathing problems and remained in the recovery room for five hours due to low blood oxygen levels. Subsequently, the patient was found without a pulse and required resuscitation. Plaintiff's counsel contended at trial that the cardiac arrest, brain injury, and developmental delays incurred by the patient would not have occurred if the physician had properly monitored his blood oxygen levels postoperatively.

Background: In 2007, the then 11-month-old patient presented to a physician's otolaryngology practice for a tonsillectomy, adenoidectomy, and insertion of ear tubes after preoperative testing revealed that sleep apnea was accounting for nearly 50 breathing episodes per hour. During these episodes, the patient's blood oxygen levels dropped, and the patient's mother feared "he might stop breathing during his sleep."

According to the sleep study performed by the physician, the patient's Apnea Hypopnea Index (AHI) reached 43, a level that is four times higher than classified severe sleep apnea, which placed the patient at an increased risk for postoperative respiratory complications. However, plaintiffs (the patient's parents) contended at trial that the physician failed to appreciate this respiratory condition and placed him on a regular-floor room rather than intensive care. Additionally, plaintiffs alleged that the physician ordered the pediatric nurses to observe the patient as they would any other patient (every four hours), neglected to conduct sufficient postoperative physical exams, and ordered that the child's pulse oximeter (the finger-mounted device used to measure blood oxygen) be prematurely removed. In its place, the physician ordered a regular heart and respiratory rate monitor.



Plaintiffs maintain that the patient was resuscitated, but his brain was without oxygen long enough to cause visible injury on an MRI.

According to plaintiffs, the patient was last observed by pediatric nursing staff at 4 a.m., and no record of his oxygen saturation was maintained for the next hour and 45 minutes. At 6:40 a.m., the patient was found not breathing and without a pulse. Plaintiffs maintain that the patient was resuscitated, but his brain was without oxygen long enough to cause visible injury on an MRI. Moreover, plaintiffs claimed that subsequent to his code, the patient was "like a newborn" and was unable to lift his head, sit up, move, or talk. Furthermore, plaintiffs presented pretrial evidence that one in four children who have an AHI in the 40s and oxygen desaturation below 80 have some type of respiratory problem. In addition, the plaintiffs contended that there is a direct correlation between a child's age and respiratory issues: the

younger the child, the greater the risk of a respiratory problem.

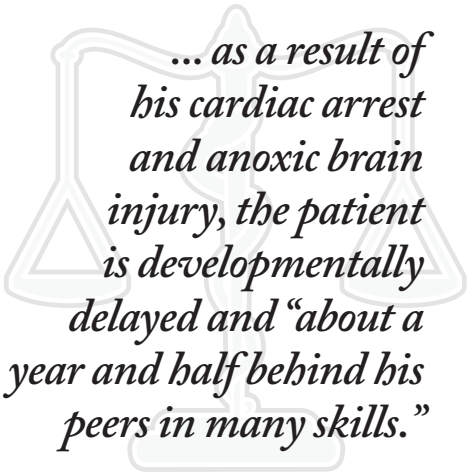
At trial, plaintiffs presented evidence that as a result of his cardiac arrest and anoxic brain injury, the patient is developmentally delayed and "about a year and half behind his peers in many skills." However, the defendant physician argued that the patient, according to his preoperative sleep study, was driven to breath by decreased blood oxygen saturation, which is typical in obstructive sleep apnea patients. Furthermore, the defendant physician attributed the patient's respiratory distress as a result of hypoglycemia and/or acute aspiration, which would not have been identified by blood oxygen saturation. In addition, the defendant physician argued that admission to the intensive care unit is not the standard of care and nurses did not observe signs of respiratory distress. Nonetheless, after a seven-day trial, a jury awarded the parents $500,000 in non-economic damages and $686,170 in loss of future earning capacity.

What this means to you:
Needless to say, a case such as this, with such a significant injury and long-term sequelae, has a very high sympathy factor and settlement value.

This pediatric patient, who suffered from significant sleep apnea documented by diagnostic testing, was recommended to undergo a tonsillectomy, adenoidectomy, and insertion of ear tubes by his otolaryngologist. This procedure is a viable option because the removal of the tonsils and adenoids opens the throat area, which allows oxygen to flow more freely during inspiration and ultimately can alleviate sleep apnea.

Once the decision was made to allow this patient to undergo this surgery, it is important that the anesthesiologist, as part of the surgical team, be made aware of the high-risk nature of this infant and provide an adequate assessment and safety measures regarding intubation and oxygenation intraoperative and postoperatively.

Once in the recovery room, the patient was monitored for five hours. The recovery room nurses are trained to provide intensive care and can provide a higher level of care and postoperative monitoring. Of importance in this and in any surgical case is the postoperative handoff when the patient is admitted to the recovery room. The nurses and other caregivers need to be aware of any information regarding the outcome of the procedure and whether the procedure was routine or there were issues encountered intraoperatively.



When the patient's oxygen levels decreased during the recovery period, this information should have been immediately escalated and communicated to the physician in charge. It would be important to know if the patient still was intubated or if the endotracheal tube had been removed. If the patient was intubated, then the oxygen administration easily could have been manipulated and monitored. If the patient was extubated, maybe it was premature to do so. Any swelling of the trachea could have contributed to low oxygen levels and would need to be treated as an emergency. If any change in respiratory or mental status was noted at any point during this child's recovery, then it was incumbent upon the caregivers to escalate that information to the attending physician.

In most hospitals, the anesthesiologist is the "captain of the ship" in the recovery room and would make the ultimate decision, based on his/her assessment and the patient's overall needs, what would constitute an appropriate transfer. The development of discharge criteria regarding the transfer of patients from the recovery room to another area of the hospital allows for consistent decision-making among the healthcare professionals.

In this case, because the infant had episodes of hypoxia while in the recovery room, a prudent decision would be to transfer the patient to a higher level of care, such as the ICU, where strict monitoring of oxygen and other indicators would be done. Then appropriate monitoring for any type of respiratory or metabolic emergency could be quickly identified and managed. Once the patient was placed on a regular pediatric floor, with limited monitoring and physical assessment, the die was cast.

In essence, proper handoff by the surgical healthcare team, an adequate postoperative physical assessment conducted by all caregivers involved, adequate and timely communication of abnormal findings to the "captain of the ship," established recovery room discharge criteria, transfer to the appropriate level of care to include a verbal handoff to the transferring unit, were required by all the healthcare professionals involved to avert this tragic event.

Reference

Graham v. Shapiro, 2009-CV-14003-MM, Dauphin County, PA (2012). ✦

Dear *Physician Risk Management* Subscriber:

The January issue of your newsletter marked the start of a new continuing education semester.

Physician Risk Management, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options. Our intent is the same as yours — the best possible patient care.

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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.
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On behalf of AHC Media, we thank you for your trust.

Sincerely,

Lee Landenberger
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