PHYSICIAN Risk Management

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Did MD fail to give new treatment? It might be just the evidence patient needs to sue

Standard of care is issue in court

A plaintiff attorney successfully argued that a teen-ager with a head injury, who was admitted to the neurological intensive care unit at a Level One Trauma Center in Washington, DC, should have had continuous intracranial monitoring as this was the legal standard of care, despite some compelling evidence to the contrary.

"The hospital did not have the equipment to perform such monitoring, and at the time, less than 50% of the Level 1 trauma centers had the capability to perform such monitoring," says **Michael M. Wilson**, MD, JD, a Washington, DC-based health care attorney.

The capability now is relatively standard, but it was not the norm at the time of case (2003), Wilson explains. "However, the plaintiff successfully argued that the defendant hospital should have used this new technology to treat such a patient and that it would have prevented his newly acquired brain damage from happening," he says. "The case settled for an amount in the high seven figures."

Madelyn S. Quattrone, Esq., a senior risk management analyst at ECRI Institute, a Plymouth Meeting, PA-based organization that researches approaches to improving safety, quality, and cost-effectiveness of care, says the standard of care is "a fluid concept." *(See related stories, p. 111, on what constitutes the standard of care, and how documentation can prove the standard of care was met.)* "This is where the concept of medical judgment arises. Some physicians, by their nature, may tend to more slowly adopt newer treatment modalities, waiting until the peer-reviewed medical evidence is more convincing," she says.

Some physicians, by their nature, may tend to more slowly adopt newer treatment modalities ...

A physician who is an early adopter of new techniques or treatment modalities might come off as arrogant to a jury or, on the other hand, might be perceived as a doctor who is "on the ball" and offered the patient the best that modern science can offer, says Quattrone.

Similarly, a physician with a more conservative approach might be seen as wise

INSIDE

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and prudent or might be cast as a doctor who is out of touch with developments in the field. "There are a myriad of reasons why a physician may be reluctant to adopt a new treatment modality or use a newer approach to treatment that is not yet established as the standard of care in the profession," says Quattrone.

The standard of care in a medical malpractice case is situation-specific, and while a jury ultimately determines whether the standard of care was met, the evidence that a jury uses to make that determination is largely provided by the expert witnesses, says **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois Medical Center in Chicago and a practicing attorney in Frankfort, IL. "The standard of care is a 'reasonability' standard," Sullivan adds. "It does not require that physicians practice as the leading medical practitioners might practice, and does not require that physicians practice 'perfect' medicine."

Alternative treatments

To avoid a "he-said/she-said" dispute during litigation, Wilson recommends that physicians take these steps:

Executive Summary

If a physician fails to use a new technique or treatment modality and a bad outcome occurs, a lawsuit could allege the standard of care was breached. Physicians can:

- ✦ document that alternative treatment options were discussed;
- ✦ have patients acknowledge that they selected the treatment to be used;
- ✦ encourage the patient to obtain a second opinion from a physician with a different approach.

• Document the various alternative courses of treatment, and the significant risks and benefits of each.

• Have the patient sign the document and acknowledge that he or she has selected the treatment to be used after receiving the information concerning the alternatives.

"This is particularly useful where one or more of the alternatives is new or experimental, or where there is a significant divergence of professional opinion as to the course to be followed under the circumstances," says Wilson.

In general, the more the treating physician documents that accurate information was provided to the patient concerning the reasonable alternatives and the risks and benefits of each, and that the patient made an informed decision, the more defensible a claim will be, says Wilson. Quattrone says, "The issue at trial often boils down to the reasons why the physician used a particular treatment approach."

She says this issue raises questions such as "Was the physician aware of alternative treatments and their risks and benefits?" "Can the defendant physician clearly articulate to a jury why he or she believed the treatment was appropriate for the patient's condition?" "Can the defendant physician's reasoning in the particular case be supported by the opinion of a credible expert witness?"

In some states, juries are instructed that a physician is allowed to exercise his or her judgment regarding the treatment modality employed, even if it turns out in retrospect to be the "wrong" choice, explains Quattrone. "This is often referred to as the `two-schools-of-thought doctrine,'" she says.

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The chosen treatment modality might be the preferred choice of a significant minority of providers, or it might even be considered a developing practice, such as an off-label use of a medication or an innovative option with a sound scientific and clinical rationale.

"Importantly, when this doctrine is applied, the defendant physician bears the burden of proving that a 'two-schools-of-thought instruction' is appropriate," says Quattrone. "This makes it different from the typical malpractice case, where the plaintiff bears the burden of proof and the burden of persuasion."

SOURCES

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Who is it that defines legal standard of care?

The definition of "standard of care" essentially comes down to a battle of the experts, with each side proffering testimony from their expert as to the standard of care that they contend should have been followed, says **Michael M. Wilson**, MD, JD, a Washington, DC-based health care attorney.

"It is helpful to have treatises or journal articles to support the expert's opinion, but these are not essential," says Wilson. "Because of the publication and review process, they necessarily lag behind the current standard of care, and treatises are out of date the minute that they are published."

Expert witnesses will contend which course of conduct would have been most beneficial to the patient, says Wilson, adding that the legal definition of the "standard of care" varies according to state law. In the District of Columbia, for instance, the standard of care is the national standard of what a physician of the same specialty should do under the circumstances.

"Therefore, it is not based upon a hypothetical poll of physicians in which the test is what course of treatment is most commonly followed, or what course is well-established, or what course is newer," says Wilson. "The standard is what a physician should do under the circumstances."

Is it admissible?

The admissibility of expert testimony regarding the standard of care varies based upon state law, says **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois Medical Center in Chicago and a practicing attorney in Frankfort, IL.

Federal courts and most state courts follow the Daubert standard, which requires that judges examine evidence to determine whether the evidence is relevant, reliable, and derived from sound scientific methodology.[1] A minority of state courts follow the Frye standard, which states that scientific evidence is only admissible if the principle upon which the evidence is based has gained "general acceptance" within the field.[2]

In determining whether expert testimony is admissible under a Daubert standard, the Supreme Court stated that judges may inquire about whether the evidence has undergone empiric testing, whether the evidence has been peer reviewed and/or published, and the degree to which the expert's theory has been accepted by the relevant scientific community, says Sullivan, pointing to research showing that new innovations typically follow a pattern of acceptance.[3]

A small minority of 'innovators' might propose a new theory, a somewhat larger minority of 'early adopters' implement that theory, and then two-thirds of the community are split evenly between 'early majority' and 'late majority' of adoption of a concept, he explains, and about one in seven people are considered 'laggards' who are hesitant to adopt even proven innovations.

"A prudent risk management strategy may be to avoid being an 'innovator' or a 'laggard,' and to weigh the risks and benefits of being an 'early adopter,'" says Sullivan. "Should a patient suffer a bad outcome due to a relatively new treatment, a plaintiff attorney would likely argue that 'innovators' are being reckless with patient care and that laggards' are out of touch with patient care."

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Your chart can prove standard of care wasn't breached

A surgeon provided a telephone order to nurses after viewing a film from home after being called from a hospital late at night regarding a change in a patient's condition post-surgery. While the care was appropriate, the

physician didn't document these interventions, says **Linda M. Stimmel**, JD, an attorney at Wilson Elser in Dallas.

"This case resulted in a lawsuit, and there were no records from the hospital to show the physician accessed the chart remotely," she says. "That omission was problematic enough, but in addition, the physician's charting only stated the order — not that the chart was viewed remotely."

The patient's chart did not make any mention of the physician's assessment of the film, which was the reason for the order, Stimmel explains.

The case was difficult to defend because no assessment was charted, despite the fact that the physician was reasonable and prudent in reviewing of the film and differential diagnosis, she reports. "If the physician had charted that the film was reviewed, it would have helped to defend the case," she says. "A jury usually believes charting at the time of the occurrence."

The most consistent way for physicians to show they met the appropriate standard of care is to make sure the assessment, differential diagnoses, treatment, and results are clearly charted, advises Stimmel.

In another malpractice lawsuit involving a physician who met the standard of care but was unable to prove it, an obstetrician was receiving updates on a laboring patient by "texts" from the nurse, but failed to document the texts. "The information in the texts was never charted by either the nurse or the physician," says Stimmel. "The physician and the hospital were sued for lack of monitoring of a patient who had a bad birth outcome. It became very difficult to prove the physician met the appropriate standard of care." ✦

Avoid successful suits alleging prescribing errors

Paper-based prescribing errors are common with primary care practices, according to a recent study which found that 27.8% of 9,385 prescriptions had at least one prescribing error.[1] The prescriptions reviewed were for 5,955 patients written by 48 ambulatory care providers in New York and 30 providers in Massachusetts.

Antibiotics had the most prescribing errors, followed by cholesterol medications, narcotic analgesics, and blood pressure drugs. According to the researchers, use of electronic prescribing with a basic clinical decision support system in place could have prevented 32% of prescribing errors, and an advanced system would have prevented 57%. *(See story on reducing risks of "alert fatigue," p. 113.)*

Medical malpractice claims involving prescribing errors typically involve prescribing an incorrect medication or prescribing the correct medication at the wrong dose, according to Lisa **Lepow Turboff**, JD, a shareholder with Munsch Hardt Kopf & Harr in Houston, TX.

Typically, any prescribing error case does not fall exclusively on physicians' shoulders, says Turboff, as nurses and pharmacists must know the rationale for prescription drugs including basic side effects and dosing information as described in the product labels printed in the Physician's Desk Reference (PDR). "Nurses and pharmacists are required to question a physician's prescription that falls outside of those parameters," she says. "Physicians must be receptive to nurses and pharmacists who question their orders, as these are the medical professions who can catch a mistake and prevent an injury and avoid a lawsuit."

Here are some liability risks involving drug prescribing:

• Prescribing opioid mediation following surgery.

"Typically, opioids are prescribed to control post-surgical pain," says Turboff. "However, they are known respiratory depressants, which could cause decreased breathing in the patient."

When patients suffer adverse outcomes related to opioid prescriptions, physicians are typically sued on the basis of either not prescribing a weaker mediation initially before defaulting to an opioid, or prescribing the opioid to be given at too-short intervals, says Turboff.

• Prescribing a drug to which the patient is allergic.

Although it's rare for physicians to prescribe penicillin to a patient known to be allergic to penicillin, it's not infrequent that a similar drug might be prescribed that should be avoided in the penicillin-allergic patient, such as ampicillin and sulbactam, says **John Davenport**, MD, JD, physician risk manager of a California-based HMO. Similarly, erythromycin-sulfisoxazole might be given inadvertently to a sulfa-allergic patient. "Drug references, the PDR, and your local pharmacist are valuable resources to help avoid allergy cross-reactivity," he advises.

• Prescribing a drug that interacts with a drug the patient is taking.

"Drug interactions with the blood

Executive Summary

Electronic prescribing with a basic clinical decision support system could have prevented 32% of paper-based prescribing errors, according to a recent study, but electronic medical records also pose potential legal risks. Claims have resulted from:

- ✦ failure to monitor a prescription drug, due in part to ease of refills;
- ✦ providers overriding warning prompts;
- ✦ prescribing opioid medication at too short intervals post-surgery.

thinner warfarin, and subsequent bleeding, are a common cause of malpractice," says Davenport. "One must be wary of prescribing many drugs to patients on warfarin."

Certain combinations of many common drugs, including selective serotonin reuptake inhibitors, fluconazole, clopidogrel, and anti-inflammatory agents can put patients at risk for bleeding, says Davenport.

"Drug lists that patients present to us are often daunting and inaccurate. But your legal duty is to be aware of the information at hand, including the drugs the patient is on, before prescribing," says Davenport. "Seek out the information a reputable physician in a similar situation would seek out prior to prescribing."

• Overprescribing pain medications.

Malpractice cases and medical board actions are increasingly directed at physicians who prescribe excessive amounts of pain medications without adequate examinations, supporting diagnoses, and proper monitoring, warns Davenport. "When pain became the 'fifth vital sign,' physicians were encouraged to use whatever pain control was necessary to alleviate pain," he says. "With an increasing incidence of overdose, addiction, and drug diversion, the pendulum is swinging back." *(See related story on claims involving prescribing narcotics, this page, and "Spotlight on doctors' role in prescription drug abuse,"* Physician Risk Management*, August 2012, p. 17.)*

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Did you override an EMR alert? Be prepared to explain why

Do you routinely ignore warning prompts given by an electronic medical record (EMR)? The alerts, given when providers prescribe a drug to which the patient is allergic, or for which there is an interaction, do increase safety, says **John Davenport**, MD, JD, physician risk manager of a California-based HMO, "but in order to avoid their own liability, the allergies and interactions programmed into these systems tend to be exhaustive and often include trivial or rare reactions."

This factor often causes "alert fatigue" — the automatic overriding of a warning prompt by providers, says Davenport. "When you override a warning prompt, be prepared to answer the trial question, 'Isn't it true that your computer record warned you that the drug you were prescribing could cause a reaction with this patient's medication?'" he advises.

Ideally, says Davenport, the physician can truthfully respond that he or she was aware and judged the interaction or potential allergy to be trivial. Davenport recommends giving feedback to the EMR provider to help them design and fine-tune more reasonable alerts.

Another potential legal risk involves the ease with which EMR prescriptions can be refilled, says Davenport. Though a medication might be refilled with just one click, it still is the physician's responsibility to know that the drug being refilled is the proper drug in the proper amount for the patient's condition, he advises.

"A common fact pattern seen in litigation is failure to monitor a prescription drug — liver function when refilling statins, or electrolytes when refilling diuretics, for instance," says Davenport. "The ease of EMR prescription refills contributes to this." ✦

Most drug error claims involve narcotics

According to a 2011 analysis of 2,646 malpractice claims from all medical specialties closed at The Doctors Company in Napa, CA, 5.8% contained medication-related errors. Of these, 18% included narcotic analgesics, with hydrocodone accounting for eight claims (27% of the total).

Hydrocodone is the most widely prescribed pain medication in the United States, and a Food and Drug Administration (FDA) panel voted to tighten restrictions on prescribing it in January 2013. "If the FDA accepts the panel's recommendation, it will go to the Department of Health and Human Services for final approval. Refills without a new prescription would be prohibited, and only written prescriptions from a physician would be permitted," says **David Troxel**, MD, medical director of The Doctors Company.

If this restriction is subject to an "FDA Alert," it will become the standard of care, and if an adverse drug event results from violating it, the physician might be held liable, says Troxel.

Many of the professional liability claims involved adverse events that occurred in the post-anesthesia care unit, intensive care unit, or critical care unit and involved pain medicine overdose, failure of communication between prescribers of pain medications, and inadequate monitoring of patients receiving pain medications, says Troxel. "The most common adverse event is respiratory depression, often in patients with unrecognized obstructive sleep apnea," says Troxel. "This can result in the need for ventilator support and sometimes in death."

Compared to medication-related errors in all claims, monitoring, administration, and ordering errors were more common in claims involving narcotic analgesics, according to the analysis. "A common contributor to these adverse drug events is failure of communication, sometimes resulting in poor coordination of care between physicians, often during hand-offs, and between physicians and nurses, often during shift changes," says Troxel. "Hopefully, monitoring protocols, e-prescribing, and [electronic health record] drug alerts will obviate this problem."

Difficult position

Troxel has seen patients' allegations of overprescribing opioids for chronic pain management result in a medical board action against the physician.

"Physicians are put in a difficult position," he says. "They can be sanctioned for overprescribing opioids, resulting in dependency or addiction, and they can be criticized for failing to prescribe sufficient opioids to relieve patient pain and thereby causing pain and suffering."

Troxel advises physicians who prescribe opioids to take the FDA's Risk Evaluation and Mitigation Strategy (REMS), a three-hour online course on long-acting and extended-release opioids. *(For more information, go to http://1.usa.gov/qiruyI.)*

"REMS covers three basic components: Prescriber training to ensure safe use, patient counseling on safe use and risks, and a medication guide for each opioid, which patients receive when prescriptions are filled," says Troxel. ✦

'Never events' resulted in $1.3 billion in settlements

One-third of cases resulted in permanent injury

Nearly 10,000 cases of "never events" occurring during surgery and totaling $1.3 billion in settlements were reported to the National Practitioner Data Bank between 1990 and 2010.[1] The average payout for a surgical never event was $133,055. In one-third of the 9,744 cases studied, there was a permanent injury to the patient.

Use of checklists resulted in a three-quarters lower likelihood of missing critical lifesaving steps, according to a recent study that looked at 17 operating room teams participating in 106 simulated surgical-crisis scenarios.[2]

"There have strong disagreements around whether under crisis conditions, people are actually better off going with their judgment," says **Atul Gawande**, MD, one of the study's authors and a professor in the Department of Health Policy and Management at Harvard School of Public Health in Boston.

The study showed that in fact, physicians are better off following protocols that can help them remember key things they might otherwise forget in a very stressful high-risk situation, he says. Every team performed better when the crisis checklists were available than when they were not, according to the study.

"Medicine has taken a different route than the airline world, where you handle a crisis with a protocol, under the argument that the complexity of human conditions is too overwhelming for a protocol," says Gawande. "This study indicates that is not true." *(See related story, below, on disclosure of surgical mistakes.)*

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Executive Summary

Nearly 10,000 surgical "never events" totaling $1.3 billion in settlements were reported to the National Practitioner Data Bank between 1990 and 2010. One-third of the cases resulted in permanent injury.

✦ Use of checklists lowered the likelihood of missing critical lifesaving steps.
✦ Use of protocols has been shown to reduce risks for physicians.
✦ Staff should mention only facts, not opinions, when disclosing surgical errors.

Surgical mistake made: Consider disclosure

Claims 'more defensible'

After reviewing an X-ray of a patient with a renal tumor who was referred from another facility showing a tumor on the left side, the physician proceeded to remove the patient's left kidney, which pathology later revealed to be normal.

"On further review, the original X-ray was mismarked. The physician was devastated, and the patient was left on dialysis," says **Erin L. Muellenberg**, JD, an attorney at Arent Fox in Los Angeles. "This was an example of the type of nightmare that every provider wishes to avoid."

Instead of hiding the error, the doctor apologized and openly explained the situation to the patient and family, and he stated that he should have repeated the films instead of relying on the single X-ray. "Further investigation showed that in fact, the doctor had offered to retake the X-rays, but the offer was declined [by the patient] as it would have been an unnecessary exposure to more radiation with very little expected difference that would have impacted his surgery," says Muellenberg.

There was no claim because everyone recognized that the surgeon had reasonably relied on the other X-ray, but the facility and the surgeon paid to compensate the patient and cover his future medical care including future transplant costs.

"Where there is a clear error, compensation is appropriate," says Muellenberg. "Had the staff or surgeon tried to hide or cover this up, it would have exposed all of the providers to punitive damages."

Most important to disclose

Because surgical errors might be more likely to lead to adverse outcomes of greater severity, it could be more challenging for physicians to feel comfortable disclosing these errors, even though they are the most important to disclose, says **Anupam B. Jena**, MD, PhD, an assistant professor of health care policy and medicine at Harvard Medical School and a physician in the Department of Medicine at Massachusetts General Hospital.

"For most physicians, I think the desire to admit to an error does not simply stem from a desire to avoid malpractice litigation, but more importantly, from professional obligation to the patient-physician relationship," he says. "The byproduct of reduced liability is but one consequence of that decision."

Jena points to data showing that that early disclosure programs can reduce liability and the time required to resolve clinical disputes.[1] Jena also points to data demonstrating that state apology laws which specify that a physicians' admission of guilt to a patient is inadmissible in court might lead to reduced payment sizes and time required to resolve malpractice cases, particularly among patients with more severe injury.[2] "I think that most would agree that further rigorous evaluation of not only these policies but others, such as 'safe harbors,' are important to guiding reforms in malpractice," says Jena.

Muellenberg recommends educating staff on how to react when there is an error, and avoiding disclosure of opinions. "Transparency has to apply to the facts and not to opinions regarding causation," she says. "Apology is similar, in that it has to avoid any mention of the cause."

For example, a family member overhearing staff comment that the surgeon "had another screw-up" is completely inappropriate, she says.

"The use of both transparency and apology can go a long way in mitigating the risk of a legal action," says Muellenberg. "Transparency always makes a claim more defensible."

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Med students inadequately supervised? Suits likely

Inadequate supervision is the main legal risk involving physicians working with medical students, according to **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.

"Teaching the next generation of physicians is an important and rewarding responsibility of current physicians," he says. "However, medical students are just that: students." The supervising physician is generally legally responsible for the medical care provided by medical students, underscores Fanaroff. He gives these risk-reducing strategies:

• Whenever a medical student is learning to perform a procedure, there should be direct supervision.

For example, a medical student might perform a lumbar puncture and fail to use sterile technique. "If an infection subsequently developed, the supervising physician may be held liable," says Fanaroff.

• Orders written by a medical student should be reviewed and signed prior to their implementation.

"A medical student may order a contraindicated medication, which is then given to the patient before the supervising physician has a chance to change the order," says Fanaroff.

• Medical students should always wear identification, and it should be clear to patients that they are interacting with a student.

"Patients have the right to know who they are talking to, and without clear identification, may think they are talking with a physician, not a student," says Fanaroff. "A lack of informed consent claim may be filed against the supervising physician."

Executive Summary

Supervising physicians may be legally responsible for the medical care provided by medical students, and inadequate supervision is the main legal risk they face.

✦ Physicians should provide direct supervision whenever a medical student is learning to perform a procedure.

✦ Providers should review orders written by a medical student and sign these prior to their implementation.

✦ Medical students should always wear identification to be clear that patients are interacting with a student.

SOURCE

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Do you need to obtain coverage to defend against their 'experts'?

Did a physician testify against you falsely in court or during a deposition?

"Physicians who have been sued, particularly those who have successfully defended their case, often have a need to resolve the feelings of betrayal by a fellow physician who has testified unethically," says **Louise B. Andrew**, MD, JD, FACEP, litigation stress counselor and principal at MDMentor.com.

Evidence of the willingness to pursue unethical experts in court — for example, having countersued an expert who testified in a prior case — could deter litigation before it occurs, says Andrew. She warns, however, that any action by a defendant physician against an unethical expert should never be initiated during the pendency of a case. "After the case is resolved, there are several possible mechanisms for pursuing an unethical expert," she says. These include reporting the testimony to the ethics committee of a medical association of which the expert is a member, reporting the testimony to the expert's licensing board as an example of unethical behavior, or simply publishing outrageous testimony verbatim on a website.

"A plaintiff's attorney is somewhat less likely to pursue litigation using an expert who is willing to say anything for a price — a so-called 'testiliar' — if he or she realizes that both the witness and the attorney might end up defending themselves against the defendant physician or that the expert may have to justify his or her testimony before a committee of peers on an ethics committee or medical board," says Andrew. *(For more information on this topic, see "Is expert witness in malpractice suit making false, misleading statements?" Physician Risk Management, September 2012, p. 25.)*

Prevent meritless lawsuits

Professional liability companies focus on defending against a claim and paying settlements or judgments within policy limits, according to **Jeffrey Segal**, MD, JD, founder and CEO of Medical Justice Services, a Greensboro, NC-provider specializing in protecting physicians' reputations and practices. They rarely, if ever, take any post-trial action against any proponent of a meritless lawsuit, he says.

Medical Justice Services focuses on preventing meritless lawsuits before professional liability coverage is triggered and providing post-case remedies against proponents of meritless lawsuits, says Segal. In one case, an orthopedic spine surgeon was sued for allegedly causing impotence and persistent pain related to his surgical technique.

"The expert witness, a pediatric orthopedic surgeon, gave this case legs," says Segal. "This expert didn't bring to the court's attention two important details."

The patient had been on erectile dysfunction medication long before the surgery, and an emergency department medical record stated that the patient reported doing well until an auto accident occurring that day.

"So the surgery had little to do with the patient's long-term pain," says Segal, adding that the expert ultimately was sanctioned by his professional organization.

Medical Justice Services does not defend lawsuits or pay settlements or judgments, says Segal, and its role is primarily before a lawsuit if filed and after a case is terminated. "To the extent there is any involvement while a case is pending, Medical Justice takes no action, unless and until cleared in writing by carrier-supplied defense counsel," he adds.

Plaintiffs are sometimes deterred from filing questionable cases against clients of Medical Justice Services when they realize their actions might be scrutinized, reports Segal. In one case, a lawsuit alleged a patient's heart stopped because an emergency physician missed high serum potassium levels and failed to treat hyperkalemia. "The doctor's defense was that the patient was dead a long time before she ever arrived at the emergency room. His position was that the potassium level was high due to death and decomposition," says Segal. In fact, the patient had been found at home after being down for at least 30 minutes, and she had remained in asystole after being found by family members, he explains.

"The physician wasn't dropped from the suit until the defense attorney contacted the plaintiff attorney to explain that the doctor subscribed to Medical Justice and had $100,000 available for a countersuit in the event the plaintiff loses the case," says Segal.

Executive Summary

A physician's willingness to pursue unethical experts in court could deter plaintiff attorneys from pursuing litigation using unethical experts.

- ✦ Insurers rarely take any post-trial action against proponents of a meritless lawsuit.
- ✦ Some physicians who have testified unethically have been sanctioned.
- ✦ Any action by a defendant physician against an unethical expert should never be initiated while a case is still pending.

SOURCES

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Receiving transferred patient? Chart injuries — Timing is key in event of lawsuit

Healthcare reform might lead to a greater number of "handoffs" and interfacility transfers, as regions establish Centers of Excellence for oncology, cardiology, orthopedics, neurology, and other specialized areas of care, says **Justin Keith**, vice president of Hiscox, a Hamilton, Bermuda-based international insurance provider.

"The creation of accountable care organizations is intended to facilitate the movement of patients to the caregiver best equipped to handle a patient, both from a care standpoint as well as a cost standpoint," he explains.

There will be more interfacility transfers, as a given geography consolidates specialized services under one organization or facility, predicts Keith. A heart patient, for example, might expect care from a particular region's cardiac Center of Excellence. If a physician fails to transfer the patient in this example to the facility deemed as the cardiac Center of Excellence and injury occurs, due to negligence or not, a claim or suit could be brought against the facility or physician for failing to transfer, says Keith.

Who is liable?

Liability transfers when the patient is admitted to the receiving facility, or when a physician consult occurs prior to transfer, Keith says.

"Practically speaking, however, when an injury occurs can be difficult to determine. Multiple practitioners and facilities will be named if a claim or suit presents," he says.

The extent to which an attending physician or facility is liable depends on the laws of the state or states in which the care is provided, says Keith, as well as the laws of contribution and vicarious liability.

Extent of injury

Keith commonly sees claims involving senior living facilities and decubitus ulcers.

"An admitting facility fails to properly document the extent of the injury at the time of the patient's admission, and as result, opens itself up to costly negligence claims," he says.

Similar claims have involved other post-acute settings when hospitals are transferring high-risk or very ill patients out of their facilities, adds Keith. "Risk management in this area has been quite effective, however. As a result, many long-term care facilities are adept at properly documenting existing injuries," he says.

When admitting physicians are dealing with a complex set of illnesses and injuries, often critical and at various stages of development, claims alleging failure to diagnosis and treat can occur, adds Keith. "Clear communication and consistent documentation is the answer to avoiding liability," he says. "The increased use of the

electronic medical record should help in the integration of care. However, many facilities still lag in this area, particularly primary care practices that are often the frontline in early diagnosis."

A recent claim involved a pediatric patient who was incorrectly diagnosed in the emergency department (ED) at an acute care hospital, but was properly treated following transfer to the children's hospital. "It was found through the course of discovery that the time period between treatment in the ED and the admission to the pediatric facility was critical and significantly contributed to the resulting brain injury," says Keith. "Documentation was poor on both ends."

Ultimately, the receiving facility incurred most of the incurred financial loss, primarily because it was responsible for treatment at the time the extent of the injury was discovered, says Keith.

"If the receiving facility or physician helps to stave off additional injury or the patient improves under its care, liability may fall upon it anyway if it does not properly document the extent of injury already present upon admission," he warns. ✦

Executive Summary

If physicians fail to transfer a patient to a facility designated as a Center of Excellence in a particular region, they face claims for failure to transfer.
✦ More interfacility transfers are expected to result from healthcare reform.
✦ Liability generally falls to the party most responsible for the adverse outcome.
✦ Physicians should document the extent of injury already present on admission.

Vendor's advice could result in medical malpractice suit

There are several disparate areas in which following a vendor or consultant's recommendations could lead to liability for an individual physician or physician practice, warns **Henry C. Fader**, JD, an attorney at Pepper Hamilton in Philadelphia. Here are some scenarios that carry legal risks for physicians:

• A practice's electronic medical record (EMR) fails to meet criteria for the Centers for Medicare & Medicaid Services' (CMS') "meaningful use" payments.

One of the Obama administration's initiatives is to expand the number of physicians using EMRs with incentive payments, but several criteria must be satisfied, notes Fader.

If a physician hires an information technology vendor to put the EMR into service, and the EMR does not meet the appropriate certification criteria or does not perform particular functions in accordance with the required criteria, the physician might inadvertently make a false claim to the Medicare or Medicaid program when requesting "meaningful use" payments, warns Fader.

"Providers should be certain that the EMR has been certified by appropriate oversight organizations, and that their legal counsel or consultant has the EMR vendor represent in writing that the planned EMR meets the certification standards," advises Fader.

• A consultant arranges for a practice to share de-identified patient information with a pharmaceutical company to examine prescribing practices with respect to a particular diagnosis.

Suppose the physician provides the consultant with access to the EMR records, and all of the patient-identifying data is loaded on the consultant's unencrypted laptop. "The laptop is stolen from the consultant's vehicle. Your practice has now suffered a breach under Health Insurance Portability and Accountability Act [HIPAA] and the HITECH [Health Information Technology for Economic and Clinical Health] laws," says Fader.

While the consultant would have joint responsibility under HITECH for the breach as a "business associate," the physician has to explain to patients how the breach occurred, says Fader. "This situation results in loss of reputation as well as potential fines from the Office of Civil Rights," he says. "Be sure that your legal counsel has reviewed your practice's business associate agreement to be sure it's compliant with HITECH requirements."

• As part of an accountable care organization (ACO) which requires that clinical guidelines be followed and patient satisfaction reported, a practice hires a consultant to assist in

Executive Summary

Physicians face some significant medical malpractice liability risks stemming from recommendations from a vendor or consultant. Some areas of risk:
✦ Electronic medical records might not meet appropriate criteria to quality for incentive payments.
✦ Data provided to consultants could result in violations of patient privacy regulations.
✦ Outsourced human resources functions might result in inadequate checks on employees.

the provision of appropriate clinical guidelines for its patients.

"But the consultant is providing advice and recording results that unfortunately enhance the practice's statistics. These are then used to qualify your patient population for gainsharing payments," says Fader.

As a result of using these enhanced statistics due to the consultant's advice, physicians might have filed a false claim and would need to return the savings to the ACO and the Medicare program, he explains.

"You must be especially vigilant that checks and balances for keeping track of patients in your care through internal controls are put in place from the beginning," says Fader. "Further, you ought to work with your compliance officer to ensure that appropriate quality measures and shared savings are being reported to CMS."

• A physician decides to outsource human resources (HR) to a consultant, who handles interviews and completion of employment and benefits paperwork and is supposed to verify credentials, verify references, and perform a criminal background check.

"As practices and facilities attempt to find ways to reduce costs, the HR function can suffer," says Fader. He gives the following scenario: An employee embezzles funds from the practice's bank account, and when you notify the police of the loss, they advise you that the employee had been convicted of theft previously.

"When you confirm the situation with the HR consultant, you get the bad news that they never performed the required criminal background check on the employee, costing the practice thousands of dollars in losses," says Fader.

Fader says that falsification of credentials is common, and that often, important due diligence steps are missed. He recommends:

— verifying transcripts by accepting only originals from an educational institution;

— ordering criminal background checks from the state police;

— checking credit reports and related lien and judgment searches where permissible.

• A consultant hired to assist a surgical practice in becoming more efficient recommends a new approach for obtaining consent.

For example, the consultant might suggest asking patients to indicate "I Agree" on a tablet computer as they are wheeled into surgery. "This device saves much time and effort in obtaining informed consent, but one of your patients sues for medical malpractice, and you have to testify that you provided the patient with informed consent," says Fader.

In this situation, he says, the plaintiff is likely to move for a directed verdict in favor of the patient since the physician is unable to testify that adequate informed consent was obtained. If informed consent is not deemed adequate by a court, the judge might find as a matter of law that the lack of consent led to the injury and damages, he explains.

"Your indemnification from the vendor may assist in recouping damages, but not overcoming the lack of consent and the resultant loss of the malpractice case," says Fader. ✦

COMING IN future MONths

✦ Strategies to convince plaintiff attorney not to sue

✦ Common allegations involving residents and interns

✦ Identify risk-prone EMR charting practices

✦ Obtain lower malpractice insurance premiums

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 what constitutes the legal standard of care, according to Madelyn S. Quattrone, Esq., a senior risk management analyst at ECRI Institute?**

   A. Physicians generally should not document that alternative treatments were discussed with the patient.
   B. Tort law principles in medical negligence cases recognize that the practice of medicine is not an exact science, that that a disease or illness may be treated in varying ways.

2. **Which is true regarding legal risks involving working with medical students, according to Jonathan M. Fanaroff, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine?**
   A. Direct supervision is not always necessary when a medical student is learning to perform a procedure.
   B. The supervising physician is generally not legally responsible for the medical care provided by medical students.
   C. Orders written by a medical student should be reviewed and signed prior to their implementation.

3. **Which is true regarding legal risks involving transferred patients, according to Justin Keith, vice president of Hiscox?**

   A. Liability transfers only when the patient is admitted to the receiving facility, and not before, even when a physician consult occurs prior to transfer.
   B. Physicians cannot be successfully sued for failing to transfer a cardiac patient simply because another facility was deemed a cardiac Center of Excellence, unless the resulting injury was due to the provider's negligence.
   C. Failing to properly document the extent of the injury at the time of the patient's admission does not by itself result in exposure to negligence claims.
   D. When admitting physicians are dealing with a complex set of illnesses and injuries at various stages of development, claims alleging failure to diagnosis and treat can occur.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Failure to order follow up on recommendations from radiologist leads to $150,000 award

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News: A 64-year-old man was seen for a CT scan in January 2004. The gastroenterologist who ordered the CT scan failed to follow through in ordering further radiology studies based on the radiologist's recommendation for the same. Eleven months later, in December 2004, the patient was diagnosed with kidney cancer with residual effects, including thrombophilia and myocardial infarction, due to the failure to timely diagnose. A jury awarded the plaintiffs $50,000 for past pain and suffering. Pursuant to an agreement between the parties, the plaintiffs recovered the stipulated minimum of $150,000.

Background: In January 2004, the patient, a 64-year-old man, underwent a CT scan of his abdomen by the defendant gastroenterologist at the physician's practice group. Prior to the CT scan, plaintiff suffered from gastroesophageal reflux disease. The CT results were reviewed by a radiologist who opined that further studies were necessary. Despite the radiologist's findings, the gastroenterologist did not order additional studies.

Despite the radiologist's findings, the gastroenterologist did not order additional studies.

In December 2004, 11 months after the initial CT scan, the patient learned that he was suffering from cancer of a kidney. The patient claimed that his cancer was not timely diagnosed or treated and that the delay allowed residual effects, including thrombophilia, an abnormality of the blood's coagulation. The patient further contended that the abnormality caused a myocardial infarction.

The myocardial infarction required two surgeries to place a graft to bypass an occluded artery. The patient and his expert claim the first surgery failed as a result of the thrombophilia. The second surgery was successful. The patient further claimed the myocardial infarction and surgeries led to the development of chronic obstructive pulmonary disease, that his heart was permanently weakened by the myocardial infarctions, and that the heart's weakness could cause additional problems in the future.

The patient sued the gastroenterologist that performed the CT scan in January 2004, the gastroenterologist's private practice group, the radiologist that reviewed the January 2004 CT scan, and a hospital that provided treatment to his condition. The patient claimed the gastroenterologist and radiologist failed to diagnose his cancer, that the hospital's staff failed to properly treat his condition, and that the failures of all constituted

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malpractice. The patient also claimed that the gastroenterologist's private group was vicariously liable for the gastroenterologist's actions. Prior to trial, the patient discontinued the claims against the hospital and the radiologist. The case proceeded to trial against the gastroenterologist and the physician practice group.

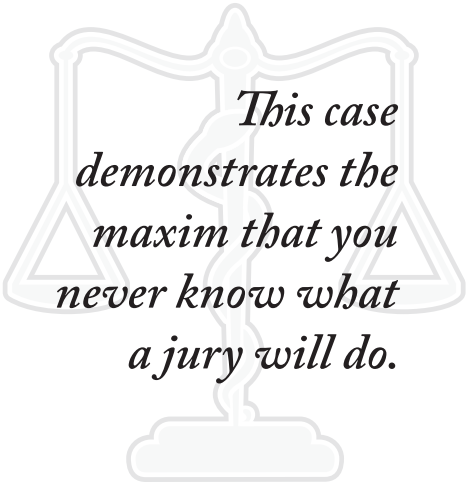
At trial, the patient's counsel claimed that the gastroenterologist ignored the radiologist's recommendations that further studies be performed and that the further tests recommended by the radiologist would have led to a prompt diagnosis of cancer. Defense counsel acknowledged that the gastroenterologist's inaction constituted a departure from an accepted standard of care but contended the inaction did not cause the myocardial infarction. Defense counsel argued the myocardial infarction was caused by an unrelated, pre-existing insufficiency of the patient's heart.

The patient and his wife were named plaintiffs in the lawsuit. The patient sought recovery of damages for past and future pain and suffering, and his wife sought recovery from damages for loss of consortium. Together the plaintiffs sought a total of $1.8 million. Plaintiff's pre-trial settlement demand was $750,000, and defendant's pre-trial settlement offer was $150,000. The parties stipulated that the plaintiff's combined damages at trial had to equal or exceed $150,000.

Following a seven-day trial, the jury found that the gastroenterologist's inaction caused the plaintiff's myocardial infarction. It determined that the plaintiff's damages totaled $50,000, all awarded for the patient's past pain and suffering. Pursuant to the parties' agreement, the plaintiffs recovered the stipulated minimum of $150,000.

What this means to you: This case demonstrates the maxim that you never know what a jury will do. The low amount of the verdict is surprising considering the facts as presented. In this case, it was conceded that the treatment by the gastroenterologist was negligent but their attorney took the position that such failure to meet the standards did not cause the myocardial infarction. Essentially, they asserted the "we-didn't-do-it" defense. The jury did allow for $50,000 in pain and suffering.

The kidney cancer was related to the CT of the abdomen, but the blood dyscrasia and the heart attack might not have been related to that condition. Risk management professionals need to be attuned to failure-to-diagnose claims as general propositions. In this particular situation, it is uncertain whether the cancer would have been detected had additional tests been done, but there is certainly the possibility that it could have been. Perhaps the testimony elicited in front of the jury was such that the cancer was treatable and the delay was not meaningful.



The case was litigated on damages and proximate cause of those damages to the patient's condition. In this case, these damages apparently were not felt to have caused significant harm. In another case or even in front of a different jury, the result might have been much different. The most disturbing thing about the case is the simplistic nature of the departure. The patient underwent testing and as is common for radiologists, the reader of the CT scan suggested additional studies. It is not unusual for a radiologist to recommend additional testing and sometimes a primary physician might think that the radiologist is being too cautious, but the primary care physician must consider many questions, including: what testing was suggested, how invasive the recommended tests were, and how expensive and uncomfortable the tests were.

The lesson here is that having ordered a CT scan, the gastroenterologist was bound to follow up on the results that included discussing the radiologist's recommendations with the patient and deciding on an appropriate care plan. At minimum, the gastroenterologist needs to make careful notes in the medical record of his thought process and the reasons for not ordering additional testing.

This case also highlights the "danger" of advanced testing. CT scans, MRIs, and other complex modalities, aside from their clinical indications, create a medical-legal two edged sword. It has become common for physicians to order additional testing in an effort to practice defensive medicine, to ensure that nothing is overlooked, and to provide coverage for the ordering physician. Looking at it from the other side, it is clear that the advanced testing also creates a burden. According to the case report, the patient came to the physicians complaining of gastroesphogeal reflux disease (GERD). Based on medical literature, is a CT scan a common modality employed in the treatment of GERD and, if not, perhaps the GI physician had

suspicions of some other more dangerous or complex condition or at least wanted to rule out a more serious malady?

If that is the case, then it would be even more important for the physician to follow up on the testing that was done and order the appropriate follow-up testing. Even if the condition was found, i.e., the kidney cancer was not in the differential diagnosis and was not what the GI doctor was looking for, the higher index of suspicion for something warranted a more complete follow through.

A different patient with a different condition using the same basic set of facts could easily have led to a verdict in excess of a million dollars. ✦

$1.5 million award in suicide malpractice case

News: A jury awarded a 51-year-old man's family $1.5 million following a finding that the defendant primary care physician was negligent and committed malpractice in treating the patient with antidepressants. The defendant primary care physician reportedly repeatedly renewed the patient's prescription for the antidepressant paroxetine without having seen or examined the patient in approximately 10 years. The patient, a teacher and assistant principal, committed suicide and left behind a widow and three daughters. The jury found the defendant primary care physician 100% responsible for the patient's death.

Background: The patient, a 51-year-old basketball coach, physical education teacher, and assistant principal, committed suicide while under the effects of antidepressants. The patient's widow filed suit against the patient's primary care physician alleging negligence and medical malpractice. Specifically, the plaintiff claimed that the physician was negligent in reportedly prescribing paroxetine for years without seeing the patient, in failing to warn the patient and his wife about the serious risks associated with paroxetine, in doubling the paroxetine dose and adding olanzapine, an antipsychotic drug, by telephone, and then in abandoning the patient during his decline.

The patient, a long-time patient of the defendant primary care physician, was prescribed paroxetine, an anti-depressant, by the defendant physician. Despite the longstanding physician-patient relationship between the patient and defendant physician, the defendant physician had not seen or examined the patient in approximately 10 years. The plaintiff claimed the defendant physician repeatedly renewed the prescription for paroxetine without examining or meeting with the patient.

The patient, a teacher and assistant principal, committed suicide and left behind a widow and three daughters.

In August 2009, the physician, via telephone order, put the patient on olanzapine and doubled his dosage of paroxetine following an anxiety attack. The plaintiff claimed this increase in the patient's drugs via telephone, without an in-person consultation, began an escalating decline in the patient's medical condition, which ended a little more than month later with his suicide.

Soon after the telephone order, the patient went to a local hospital with what he thought was a heart attack. At the hospital, a heart attack was ruled out, though the hospital physician put the patient on a lower dose of paroxetine.

Following the hospitalization, the patient was seen by the defendant primary care physician for their first office visit in 10 years. The plaintiff claimed that the defendant physician was furious that the patient had gone to the hospital and "exposed his treatment." The patient reportedly was thrown out of the defendant physician's office without further treatment.

The patient then was seen at another local hospital, where the hospital physician switched him from paroxetine to three other medications but failed to schedule any follow-up visits upon discharge from the hospital. The plaintiff claimed that after the second hospitalization, the patient got worse. She claimed he was feeling the side effects of the medication, including burning in his head and feelings like hot poison was going through his veins. The patient committed suicide shortly thereafter, and he left behind a wife and three daughters.

In February 2012, the state health department charged the physician with practicing with negligence for prescribing drugs to patients for many years without seeing them in his office. He was placed on probation for three years. In September 2012, the state dis-

ciplined the physician for abusing drugs and alcohol himself. His probation was extended to five years.

Following the two-week trial, the jury deliberated over two days. Ultimately, the jury found the defendant primary care physician 100% responsible for the patient's death. The jury awarded $800,000 to the plaintiff for the loss of her husband's income. The jury also awarded $200,000 to the patient's youngest daughter and $100,000 to each of his two oldest daughters for their loss of his support, guidance, and nurturing. An additional $324,000 in interest will be added to the verdict, which brings the total to $1.5 million.

What this means to you: Clearly nothing went right with this case. The physician caring for the patient committed outright malpractice and in addition to the adverse result of the suit, the physician was cited by the Office of Professional Medical Conduct for treatment failures and personal addiction issues.

The main areas of danger are clearly the failure to maintain appropriate oversight over the patient and his condition, the prescribing of drugs inappropriately by telephone, the failure to engage when presented with a clear issue, and the competency of this practitioner treating this condition.

Obviously, there is no arguing with the failure to see the patient on a routine basis. There is a tendency among some practitioners to consider "a little depression" as a small issue that can be dealt with in the office of a primary care physician. While that might be the case in mild cases of short duration, this particular patient had a problem for years. The failure of the family doctor to see the patient on a regular basis creates instant liability.

When the patient got into trouble, the family appropriately took him to a hospital for evaluation. Upon being advised of this action, the family doctor became angry and essentially discharged the patient from care. This step resulted in a new physician seeing the patient without the benefit of knowing the full history and the patient's prior response to medication. This case was clearly one of abandonment and subjected the physician to further liability.

The doctor routinely prescribed antidepressant medication over the phone without seeing the patient.

This particular patient had a long history of anxiety disorder and likely would have benefited from an evaluation by a specialist physician.

One short renewal until the next office visit might have been acceptable, but not prescribing for years without the benefit of the ability to see the patient, examine him, and take a history. This statement is especially relevant for these particular medications that have been identified as not so innocuous and contain explicit warnings from the Food and Drug Administration (FDA). In 2007, the FDA ordered makers of paroxetine and other anti-depressants to add warnings to their packaging saying the drugs increased the risk of suicidal thinking. As such, in this case, especially given the nature of the medication, the physician erred in routinely renewing the patient's prescription without examining or considering his history.

The other issue in this case is the propriety of this type of physician treating a patient such as this one with these types of drugs for an extended time. From a risk management perspective, the use of drugs that alter the brain chemistry and which have the potential for devastating side effects should probably be under the control of a psychiatrist or other trained practitioner. A short course prescribed by a family doctor or an internist to get the patient over a psychological bump in their lives is common. This particular patient had a long history of anxiety disorder and likely would have benefited from an evaluation by a specialist physician. The length of time that a medication is used does increase the risk.

Just as a primary doctor may prescribe antibiotics for a simple infection but will turn to an infectious disease specialist when the infection becomes chronic, patients on long-term selective serotonin reuptake inhibitors (SSRIs) such as this patient create medical legal risk and should be seen by the highest level of provider credentialed to prescribe the medication.

This case is an unfortunate one, and given that the treating physician was cited for his own use of alcohol and medication use, it might be that the root cause is the physician's own loss of reasoning ability. This brings up yet another risk management issue. We must be vigilant in monitoring providers for any hint of inability to perform at the appropriate level and intervene. This step is easier done in a hospital setting where the provider is out in the open, but any sign of compromise in a provider's status should be taken seriously before harm ensues. ✦