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Negative online review of MD? Keep legal risks front of mind

Patient postings coming up 'more and more' in med/mal suits

Did a dissatisfied patient post a negative review online about you or your practice? "We often hear from physicians who really, really want to tell their side of the story," says **Brandy A. Boone**, JD, a senior risk management consultant at ProAssurance Companies in Birmingham, AL.

Physicians should consult with an attorney before responding to a negative post, cautions **Bruce D. Armon**, JD, an attorney at Saul Ewing in Philadelphia. "Make sure there is an awareness of long-term implications. Pause and reflect before sending any response," Armon says. "You don't want to talk about the treating circumstances or any complications in a public setting. There is nothing to be gained from that."

Responding online could lead to litigation alleging invasion of privacy or unauthorized disclosure of protected health information under the Health Insurance Portability and Accountability Act (HIPAA). "There are no provisions in HIPAA that waive privacy regulations when a patient posts an online review," Boone explains.

Therefore, referencing a patient's health information in response to an online review could be viewed as an unauthorized disclosure, she says.

John W. Miller II, a malpractice insurance broker and principal of Sterling Risk Advisors in Marietta, GA, says, "A response can turn a well-intentioned statement to defend one's professional reputation into an actionable item for the patient, not to mention the fines and penalties that a physician could then face for HIPAA violations stemming from the response." A physician's response online to a negative posting can be taken out of context and damage the physician's defense, adds Miller. "Jurors expect their own physicians to be consummate professionals," says Miller. "For many, responding to negative postings is perceived to be beneath a physician who they view as a professional, especially when the physician's response is either not complete or casual."

A physician's response online to a negative posting can be taken out of context and damage the physician's defense...

Physicians might want to address

INSIDE

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underlying reasons for a patient's bad outcome, such as extenuating circumstances, other providers' negligence, or patient non-compliance, says Miller, "but bifurcating causation in a response to a posting is difficult at best."

Boone says physicians should consider these approaches prior to responding to an online review:

• Contact the patient directly to address any of the patient's complaints, if there is no ongoing litigation regarding the subject of a negative post.

"If there is ongoing litigation, we would not advise that, because both would be parties to the litigation and represented by counsel," says Boone.

There is no guarantee that a patient who posts a negative review also will sue, she says. There also is no guarantee that contacting the patient and trying to discuss the issue would not provoke the patient into considering litigation when he might not have been considering it previously, adds Boone. "Physicians who elect to contact patients posting negative reviews should be reasonable in any discussion, regardless of how strongly they disagree with the patients' allegations," she says.

• Document any conversations with the patient.

If a lawsuit is filed, patients will be able to testify regarding the substance of the conversation, and the physician will also get the opportunity to testify about what was said, Boone explains.

• Contact the organization that sponsors the website where the review is posted.

"Find out if there are options regarding retraction or issuing a generic denial of any allegations," says Boone.

Negative online reviews written by patients are coming up "more and more often in litigation," according to Miller.

"The first thing many defense attorneys do with every case is to Google the defendant, the plaintiff, and opposing counsel," he says.

Plaintiff attorneys can take advantage of negative online reviews in several ways, Armon says. "If there are multiple criticisms, fair or unfair, that might affect their strategy or decision to move forward," he says. "Just because something is posted doesn't make it accurate, but it could at least make them do additional digging." If they see another patient complained, the attorney could do a public record search to find out if any case was filed between that individual and the physician.

Review might be admissable

While in most cases, a patient's negative online review wouldn't be admis-

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Negative online reviews posted by patients are increasingly a factor during medical malpractice litigation. If a physician responds to a negative online review posted by a patient, the physician risks violating patient privacy regulations.

- ✦ Physicians should document conversations with patients.
- ✦ Exaggerated or false postings can make plaintiffs less credible.
- ✦ A physician's response can make a claim less defensible.

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sible in court, there might be exceptions depending on the specific facts of the case, says Boone. "But if the online review was posted by the plaintiff, that person can testify in court to the same information," she says. "It could possibly be used by the defense side to impeach the patient's testimony if they differ."

It would be more difficult for the plaintiff in a lawsuit to use negative reviews by another patient since in most cases, this information wouldn't be considered relevant, says Boone.

Miller says that online reviews of providers in the public realm could be used to substantiate a pattern of negligent care, especially if the reviews are "on point" relative to the facts and allegations in the filed action. "Equally often, however, negative reviews can hurt the plaintiff's case, especially when the plaintiff might have exaggerated their injury or condition on a social network site," says Miller. Such statements might be proven to be an exaggeration or simply false during discovery or at trial.

"The defense always indicates that credibility of the party to the suit is a huge factor when a jury convenes," says Miller. "The less credible the plaintiff, the better the physician's chance of prevailing at trial." ✦

You can prevent negative reviews

Give your patients the opportunity to have their voices heard

Instead of learning about a patient's dissatisfaction from reading a negative online review, physicians should take steps to prevent the patient from posting such a review in the first place, urges **Molly Farrell**, vice president of operations for MGIS Underwriting Managers, Inc., in Salt Lake City, UT.

"It's all about how you communicate with a patient and giving them an option to give you that information first," says Farrell. "Patients post on sites because they don't feel like they can communicate directly with the physician."

Physicians can survey patients via email to ask the question, "What are three ways you think I can improve my service?" and give patients an option to be called back, for example. "And if the patient gives their information, for crying out loud, please call them back," says Farrell.

Various studies over the years have shown a significant link between litigation and a breakdown in communication, according to **Elke Kirsten-Brauer**, chief underwriting officer for MGIS.[1-6]

If a negative review is posted, an office manager might contact the patient to say, "We understand you had a bad experience and we'd like to see what we could have done better," says Kirsten-Brauer. "Many patients would never speak up directly to the physician," she adds. The goal is to give the patient a chance to get a complaint resolved before it goes any further, says Farrell. "Negative reviews are available to everyone to see — including your underwriter, who might take a look and say, 'Here's a bad communicator,'" she adds.

Patients generally are much more critical online than they would be in person, notes Farrell. "The biggest thing you can do is address the situation before it ever becomes a negative review or malpractice suit," she says.

Farrell recently spoke with the head of a provider of medical liability insurance who said that if he could do one thing to reduce risks, he'd send a shirt to every physician stating, "Just Be Nice." If a patient suggests an improvement and the physician implements it, he or she is much less likely to file a lawsuit, adds Farrell. "Ask for feedback so you can be better," she says. "Then, take the input and actually do something with it."

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Will insurer want to settle med/mal claim?

When a professional liability carrier learns one of their insured is being sued, will they recommend a quick settlement or vigorous defense?

"Obviously, the insurance company is a for-profit organization. They are in business to make money, not to lose money. But they also realize that the reason for their existence is to support the rights of their physician insured," says **Leonard Berlin**, MD, FACR, professor of radiology at Rush University and University of Illinois, both in Chicago, and author of Malpractice Issues in Radiology.

"The first thing they do when a lawsuit is filed is to assign a claims manager to size up the case and make

an initial determination," says Berlin.

A medical malpractice case that appears easily defensible at first glance could suddenly be a strong candidate for settlement, depending on what defense attorneys learn during litigation, says **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician. McMenamin is also CEO of Clinical Advisory Services and principle consultant at the Venebio Group, both in Richmond.

"You have to keep your eyes open and maintain a measure of flexibility," says McMenamin, adding that he makes a point of bringing a case's strengths and weaknesses to physician defendants early in the process. "It's important for doctor to have realistic expectations and be clued in to potential downsides and potential threats," he says.

Berlin is aware of a case that was going well for the defense until the physician defendant's cell phone rang on the stand and the judge gave him permission to take the call. "He said, 'No, it can wait,' and the insurance company's claims manager, who was sitting in the courtroom, saw sudden grimaces on many of the jurors' faces, and they lost the case," he says. "He came across as a callous individual."

Here are some factors that could cause a carrier or defense counsel to think seriously about settlement:

• An opposing counsel of high caliber.

While some law firms win 90% of the malpractice cases they try, others win only 30% of the time, notes Berlin. "Just as you have both superb and mediocre doctors, the same thing is true for the law," he explains. "Without even looking at the medicine, if a 'blue chip' law firm takes the case, it doesn't mean you can't beat them, but it certainly throws the statistics in the plaintiff's favor."

• A judge that interprets the law in a way that makes it difficult for the defense to prevail.

"Most judges are ethically committed and straight shooters. It's a rare judge that puts his thumb on one side of the scale, but they do exist," notes McMenamin. "And there are jurisdictions where a case that could be won elsewhere might very well be lost."

• Information that taints the defense expert.

"If you hire an expert and discover on the eve of trial something damning about his resume or capabilities, that could change the complexion of the case quite a bit," say McMenamin.

• Negative information that comes up during a deposition.

"I try to learn the good, bad, and ugly quickly," says McMenamin. "If you do have a case that should not be tried, it is far better and far cheaper to know it upfront than to figure it out on the eve of trial."

Still, sometimes surprising information comes to light during litigation. In one medical malpractice case, McMenamin's client, an emergency physician who was sued for failing to diagnose a heart attack, openly admitted fault to opposing counsel during his deposition, which occurred late in the discovery process.

"He effectively confessed to having missed the diagnosis. But the clincher was that he also testified that after he was unsuccessful trying to resuscitate the patient, he met with the new widow, got down on his knees, and asked forgiveness for his mistake," he recalls. This confession prompted McMenamin to call the carrier immediately to discuss the possibility of settling an otherwise defensible case.

• A sympathetic plaintiff.

If the plaintiff is a child who is neurologically disabled due to a missed subdural hematoma, or a father who is now quadriplegic due to a missed fracture, for example, the defense is likely to strongly consider settling the claim. "Even if the medicine is good and the defendant makes a good appearance, the jury is very likely to rule in favor of a plaintiff they feel sorry for," says Berlin.

Demographics can also play a role. "If you have a plaintiff who you think is going to be exceptionally well-received, that may tend to influence your thinking a bit," says McMenamin. Depending on the circumstances and the venue, for example, if the plaintiff is a member of an ethnic group heavily represented on the jury, while your defendant is a member of a different ethnic group, especially one to which members of the plaintiff's ethnic group often feel a measure of hostility, the defendant might be at a disadvantage wholly unrelated to the merits of the claim, he explains.

"In a perfect world, this would not be an issue. In the world we actually live in, however, it can be," says McMenamin. "By no means does this mean that in such situations settlement is necessary, nor even desirable. It does mean, though, that in making judgments about the best course of action, one ought not to ignore such factors."

• Critical documentation cannot be located, which could eliminate doubts about the appropriateness of care.

Katherine A. Miller, RN, CPHRM, a risk/claims consultant at

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A sympathetic plaintiff, high-caliber opposing counsel, and negative information that comes to light during a deposition are some factors that make insurers seriously consider settling medical malpractice claims. Physicians should consider:

- ✦ whether there is excess exposure over the policy limits;
- ✦ if their defense is compatible with codefendants;
- ✦ how they appear as a defendant witness.

RCM&D Self-Insured Services Co. (SISCO), says, "You might have a clear recollection of what is contained in this missing data, but jurors may believe the records were destroyed to cover up an error." SISCO is a Baltimore-based subsidiary corporation providing specialized claim administration and risk control services to the healthcare industry.

• The plaintiff can establish that the chart was altered or deceitfully filled out.

"If based on the testimony of witness or evidence that a doctor was not called when the chart says he or she was called, this will greatly increase the likelihood that the case will be settled," says Miller.

• The defendant fails to comply with one of their own organization's written policies.

"Any policy, procedure, or protocol can be admissible as evidence and can be used to help establish or disprove that standard of care was met," says Miller. "It proves very difficult to successfully defend when the defendant is not aware such a policy even existed." *(See related stories on how physicians can help their defense, below, and what physician defendants should consider before agreeing to settle a claim, below.)* ✦

To help defense, provide this input

While most malpractice policies state that the physician has to agree to a settlement, some state that the insurer has the right to settle a claim without the physician's consent, notes **Leonard Berlin**, MD, FACR, professor of radiology at Rush University and University of Illinois, both in Chicago, and author of Malpractice Issues in Radiology.

If the insurance carrier wishes to settle a malpractice claim, defense counsel still should consult with the physician, even if his or her consent isn't required to settle, according to **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician. *(For more information on this topic, see "Check policy now for 'consent-to-settle clause,'* Physician Risk Management*, March 2013, p. 105).*

"Counsel's job is to represent the client first and foremost. The carrier, although also a client in a sense, is in a subordinated position in terms of the magnitude of counsel's duty," says McMenamin. "You have to look after the insured first." Here are some ways in which physician defendants can provide input that can help their defense:

• Look at the situation objectively.

Physicians should keep in mind that the insurance company is unlikely to recommend settlement if a claim is really defensible and plaintiff attorneys do their homework before filing a malpractice claim, says Berlin.

"Plaintiff attorneys work on a contingency basis. They may spend upward of $100,000 or $200,000 on a case and are paid nothing if he or she loses," he adds. "So therefore, they will be very careful when taking a case."

• If you are unhappy with the defense lawyer, ask your insurer to provide you with another attorney.

"All the physician has to do is write a letter and say, "I don't think this attorney is representing me properly, I want another defense lawyer,' and the carrier will give him one," Berlin says. The reason is that physicians have sued successfully for negligent representation. The physicians claimed that they complained about their lawyers, the insurers did nothing, and as a result, the physicians were found liable, he explains.

• Attend the deposition of the plaintiff's expert.

"It's hard to intimidate a plaintiff's expert if the medicine is on the plaintiff's side. But if it's a shady case — and you do have experts that are out there just for the money — sit across the table and stare at the expert," says Berlin. "Sometimes they do back off a little." ✦

Consider these items before settling claim

Lawsuits arising out of premises liability or automobile accidents are often just a matter of economics for the insurer and the insured, says **Katherine A. Miller**, RN, CPHRM, a risk/claims consultant at RCM&D Self-Insured Services Co. (SISCO), a Baltimore-based subsidiary corporation providing specialized claim administration and risk control services to the healthcare industry.

Professional liability claims, such as medical malpractice, on the other hand, often have an adverse effect on the insured's life far beyond just the amount of money paid to the plaintiff and the defense attorney, says Miller.

"The decision to settle or defend a medical malpractice case is one that deserves careful consideration on all parties' part," says Miller, noting that about 6% of medical malpractice lawsuits go to trial.[1] "Most are dismissed for a variety of reasons without any remuneration to the patient," says Miller. "In reality, most medical malpractice lawsuits do not go to trial and are settled out of court, with payment made to the patient."

The physician-defendant needs to

confront settlement issues and understand the settlement process to make or be a part of this decision whenever possible, urges Miller. She says physicians should consider these items:

• Are your personal earnings at risk?

"In some serious cases, the verdicts awarded by juries have been higher than the limits of the professional liability policy," says Miller. "The defendant's attorney will be able to assess if the case has an excess verdict possibility."

For example, if the jury awards a verdict of $3 million and the policy limit is $1 million, the physician's personal assets and future earnings are at risk. "Evaluate whether you want to risk the possibility of a verdict in excess of your policy," advises Miller. "If the plaintiff's attorney is willing to settle the case within your policy limit, you need to evaluate whether you should consent to settle."

In some cases, there is excess exposure over the limits of the policy, says **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based healthcare attorney and former practicing emergency physician. "… in this case, there is probably an obligation to point out to the defendant that there is a possibility that his personal assets could be at risk," McMenamin says.

In one case, McMenamin learned that a physician's insurance company had gone bankrupt, putting the client's own funds at risk. "I called the opposing counsel and was very candid," he says. "Fortunately, he was not really aggressive about poking into my client's assets, and we settled early and cheaply."

• If other physicians, health professionals, or healthcare institutions are named as codefendants, are your defenses compatible?

Do the defendants present a united front? Conversely, will the other defendants point to your treatment of the patient as beneath the standard of care? Or, in the course of your defense, will you focus on other physicians or institutions as the cause of the plaintiff's condition?

"To be the only defendant remaining on trial when all other codefendants have settled will put you in an unpredictable and explosive position," warns Miller. "Remember, the other treating physicians will probably be called to testify at trial. The jury will wonder why you are a lone defendant."

• How do you appear as a defendant witness?

"Insurance companies will look closely at this," says Miller. Do you appear arrogant, defensive, or misinformed at your deposition? Was your testimony confused or disorganized? Do you appear logical, compassionate, and willing to listen? Will the jury respect and believe you at trial?

"These are difficult questions to ask oneself but play a significant role in the settlement decision," says Miller.

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Is physician liable when parents don't comply?

If a parent refuses to comply with your treatment recommendations for a child, are you legally required to report this information to authorities?

"At an extreme point, this becomes child abuse and neglect. All states have laws, as does the federal government, requiring physicians to report it to the appropriate authorities, whether child protective services, public health, or the police," says **Maxwell J. Mehlman**, JD, Arthur E. Petersilge professor of law and director of The Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH.

Courts have allowed parents to pose significant risks to their children in pursuit of what they think is best for them, says Mehlman, but the law also has stepped in when parents have made decisions harmful to children. "There isn't a clear rule as to what parents can and cannot do. It depends on the court or the agency that's been asked to step in," says Mehlman. "My advice to physicians is they have to protect the children and also protect themselves."

Mehlman says physicians should not hesitate to involve juvenile court offices or the legal department of a hospital to obtain advice in protecting themselves legally. "When in doubt, raise the issue, and pass the buck to the law if you want to be protected," he advises. "In this situation, it's imperative for physicians to get some kind of decision from a juvenile court — either that you can expose this child to this risk, or you can override the parent's judgment."

Physicians have to "follow their instinct to protect the child, who is the vulnerable party, and let the chips fall where they may afterward." "If you do something medically to improve a child's health, particularly in case of serious illness or a life-threatening situation and a parent sues, you can debate afterward whether it was the right thing to do," says Mehlman. "But if the physician doesn't step in, the child can be permanently harmed." To reduce legal risks, he says physicians should:

• Document what they told the parents.

Have them sign to acknowledge that the instructions were received and that they understand the instructions, advises Mehlman.

• Know state laws requiring physicians to report knowledge of parental noncompliance as possible abuse and neglect.

"Most states have an immunity provision which legally protects physicians reporting in good faith," says Mehlman.

State laws vary somewhat. However, most use general language such as prohibiting parents to take actions that seriously impair or retard a child's mental health or development, he says. They typically don't define these terms, which are left open to interpretation, he says.

"You can look at past cases and see how they were decided, but they are somewhat all over the place and very fact-specific," says Mehlman.

• Consider the child's own wishes.

If a child refuses something that the doctor and parents want, the physician cannot simply ignore that, says Mehlman. "As you move toward something that is more elective, physicians should definitely pay attention to the child's own wishes," he advises. "If the child refuses to give assent, the physician can always get a judge's view on how to deal with that. But don't assume that just because it's a child, that the patient has no role in decisions."

The older and more mature the child, the more important it is for physicians to consider a minor's wishes, adds Mehlman. "All states have some version of a mature minor doctrine," he explains. "Even if child hasn't reached the state's age of majority, if the child is mature enough — and this is a judgment call the physician can make — the physician is entitled to treat the child as if she were a legal adult." *(See related story on using non-compliance as a defense strategy, below.)* ✦

Executive Summary

If a parent refuses to comply with treatment recommendations for a child, physicians might be required to report this information to authorities.

✦ Physicians should not hesitate to involve juvenile court offices or a hospital's legal department.

✦ Document that parents received and understand instructions.

✦ Know state laws requiring reporting of knowledge of parental noncompliance.

Parent's non-compliance: Is it an effective defense?

A physician defendant could use a parent's non-compliance as a defense in some cases, "but courts are reluctant to allow doctors to pass the buck to their patients," says **Maxwell J. Mehlman**, JD, Arthur E. Petersilge professor of law and director of The Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH.

If the parents are suing in their own right, the defense could argue that they were contributorily negligent, Mehlman says, and if the parents are suing on behalf of the child, the defense could argue that the parents, not the physician, caused the bad outcome.

"Generally, medical malpractice law doesn't tend to recognize contributory negligence on the part of patients," he adds. "Courts, with a few exceptions, tend not to accept those arguments by doctors, on the theory that patients are not experts." On the other hand, if the patient has not complied with the physician's explicit instructions, the doctor can use the non-compliance as a defense, Mehlman says. "Most states have gotten rid of contributory negligence in favor of comparative negligence," he notes. "If a parent sues a doctor for $1 million, and the jury decides some of it is the parent's own fault, the verdict would be reduced in proportion to their own misdeeds."

The physician cannot abdicate responsibility entirely to the parents, emphasizes Mehlman. "The physician has to take reasonable steps to ensure child's welfare is maximized, and what is 'reasonable' will vary very much on the specifics," he says. "If parents walk out saying, 'We're not going to do that,' you can't just leave it at that. On the other hand, there is a limit to how much a physician can be expected to oversee what parents do." ✦

New data on team training: It lowers MDs' legal risks — Evidence is 'very encouraging'

TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety) wasn't designed specifically to decrease legal risks, but reduced liability appears to be an important side benefit to improved teamwork, reports **James B. Battles**, PhD, AHRQ's social science analyst for patient safety.

TeamSTEPPS is an evidence-based communication and teamwork curriculum jointly developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense to help healthcare teams operate more efficiently and to make care safer. *(See resource at end of this article for more information.)*

"Research from analyzing adverse events and reviewing closed liability claims shows that two of the biggest

contributing factors to adverse events that lead to patient harm are poor communication and lack of teamwork," says Battles.

There are TeamSTEPPS materials for hospitals, nursing homes, and primary care practices, and modules for teams that treat patients with limited English proficiency, he adds.

"We know that improving team work and communication contributes to lowering liability risk," says Battles. "There have been large-scale efforts at implementing teamwork, and we are seeing that they may be associated with reductions in liability." A 2010 study done by the Veterans Administration reported a significant reduction in surgical mortality based on teamwork training.[1] A 2006 review of malpractice claims indicated that communication problems were major contributing factors in 24% of cases that result in such claims.[2] Other studies using root cause analysis to examine contributing factors have found teamwork and communication issues cited as root causes in 52% to 70% of adverse events.[3,4]

"The use of teamwork training and simulation and shown to improve performance and have had a positive impact on medical liability in labor and delivery," says Battles.[5,6]

Early data from AHRQ's medical liability demonstration projects are showing that teamwork and effective communication reduce risks, he reports. For example, an obstetric project has resulted in fewer birth injuries and medical liability claims.

"The data is just beginning to come in, but it's very encouraging," says Battles.

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RESOURCE

• **TeamSTEPPS** (Strategies and Tools to Enhance Performance and Patient Safety) training is available at no charge. Prospective trainees are asked to complete a readiness assessment. For more information on TeamSTEPPS, contact the Agency for Healthcare Research and Quality, Rockville, MD. Phone: (312) 422-2609. Email: AHRQTeamSTEPPS@aha.org. Web: http://teamstepps.ahrq.gov. ✦

Working with residents? Avoid these med/mal allegations

Before a second-year resident performed an intraocular steroid injection, he decided that since he'd done the procedure many times, there was no need to call in the attending physician.

"But when the patient developed an acute infection and began losing his sight, all hell broke loose," says **Karen Byank Mathura**, RN, JD, CPHRM, a claims and risk management consultant in the Bethesda, MD, office of RCM&D, a Baltimore, MD-based insurance brokerage firm, and a former medical malpractice defense attorney.

The patient sent a certified letter to the hospital's CEO that threatened to go public with his allegations, call the press, and file a lawsuit. "The letter mentioned it was the 'junior doctor' who 'screwed up,' and that his 'regular eye surgeon' wasn't even around during the procedure," says Mathura. "The hospital quickly intervened and settled the claim, but had there been an attorney involved, it could have gone very differently."

Michelle Hoppes, RN, MS, DFASHRM, senior vice president of Global Risk Management and Loss Control Services at Allied World, a Farmington, CT-based provider of specialty insurance and reinsurance solutions, has seen malpractice claims involving residents with these contributing factors: errors in judgment, memory lapses, lack of technical competence or skill, delay in notifying an attending of a patient change in status, and problems with handoffs and communication.

"Studies indicate that over 50% of these cases involving medical residents involved a lack of supervision by the attending physician," Hoppes says.[1]

Mathura says, "Plaintiff attorneys can usually find a way to bring any healthcare provider who 'touched' a patient into their client's claim or lawsuit. Unfortunately, attending physicians often get roped into a lawsuit for practically anything that their resident may do wrong." For example, if a patient has an elevated potassium or international normalized ratio level, both the resident and the attending will be "charged" with the obligation to know this particular critical laboratory result, she explains.

"I have seen situations where a resident gets a call from the lab about a critical value, writes the finding in the chart, and begins to treat the patient," says Mathura. "Should the patient

arrest, it is almost a certainty that both the resident and the attending will be named as defendants."

The plaintiff's attorney then could argue that the attending physician should have been aware of what was happening to the patient, and the argument will be made by the attending's counsel that the resident should have made a call and keep the attending in the loop. "Then there is finger pointing amongst the named defendants. This is truly a plaintiff's attorney's best case scenario," she says.

It is ideal for residents and attending physicians to have a "united defense," says Mathura, as "should one 'finger point' at the other, the defense becomes incredibly difficult." Mathura says to consider these risk-reducing practices:

• Know what particular polices and protocols your hospital, practice, or department has in place regarding supervisory guidelines.

If the physician is compliant with all policies and protocols, it will difficult for a plaintiff attorney to argue that he or she did not act "reasonably," says Mathura.

• Discuss expectations with the intern and resident.

Many physicians have their own guidelines for when the attending should be called and awakened from sleep, such as critical labs, vital signs, or the need for prompt surgery, Mathura says.

"Do this before you 'cover their call' or have them see your postops over the weekend. A little communication goes a very long way in this regard," she says. "Although this will not prevent mishaps from occurring, it should hopefully prevent undue surprises."

Hoppes recommends establishing communication triggers for when a resident/intern is to notify an attending. For example, one organization documented specific conditions on a card that was provided to residents/interns of the type of conditions and changes that need to be escalated.

"The bottom of the card indicates that if these conditions exist, you need to call the attending physician," says Hoppes.

• Be familiar with the supervisory guidelines for your particular specialty, as to what is and is not recommended practice.

The "golden rule" in the supervision of residents is this: to know exactly what is expected and "reasonable" within your particular field, department, and institution, says Mathura. For example, many hospitals have guidelines that specify that residents may not place subclavian, internal jugular, femoral, or Swan-Ganz central venous catheters or insert arterial lines, chest tubes, or endotracheal tubes without attending supervision.

However, if a resident were the sole physician on a floor and a patient arrested and needed the placement of an endotracheal tube, he or she would be penalized for not performing the procedure, notes Mathura. "In exigent or emergency circumstances, the resident will eventually be charged with doing what a similarly situated resident would have done under like circumstances," she says. *(See related stories on negligent supervision, below, and claims involving fatigue, p. 130.)*

Executive Summary

Negligent supervision is a common allegation in medical malpractice claims involving residents and interns. Physicians should do the following:

✦ Comply with supervisory guidelines.

✦ Discuss with residents your expectations as to when the attending should be called.

✦ Be familiar with the supervisory guidelines for their particular specialty.

Reference

1. Singh H, Thomas EJ, Petersen LA, et al. Medical errors involving trainees: a study of closed malpractice claims from 5 insurers. *Arch Intern Med* 2007; 167(19):2030-2036. ✦

Claims often allege negligent supervision

The most common medical malpractice allegation involving residents or interns and an attending physician is negligent supervision, according to **Karen Byank Mathura**, RN, JD, CPHRM, a claims and risk management consultant in the Bethesda, MD, office of RCM&D, and a former medical malpractice defense attorney.

"Once the allegation is asserted, it is very difficult battle," says Mathura, adding that she has seen many such claims. "Even in obstetrics, while the majority of deliveries go off without a hitch, an allegation of negligent supervision can quickly arise," she says. Mathura has reviewed several lawsuits in which the attending obstetrician was tied up in the OR performing an emergent caesarian section and the resident was forced to deliver a seemingly uneventful birth, unsupervised.

"Whether a shoulder dystocia with associated brachial plexus injuries occurs, a vacuum extraction results in extensive hematomas and potential neurological injury, or most significantly, there are decelerations with alleged hypoxic ischemic encephalopathy, both the delivering resident and the supervising attending will get named in the patient's claim or lawsuit,"

says Mathura.

These circumstances, albeit rare, "are incredibly difficult to prevent, especially at smaller, community hospitals without a large, on-site, attending OB presence," she says.

"Reasonable" standard

Negligence is proven by the "reasonable person" standard: whether a reasonable person could have foreseen the injuries or loss that was sustained under very similar or like circumstances, Mathura explains.

"Negligent supervision comes into play when someone who is charged with the duty to supervise neglects that role, intentionally or not, and allows the lesser-qualified individual to perform the task at hand," she says. For example, a claim might involve an unsupervised intravitreal injection or surgical procedure. Even if the attending physician argues that the intern or resident was not "under his or her control," a plaintiff's attorney could successfully argue that "control" is not necessary, she adds.

"If you as the attending failed to exercise reasonable care and caution while fulfilled your supervisory duties, you could be liable," says Mathura. For example, if you are charged with supervising an intern or resident by being on call for a particular service, it is ultimately your responsibility to supervise, even if the misadventure occurred at 3 a.m. and you, as the attending, were asleep in your bed.

If an injury occurred and it was arguably causally connected to the lack of your supervision, a judge or jury would be asked to apply the "reasonable person" standard, says Mathura.

"If a conclusion were reached that you should have come into the hospital at 3 a.m. and examined the patient yourself, then you may be as liable as the intern or resident who committed the deviation," Mathura explains. ✦

Fatigue and workload are factors in lawsuits

The prevalence of medical malpractice claims against medical residents and interns is attributable to several factors, including fatigue, according to **Stephanie M. Godfrey**, JD, an attorney in the Philadelphia office of Pepper Hamilton.

"A physician-in-training who is not technically competent, has an excessive workload, and lacks sleep is more likely to produce poor patient outcomes and medical errors than a seasoned physician, especially in circumstances where supervision is minimal," says Godfrey.

Residency programs must "tread a fine line" of allowing residents and interns to obtain hands-on-training and develop confidence in their own skills while ensuring that patients' lives are not endangered, she says. "Plaintiff's attorneys include medical residents and interns in medical malpractice lawsuits to ensure that every person who may bear responsibility for their clients' injuries is included in the lawsuit," Godfrey emphasizes. She suggests these strategies to reduce the risk of bad outcomes resulting from fatigued residents or interns:

• Implement and enforce hours restrictions applicable to residents and interns.

• Ensure that supervising physicians are vigilant about recognizing and providing necessary support for overly fatigued or otherwise impaired physicians.

• Periodically review policies and procedures for effectiveness and to ensure that they are consistent with applicable guidelines.

• Standardize patient care management and procedures for handoffs.

Implement checklists and protocols to ensure that residents and interns are aware of proper procedures and what is expected of them, says Godfrey. "Use best practices when caring for patients, communicate effectively when transitioning the care of a patient to another physician, and document every step," she advises. ✦

Rising number of claims filed by obese patients

In a recent multi-specialty review of claims over four years, The Doctors Company, a Napa-CA based medical malpractice insurer, noted an increase in claims filed by patients who were overweight or obese, reports chief patient safety officer **Robin Diamond**, JD, RN.

Based on the findings, The Doctors Company performed an in-depth analysis of some of the claims related to postsurgical risks of obese patients. "The analysis found several claims in which patients with either a suspected or known diagnosis of obstructive sleep apnea suffered severe respiratory depression during the post-op period," says Diamond. Also, using opioids for these patients greatly increased the risk of harm. These risk-reducing practices were identified from the claims analysis:

• Include a focused history and calculation of BMI and neck circumference in the preoperative evaluation.

• Consider a sleep apnea study prior to surgery.

• Use continuous oxygen and carbon dioxide monitoring.

• Prescribe opioids only with the greatest care, and consider the use of non-opioids.

• Do not assume that the obese patient needs higher levels of medica-

Executive Summary

Medical malpractice claims filed by overweight or obese patients increased, according to a review of claims conducted by The Doctors Company. These risk-reducing strategies were identified:

✦ The pre-op evaluation should include a focused history and calculation of BMI and neck circumference.

✦ Consider the use of non-opioids.

✦ Don't assume the obese patient needs higher levels of pain medication.

tion to control pain.

"It may be just the opposite in obese patients, who may be unable to metabolize these medications as effectively as a patient of average weight," says Diamond.

There is an increased risk associated with an obese patient who undergoes a procedure with anesthesia, she notes.

Physicians treat obese patients for chronic conditions that co-exist with obesity, such as diabetes and heart disease, notes Diamond. "With the rate of obesity increasing, physicians have to address more complex issues with this population," she says.

Obese patients have an increased risk of developing pulmonary emboli post-surgery, an increased risk associated with establishing and maintaining an airway, and those who have diabetes will have a higher probability of prolonged healing time, says Diamond.

Patients don't generally mention obesity as a factor when the complaint is filed. They might instead allege negligent technical performance of a procedure or failure to manage the patient post-surgery, she explains. "As we prepare to respond to the complaint, we learn about the patient's medical history, including obesity," says Diamond. "Then we dive into the 'causation,' and whether the patient's obesity and other co-morbidities could have been a causative factor of the alleged injury." Consider these approaches:

• Address negative attitudes or discomfort about obese patients.

Physicians need to speak openly to patients about a characteristic such as obesity that places them at higher risk for an adverse event, she explains.

"This is a difficult issue for anyone to acknowledge. However, everyone has preconceived feelings or impressions about a certain characteristic or stereotype," says Diamond.

• In the history and physical, obesity must be identified as a problem.

"A plan then should be established to deal with it," says Diamond.

• Fully inform the patient of the risks of obesity related to the current diagnosis, as well as the potential health problems that are more likely to arise. Document these discussions.

The defense attorney then can show through documentation that the physician addressed any health conditions or habits that could increase the patient's risk, says Diamond.

"Even when the patient alleges harm, the defense attorney can more easily demonstrate that the patient was not compliant with the health education provided by the physician, and therefore that the patient's noncompliance mitigated or neutralized the patient's allegations," she explains. ✦

COMING IN future MONths

✦ Why failing to refer to specialist can get you sued

✦ Update on safe harbors and malpractice reform

✦ Avoid suits stemming from poor communication

✦ Work with insurer to ID risk-reducing practices

CME OBJECTIVES

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

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

CME INSTRUCTIONS

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

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

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

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

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

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

CME Questions

1. **Which is true regarding liability risks of patients' negative online reviews posted by patients, according to Brandy A. Boone, JD, a senior risk management consultant at ProAssurance Companies?**
   A. Physicians' responding online could lead to litigation alleging violations of patient privacy regulations.
   B. Patient privacy regulations are waived when a patient posts an online review.
   C. Referencing a patient's health information in response to an online review could not be viewed as an unauthorized disclosure.

2. **Which is true regarding decision-making as to whether a claim should be settled, according to Katherine A. Miller, RN, CPHRM, a risk/claims consultant at RCM&D/SISCO?**
   A. Whether the physician's defense is compatible with that of codefendants should not be a consideration.
   B. If the plaintiff can establish that the chart was altered or deceitfully filled out, it's more likely the case will be settled.
   C. Inability to locate critical documentation isn't problematic for the defense, as long as the physician clearly recollects the missing data's contents.

3. **Which is true regarding physicians' liability if parents don't comply with treatment recommendations, according to Maxwell J. Mehlman, JD, director of The Law-Medicine Center at Case Western Reserve University School of Law?**
   A. Physicians should not involve juvenile court offices except for life-threatening circumstances.
   B. There is no variation in state requirements to report knowledge of parental noncompliance.
   C. Physicians should not hesitate to involve juvenile court offices to obtain advice in protecting themselves legally.

4. **Which is true regarding allegations of negligent supervision, according to Karen Byank Mathura, RN, JD, CPHRM, a claims and risk management consultant for RCM&D?**
   A. Physicians should not identify specific triggers for when a resident is to notify them.
   B. It is not advisable for residents and attending physicians to take a "united" defense approach if both are named in a suit.
   C. If the physician is compliant with all policies and protocols, it is difficult for a plaintiff attorney to argue that he or she did not act "reasonably."

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Medical student awarded $1.42 million after improper removal of right ovary and fallopian tube

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News: A medical student was awarded $1.42 million against a gynecologist for removal of her right ovary and fallopian tube when she was supposed to remove only a cyst on her left ovary. The patient was diagnosed by a gynecologist with a mass in her left ovary, which could possibly grow, rupture, and/or become malignant. The patient underwent surgery to have the cyst on her left ovary removed. Weeks later she continued to complain of pain to the gynecologist, who ignored her complaints. After presenting to a hospital with complaints of pain to the right side of her pelvis, it was discovered the gynecologist had improperly removed the entire right ovary and right fallopian tube.

... seven sonograms prior to the surgery showed the cyst was on the patient's left ovary.

Background: The patient was a 28 years old and pregnant. She presented to a gynecologist for an ultrasound related to the pregnancy. The ultrasound discovered a mass growing on her left ovary. A month later the gynecologist told the patient the mass was approximately 3 by 2 cm and likely a benign dermatoid cyst. However, the gynecologist warned it could grow, rupture, and/or become malignant. An ultrasound just before the procedure clearly reflected a cyst on her left ovary. In fact, seven sonograms prior to the surgery showed the cyst was on the patient's left ovary. The patient then underwent the procedure to remove the cyst on her left ovary.

The gynecologist's operative report, made the following day, noted the right ovary and fallopian tube had been removed. The patient met with the gynecologist three and four weeks after the procedure. During both appointments, the patient complained of pain to her right lower pelvis. The gynecologist failed to advise the patient that her right ovary and fallopian tube had been removed, and she was still suffering from the left ovarian cyst. A week after her final appointment with the gynecologist, the patient called the gynecologist's office regarding pain in her pelvis but was unable to reach the doctor. She never received a return call. The next day, the patient presented to the emergency department because she no longer could tolerate the pain. A scan showed the pain originated from her left ovarian cyst which had not been removed. It further revealed gynecologist had removed her entire right ovary and fallopian tube.

Patient and her husband sued the gynecologist for medical malpractice and lack of informed consent.

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The damages claimed included the improper removal of the right ovary and fallopian tube, pain and future surgery of the left ovarian cyst, injury to her marital relationship, anxiety, mental distress, and possible loss of procreation. It was discovered during litigation that the gynecologist had altered two preoperative medical records to indicate patient had complained of right-sided pelvis pain, when in fact, she had not. Attorneys for the gynecologist argued that the patient's right ovary was enlarged and therefore did contain a cyst, which justified its removal. However, every pathologist and expert called to testify opined that the cyst in her right ovary was the normal cyst that forms in every woman's ovaries during the monthly ovulation cycle. This cyst disappears naturally within one to two weeks of forming.

The jury found the gynecologist liable for medical malpractice, failure to obtain informed consent, and that the failed informed consent and medical malpractice caused the patient's injuries. The patient's new gynecologist has recommended the left ovarian cyst be removed. He warns that if the cyst cannot be removed without removing the left ovary, the patient will be left infertile and must undergo hormone therapy for the rest of her life. He described the procedure by the gynecologist as "overly aggressive in removing the entire tube and ovary." Accordingly, the jury awarded the plaintiff $1.42 million.

What this means to you: In this instance, the two risk management processes that immediately come to mind are the "timeout" process and the "disclosure" process. In spite of the extensive efforts that have been made to eliminate wrong-side and wrong-site surgery, cases such as this one demonstrate that this adverse event remains a problem. Interestingly, in this case, the jury appears to have brought back a verdict exclusively against the OB/GYN physician that performed the procedure. Certainly a reasonable argument could have been made that the hospital in which the procedure was performed did not have an adequate process in place to prevent wrong-sided surgery and, therefore, is at least partially liable.

In general a timeout seeks to make sure that the procedure about to be performed is for the correct patient, on the correct site and when appropriate, on the correct side. The hospital should have a policy and procedure explaining how a timeout is to be conducted. This policy and procedure will vary from hospital to hospital, but it generally will include the person(s) responsible for leading the timeout, those who participate in the timeout process, how the surgical site is to marked, and who is responsible for marking the surgical site. There are surgical safety guidelines (that include processes for a timeout) put out by numerous organizations including the World Health Organization (WHO). *(See the timeout checklist at http://bit.ly/bsGZsP.)*

It was discovered during litigation that the gynecologist had altered two preoperative medical records ...

In spite of all of the policies and procedures and guidelines and safeguards that might be put into place, system error and/or human error still can occur. Once an error does occur, the manner in which it is handled is crucial.

When a significant error is discovered, it should be disclosed to the patient as soon as possible. Each hospital should have a disclosure of adverse events policy. Such a policy is a requirement from The Joint Commission. It is also the right thing to do ethically and morally. The actual disclosure policy will vary significantly from hospital to hospital and from state to state. Clearly, state laws that protect disclosure of adverse events from discovery will ease a hospital's or physician's hesitancy to discuss such events. There is no good way to disclose an event such as the one being discussed here. The disclosure should focus on apology and immediate health/treatment considerations resulting from the error. Discussion as to what caused the error and what steps will be taken to prevent future errors (if known) are appropriate for disclosure. There is a possibility that a patient may "shut down" after receiving bad news, and it should be determined by the person conducting the disclosure whether the patient is capable of absorbing any further information. If it is determined that the patient cannot absorb any further information, or if unable to answer the patient's questions, there is nothing wrong with setting up a follow up disclosure session as more information becomes available. In some cases in which the facts have been established, it might be wise to invite the patient to bring his or her attorney to the follow-up disclosure meeting and consider offering to settle the case.

Obviously, risk management and/or the legal department should be notified. The involved physician, if commercially insured, should immediately notify his or her carrier. The medical records department should be notified as well. The original medical record should be sequestered so that it

cannot be altered. Any alteration, even with the best of intentions, can be interpreted as spoliation of evidence. A circulation copy for a sequestered record can be made available for those that will need to examine the medical record, as well as for the continuum of care. If the hospital is using an electronic medical record, there must be a process to "lock" the record as close to discharge time as is reasonably practical.

Wrong-sided or wrong-site surgery has been deemed to be a "never event." One should give serious thought to settling out of court and think twice before bringing such a case to a jury.

Reference

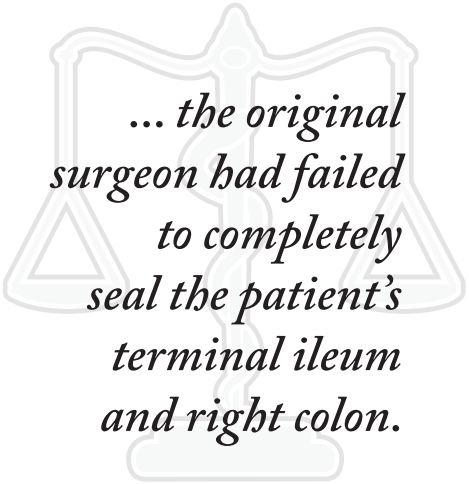
2012 WL 7088777 (Md.Cir.Ct.), 24-C-11-006058 OT. ✦

$19.5M awarded for death after failure to seal colon following benign polyp removal

News: A woman's family has been awarded $19.5 million against a surgeon who improperly performed a procedure on her colon to remove a benign polyp. The procedure resulted in complications that eventually led to her death. In 2008, a benign polyp was discovered in patient's colon during a routine colonoscopy. To remove the polyp, a surgeon resected approximately 2½ feet of her colon instead of simply removing the polyp through a minimally invasive endoscopy. The surgeon failed to completely close patient's colon following the resection, which resulted in the leaking of fecal matter into her body cavity. Patient developed sepsis and required multiple revisionary surgeries before eventually dying from complications related to the infection.

Background: Patient was 57 years old and had a significant medical history including renal disease, chronic back pain, and four prior abdominal surgeries. A colonoscopy in 2008 revealed a noncancerous mass on her bowel. A surgeon argued that patient requested the mass be removed by resection because she was afraid an endoscopic or colonoscopic approach would result in a perforation. The patient's husband, who was present at this appointment with the surgeon, claimed it was the surgeon who suggested a resection and his reason being that it was the easier approach.

Ultimately, a resection was performed. The surgeon encountered difficulty during the resection due to the multitude of adhesions within the plaintiff's abdominal cavity. The surgeon's operative report indicated that the difficulty of the surgery, despite being aware of patient's prior abdominal surgeries, was unexpected. The adhesions encountered during the surgery were present because of patient's significant abdominal surgical history. The surgeon resected 2½ feet of patient's colon and surgically reconnected her bowel. During recovery, patient experienced severe abdominal pain, elevated blood potassium, sinus tachycardia, hypertension, and decreased urination. An EKG indicated a thickened mitral valve, and a heart murmur was observed. At times, the patient was febrile. Her symptoms included a fever over 101 degrees, lethargy, confusion, and disorientation.



Eventually, the patient was transferred to the intensive care unit. While in the intensive care unit, her wound began draining purulent odorous fluid, and she was noted as appearing toxic. Her white blood cell count continued to increase. A CT scan of the patient's pelvis indicated a build-up of fluid. Two weeks after her resection, a different doctor performed surgery to correct intra-abdominal sepsis and gastrointestinal bleeding. Upon opening patient's abdomen again, the doctor discovered that the original surgeon had failed to completely seal the patient's terminal ileum and right colon.

During this procedure, the patient was provided a colostomy bag, but due to the severe infection and swelling, her abdominal cavity was left open. It took over one month for her condition to improve to a point where doctors were able to surgically re-close her abdominal cavity. Three months later patient left the hospital for a long-term care facility. During this stay, the patient required another bowel resection, abdominal washouts, debridements, and suffered from a right occipital

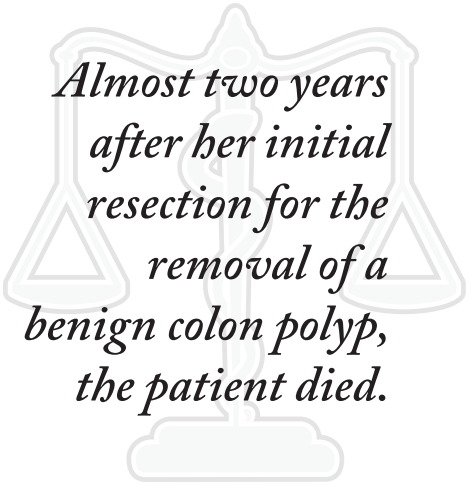
infarct, seizures, respiratory failure, and acute renal failure. Almost two years after her initial resection for the removal of a benign colon polyp, the patient died.

Patient's husband brought suit for medical-malpractice, wrongful death, and loss of consortium on behalf of him, their two children, and patient. Their counsel claimed the surgeon failed to perform a preoperative workup on patient, failed to obtain proper consultations, failed to appreciate the complexity of the surgery, failed to close patient's bowel, and failed to diagnose the breach of the bowel and resulting infection in a timely manner. Counsel for the surgeon argued there was no malpractice and that patient had requested the resection over the endoscopic or colonoscopic approach despite the risks involved. The jury returned a verdict of 11-1 for patient. The patient's family was awarded $9 million for her medical malpractice claim and $10.5 million for her wrongful death claim.

What this means to you: In a surgical case involving alleged improper surgery, conventional wisdom would usually conclude that the surgeon in the role of "caption of the ship" would be the main target. It is interesting to note that in the above case, the jury determined negligence against the medical center and the surgeon.

In this case, the surgical procedure itself came under question. When a surgical procedure itself comes under question, the informed consent and the process by which the procedure was agreed upon must be diligently documented. If as in this case, the surgery was an elective procedure, the appropriateness of the procedure must be documented as well. The informed consent must be carefully crafted to memorialize in detail the risks and benefits as well as all of the known complications associated with the procedure. If the procedure that is agreed upon is the more invasive procedure or a procedure other than the more common procedure, it becomes even more important to meticulously document the entire process. Obviously, expert witness opinion would be crucial in such a situation. In a situation where the rationale for choosing a type of procedure becomes an issue, this opens the doorway for misunderstanding between patient and physician. If there is more than one defendant involved in the case, it creates an opportunity for finger-pointing.

Whereas the surgeon is likely to be held responsible for what takes place in the operating room during the procedure, the preoperative work up, and even the postsurgical treatment, those people doing the day-to-day postsurgical monitoring after the procedure can be exposed to allegations of failing to appreciate changes in blood pressure, changes in temperature, complaints of pain, etc.



When a patient suffers postsurgical complications, the manner in which the complications are treated can become as important, if not more important, than the complications themselves. If the complication that the patient sustained is listed on the informed consent as a recognized complication associated with that particular procedure, it will be very helpful in defending the case. Instead of focusing exclusively on the surgical technique, it might shift the focus of the case to whether the signs and symptoms of the complications were diagnosed and treated in a reasonable and timely manner. Here is where the hospital becomes vulnerable to allegations of negligence. If anyone in the care team believes that symptoms are not being appreciated, they must feel free to express their opinion to challenge treatment decisions without fear of incrimination. More importantly, they must also know the process for the chain of command so that they can communicate their concerns to a higher level if they believe that their concerns are being disregarded. While this advice might sound simple enough in theory, the reality is that it takes courage to question someone who is higher up in the hierarchy. Even though we strive for a culture of safety and a just culture, a nurse still has to be able to shrug off comments such as "and what medical school did you graduate from?" One technique for dealing with difficult communication situations might be drills or rehearsals. Another more specific technique might be role playing. Although snide remarks should not be tolerated, they do occur. Role-playing exercises help prepare for difficult communication situations and can help take some of the sting out of inappropriate remarks by scripting responses to such remarks. Patient safety is a team process. People must be encouraged to express opinions and ask questions. A good motto is "the only stupid question is the one that has not been asked."

Reference

2009 WL 9046824 (Pa.Com.Pl.), No. 004756 (2013). ✦