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Address EMR practices before suit occurs — It's an 'evolving area of risk exposure'

Physicians are becoming increasingly aware that in many cases, electronic medical record (EMR) documentation creates legal risks that didn't exist with paper charting.

"EMR is an evolving area of risk exposure," says **Richard E. Moses**, DO, JD, a Philadelphia-based gastroenterologist, risk management and compliance consultant, and adjunct assistant clinical professor at the Temple University schools of medicine and law. "As more healthcare providers move to EMR charting, we are going to see new areas of risk and theories of liability emerging." For example, copying and pasting portions of a progress note has the potential to carry an error throughout the patient's chart and medical record.

"The philosophy has changed from 'If it's not documented, you didn't do it," to 'You documented it, but did you do it?'"

Current EMRs are not designed as physician workflow tools, but as a data repository tool that evolved from hospital billing systems, according to **Luke Sato**, MD, chief medical officer and senior vice president of CRICO, the Cambridge-MA based patient safety and medical professional liability company serving the Harvard medical community. "Doctors are overwhelmed with information, time constraints, and the pressures of seeing 20 to 30 patients a day," says Sato. "The result is a huge potential risk that, in the average eight-minute patient/physician encounter, something is bound to be missed."

EMRs increase this risk to some extent, says Sato, because doctors have to comb through the EMR to search for information needed to care for their patients.

CRICO's recent analysis of more than 40 claims occurring in 2007-2012 involving an EMR found that many involved missed and delayed diagnosis by a primary care physician. "Information overload contributes to [these claims]," says Sato. "These cases are expensive to defend and result in a higher average indemnity."

Defense is complicated

EMRs often complicate a physician's defense against medical malpractice allegations, according to CRICO's claims analysis. When a physician is sued, the insurer receives a printout of the entire medical

INSIDE

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record, but this record is a poor representation of the actual information the doctor used to make a decision, Sato explains.

"You can't make judgments on the physicians' cognitive or decision-making capabilities, because the paper record is not an accurate representation of how that information was seen by the physician in the EMR," says Sato. "That is the biggest challenge right now in defending physicians dealing with errors related to today's EMRs."

EHRs can hinder physician defendants from demonstrating that the standard of care was met, says **Ron Sterling**, CPA, president of Sterling Solutions, a Silver Spring, MD-based firm that guides medical practices in the use of technology, and author of *Keys to EMR/EHR Success* (Greenbranch Publishing; Phoenix, MD; second edition, 2010). "Unfortunately, inadequate use of EHRs can undermine the ability of the physician to show that proper care was provided," he says. "The biggest risk is that that information entered in the system will tell a story different from the physician's actions, when the computer records are examined in the course of discovery."

Physicians have to take a carefully planned approach to EHR use, argues Sterling. "Indeed, they literally need to make sure that their charts are properly maintained on a daily basis," he says. Consider these practices to reduce legal risks involving EMRs:

• Validate, correct, or update data automatically filled by the system when using templates.

"If the data is not validated or updated consistently, the result can be a series of encounters that appear to be exactly the same," says **Kathy Ferris**, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance in Seattle. When the chart is reviewed, it might appear as though the physician or practice didn't pay attention to the patient and cared more about administrative efficiency than the individual patient. "This can contribute to clinical decision-making based on bad information and may also call into question whether or not the care being billed for is appropriate."

• Don't assume previous providers validated the patient's history.

Electronic information can be

Executive Summary

Electronic medical record (EMR) documentation creates some legal risks that didn't exist with paper charting. Information that doesn't accurately represent patient encounters is more easily added to the medical record. To reduce risks:

- ✦ Correct or update data automatically filled by the system.
- ✦ Validate patient history documented by previous providers.
- ✦ Use free-text entry in addition to system tools.

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easily copied from one record to another or from one encounter to another, but this step creates a risk of copying incorrect information that might be used for future clinical decision-making, says Ferris.

In a recent case reviewed by Ferris, multiple providers cared for a single patient, and each allowed the history information to autofill without adequately reviewing it with the patient. "Significant inaccuracies were contained in the history because one provider, trying to be efficient, had copied history from a different patient record and failed to make patient-specific changes," says Ferris. "Fortunately, the patient had not suffered a medical injury caused by the inaccurate information."

• Use free-text entry in addition to system tools.

"This can strengthen documentation of the history of the physician-patient partnership that defines quality care," says Ferris.

If physicians rely too heavily on templates and preformatted lists, discussions and clinical details unique to individual patients might become lost. "Free text entry in available fields or notes can document clinical decision-making more clearly than a time stamp followed by a preformatted order," she underscores.

• Be sure that use of drop-down menus, default information, macros, and templates don't lead you to inadvertently document interventions that weren't performed.

"The philosophy has changed from 'If it's not documented, you didn't do it," to 'You documented it, but did you do it?'" says Moses.

Use of prepopulated templates can create inaccuracies in the record, such as failing to document certain abnormalities, documentation of abnormalities that do not exist, or creating conflicts between different entries, he warns.

Providers need to read the chart after it's created and make any corrections as appropriate, advises Moses.

"Providers don't always read what they've typed, dictated, or clicked on," he says. "Ultimately, you are responsible for that note." *(See related story, below, on how fraud is coming up in medical malpractice cases.)*

SOURCES/RESOURCE

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• **CRICO**, the patient safety and medical professional liability company serving the Harvard medical community, has produced a video on how electronic medical records can be embedded into the physician workflow in a manner that would improve healthcare, with a dramatization based on real malpractice cases. To view the video, go to: www.rmf.harvard.edu/EMR. ✦

Medical malpractice cases: Crossover with fraud

After an investigation by the Department of Health and Human Services' Office of Inspector General (OIG) concluded that a Maryland interventional cardiologist allegedly placed hundreds of medically unnecessary coronary artery stents, a flood of medical malpractice litigation quickly followed.

"The health fraud allegations prompted advertising by plaintiff attorneys, resulting in hundreds of malpractice lawsuits," says **Richard E. Moses**, DO, JD, a Philadelphia-based gastroenterologist, risk management, and compliance consultant, and adjunct assistant clinical professor at the Temple University schools of medicine and law.

More cases will arise involving the crossover of medical malpractice and healthcare fraud, he predicts, due to the OIG making the over-utilization of services submitted for payment an enforcement priority for 2013. *(To view the OIG's 2013 work plan, go to http://1.usa.gov/PatqZX.)* "The government has also noticed a trend in upcoding due to electronic health record coding engines creating the level of care rendered," says Moses. "Just because a level of care is documented does not mean that that level of service was provided."

Moses relates that in his own documentation, he chooses to free text instead of using a drop-down menu or fixed templates. He then determines the appropriate evaluation and management (E&M) code for the level of care provided for that service. He has switched the coding engine option "off."

Providers should review the electronic record that they created for the patient's visit. The level of care and associated documentation provided should drive the appropriate E&M code, as is done with paper charting, rather than accepting the code recommended by the coding engine, says Moses. When providers finalize the progress note, they are attesting that the level of care to be billed is honest and appropriate, he adds.

"Coding engines tend to be created in order to maximize reimbursement," he explains. "Providers should submit the appropriate E&M code based on what they did, rather than what the coding engine tells them." ✦

If you make these changes, you can obtain lower premiums

It's possible to obtain lower premiums for professional liability coverage, but "to put yourself in that position, you have to outperform the average in your state or community," advises **Jonathan Katz**, president of Oros Risk Solutions, an Orlando, FL-based insurance and consulting agency specializing in selling medical professional liability insurance.

"How, in a malpractice arena, can physicians modify their behavior to put themselves in a better position? One way is to avoid risky behavior," he says.

Katz notes that rates have greatly improved since the medical malpractice crisis a decade ago, in part due to the fact that physicians with poor loss ratios were pushed to nonstandard types of insurance arrangements. There were penalties for risky behavior, so practices stopped doing some of the things that were leading to claims, and physicians embraced the patient safety movement. "They didn't want to pay double everyone else and have worse coverage," Katz says. "They wanted to get back to the standard market, with quality coverage at reasonable rates."

"The insurance market is soft right now, but that is going to change," warns Katz. He says physicians can do these things to put themselves in a better position before the market turns:

• Avoid performing procedures without adequate training.

Katz says insurers are seeing a trend in claims involving this scenario, the most egregious instance involving an ophthalmologist performing full plastic surgery procedures such as breast augmentation and liposuction.

"Doctors are looking for ways to make money outside their normal practice. One of the big trends is doctors getting certified over the weekend to do procedures," he says. "When doctors [provide care that is] outside their training, they are more apt to make errors in that area."

The fact that the procedure wasn't within the physician's training or scope of practice will make a claim less defensible, adds Katz.

• Take advantage of free patient safety services offered by your insurer.

Most physicians and medical groups don't take advantage of services such as surveys, education, and file reviews offered by insurers, reports Katz. "You can get a lot of good consulting and advice for free," he says.

• Look closely at the circumstances involving claims before judging a provider.

Just because a provider was named in several claims isn't necessarily an indication he or she is not practicing good medicine. "Don't make harsh decisions without digging deeper," says Katz.

On the other hand, Katz also has heard from claims managers that although a particular case was won at trial, the physician named in the lawsuit was practicing poor medicine. If after looking closely at a claim, you conclude a physician is not practicing good medicine, "you may want to exit that bad actor from the group," he says.

• Identify and act upon claim trends.

If claims involve misdiagnosis in a certain area, this misdiagnosis is an indication that education for everyone involved is warranted, advises Katz. Claims might involve a certain type of procedure done infrequently. If an orthopedic surgeon is experiencing major losses from claims involving rarely performed spinal surgery, for example, "the provider should seriously consider discontinuing the procedure," says Katz.

SOURCE

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Executive Summary

Professional liability rates have greatly improved since the recent medical malpractice crisis, but physicians should consider improving their claims history before the market turns. To obtain lower premiums, do the following:

✦ Avoid performing procedures for which physicians are poorly trained.
✦ Obtain patient safety services offered by insurers.
✦ Closely examine the medicine involved in recent claims.

Are you guilty of negligent prescribing?

"Prescription drugs are killing patients at an alarming rate." "Overdoses from prescription painkillers have risen for 10 straight years." "Over 40% of deaths involving prescription drugs were due to opioids."

"These are common things I hear from the plaintiff's attorney while defending physicians in claims alleging negligent prescribing," reports **Kathrine E. Fisher**, JD, a partner with Yates, McLamb & Weyher in Raleigh, NC. All are accurate statements based on recent statistics from the Centers for Disease Control and Prevention, she adds.

After a patient died from methadone toxicity a week after a physician prescribed the drug, the family filed a wrongful death lawsuit. "The physician also had to respond to a complaint and

investigation by the medical board. It was not a clear case of liability for the physician," says Fisher, who defended the physician named in the lawsuit.

There was a question as to whether the dosage prescribed was appropriate, but the patient had a history of illicit drug use and "doctor shopping" for opioids. There was also evidence that, in the days prior to his death, the patient might have taken methadone or oxycodone that he obtained from the streets.

However, due to the physician's unfamiliarity with the medication dosing and the possibility of a large damage award, the lawsuit with the family was settled. "The investigation by the medical board resulted in a consent order limiting the physician's ability to prescribe narcotic medications," adds Fisher.

Plaintiff must prove this

To prove negligent prescribing, generally the plaintiff must prove that the physician was negligent, and that the negligence was a proximate cause of his injury, says Fisher.

"The plaintiff must prove that the defendant physician or other healthcare provider violated the standards of practice with respect to the prescribing of the specific medication involved, and that the negligence was a cause that a reasonable and prudent healthcare provider could have foreseen would probably produce his injury," she explains. Fisher says to consider these practices to reduce legal risks:

• Have a pain management contract with the patient.

"This is good documentation to have in the chart," says Fisher. *(See related story, p. 138, on other types of documentation that can help the defense.)* The contract should include an acknowledgement by the patient that you have discussed with him or her possible addiction and potential side effects of the medication being prescribed, and an agreement that the patient:

— will not accept narcotic prescriptions from other providers;

— will take the medication as prescribed;

— will refrain for using illicit drugs or alcohol while taking the medication;

— will inform you of other medications being taken, particularly antidepressants, benzodiazepines, or other medications that might have an adverse interaction.

"... it is always beneficial to show that you are being proactive about a patient's complaints of pain."

• Check the patient's prescription record if you have access to a state database.

"Put documentation in the chart that you checked and the information you learned," says Fisher. "Check the database on a regular basis while you are treating a patient with narcotics."

• Obtain a copy of the patient's prior medical records from the provider previously treating him or her.

If a patient is seeking treatment for chronic pain or an injury, for example, the prior medical records might contain valuable information concerning use of narcotic medication or other illicit drugs and alcohol.

A physician is legally required to do that which the standards of practice among other members of the same profession do to find out what other medications a patient is taking, notes Fisher. "Patients lie or forget to tell their physician about a new medication. The best course of conduct is to do what is reasonable under the circumstances," she says.

Routinely ask the patient what medications he or she is taking, check the available controlled substance database, and review the notes that specialists, hospitals, or other healthcare providers send to you to see if medications have been prescribed, Fisher advises.

• Refer the patient to a pain specialist when appropriate.

"Whether or not the standards of practice require that you refer a patient to a specialist, it is always beneficial to show that you are being proactive about a patient's complaints of pain," says Fisher.

• Make a detailed note of each visit with the patient in the chart.

"What you write in your note should support why you prescribed the medication and the dosage," says Fisher.

Executive Summary

Physicians are increasingly being sued for medical malpractice alleging negligent prescribing. Document these items to reduce risks:

✦ medications the patient is taking;
✦ a pain management contract;
✦ the patient's refusal to comply with treatment recommendations.

SOURCES

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Prescribing pain medication? Be sure this documentation is in chart

When a physician is sued for negligent prescribing, a particular piece of documentation invariably becomes critically important, says **Catherine J. Flynn**, Esq., an attorney at Weber Gallagher in Warren, NJ.

"Plaintiffs always zero in on the documentation of the history, with respect to the medications the patient is taking," she says.

Flynn is seeing an increasing number of medical malpractice claims involving allegations of negligent prescribing, in the office and hospital setting. "Physicians should be exceedingly careful," warns Flynn. "The standard of care is evolving as we learn more about the negative effects of these drugs."

Here she gives items that, if documented in the chart, can make negligent prescribing allegations easier to defend:

• Evidence that a thorough history was obtained.

The standard of care requires that at some point prior to prescribing any medication to a patient, physicians ascertain what medications the patient is taking, and if dealing with an issue that involves pain management, what medications the patient has taken in the past, says Flynn.

Negligent prescribing lawsuits typically involve patients with catastrophic injuries, such as respiratory depression resulting in profound neurologic impairment, and cases often hinge on whether the patient's medication history was obtained, says Flynn. "If a medication history isn't obtained or isn't documented, providers are not protecting themselves from that type of allegation in front of a jury," she says.

• Documentation that an appropriate clinical workup was done.

"Relying just on the patient's report of pain or clinical presentation is not necessarily the best idea. If indicated, the appropriate diagnostic tests should be done" to investigate a patient's complaints, says Flynn.

• A patient's refusal to comply with treatment recommendations.

Clear documentation that a patient refused a diagnostic test that could establish an underlying condition such as a herniated disk, for example, can help the physician's defense.

"Otherwise, the chart will show that the test was not done as ordered, but with no discussion as to why the patient didn't have it — yet the physician continued to prescribe the medication," says Flynn. ✦

Caring 'informally' for colleagues, others?

A recent medical malpractice case involved a physician treating his significant other for a chronic pain problem with narcotics and muscle relaxants that resulted in an overdose and death.

"It was never clear whether the overdose was inadvertent or intentional, but the family was awarded a settlement in excess of $1 million," reports **Richard J. Wadas**, MD, FACEP, president and chief medical officer at Emergency Resource Management in Pittsburgh, and clinical associate professor of emergency medicine at University of Pittsburgh (PA).

In another case, an emergency department (ED) nurse developed a headache while at work and was treated with intravenous fluids and prochlorperazine. No chart was created, despite the fact that the care was provided in the ED. "She returned the next day with subarachnoid hemorrhage and went on to have mild to moderate disability," says Wadas. "She filed suit against the physician on duty that day as well as the hospital and was awarded a settlement at trial."

A current malpractice case in New York involves a woman who suffered a cardiac arrest seven days after an undocumented encounter with her physician of 20 years. "She went to the office on a day when they were not seeing patients, but ran into the physician in the parking lot," says Wadas. "She informed him that she had been having problems with chest pain. He prescribed nitroglycerin and a stress test. However, she expired before the test was ever obtained."

In general, physicians have an obligation not to provide care outside of established physician-patient relationships, says **Charissa Pacella**, MD, FACEP, chief of emergency services at UPMC Presbyterian in Pittsburgh and associate professor of emergency medicine at University of Pittsburgh. "The reasoning is straightforward. Quality medical care requires openness and objectivity that cannot be guaranteed when the patient is a friend or family member," say Pacella.

Pacella says to imagine prescribing antibiotics for a teen-age niece who is reluctant to tell you she is taking an oral contraceptive, or treating abdominal pain and vomiting in a friend who doesn't want to tell you how heavily he drinks. "A risk with all of these underlying relationships may be increased frequency of cognitive medical errors such as premature closure, given one's personal knowledge of the 'patient,'" says Wadas.

Physicians might alter medical decision-making based on the pre-existing relationship, he warns. "Deviations in care may be accentuated by real or perceived medical knowledge on the part of a staff member and may lead to errors in over- or under-testing," he explains.

"Informal" advice

If a physician-patient relationship already clearly exists, "legal risks are clearly higher," says Wadas. For example, a primary care physician might have a casual, undocumented encounter with a patient in the grocery store.

"Giving 'informal' advice in very general terms is probably OK, but should always include a recommendation to seek formal care," says Wadas.

A physician might say, for example, "If you are having these symptoms, it could be something more serious. There is no way for me to tell what the cause is," and instruct patients to seek a formal evaluation.

Specific or personalized advice regarding a specific condition likely would be construed as establishing a patient/physician relationship, and prescribing a specific treatment plan, such as by issuing a prescription, almost always would be interpreted as establishing such a relationship, Wadas says.

Avoid recommendations regarding treatment specific to the patient's symptoms, such as stating, "That cough is probably just bronchitis. Just take some cough medicine and get some rest," he says.

"One should be clear that the encounter does not establish a diagnosis," says Wadas. "Providing any instructions or specific treatment in writing should also be avoided."

Executive Summary

If physicians provide medical advice during a casual, undocumented encounter, a physician-patient relationship could be established and pave the way to medical malpractice litigation. To reduce risks of this scenario:

- Give a recommendation to seek formal care.
- Avoid giving specific recommendations regarding treatment.
- Don't provide any instructions in writing.

SOURCES

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Excessive workload coming up at trial — Plaintiff attorneys are calling it 'factory medicine'

Forty percent of attending physicians reported that once a month they have an unsafe workload that could lead to patient harm, according to a recent survey.[1]

"Clinician workload is only getting worse because so far, the main way health reform reduces costs is to pay providers less. Yet productivity has not improved," says **Peter J. Pronovost**, MD, PhD, FCCM, one of the study's authors and senior vice president for patient safety and quality and director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore, MD.

As a result, says Pronovost, nurses are now caring for seven rather than five patients, and hospitalists and intensive care unit physicians are caring for 15 rather than 10 patients. "These workloads often exceed a safe threshold," he warns.

Seven percent of the 506 hospital-based physicians surveyed said their heavy workload likely led to a patient complication, and 5% reported it probably caused a death over the past year.

Hospital leaders should have a mechanism to monitor workload or perceptions of workload, and they should evaluate if reduced staffing is truly saving money, advises Pronovost. "It may be that the increased patient complications, staff burnout, and turnover associated with excessive workload exceed the savings from reduced staffing," he says.

The theme of "the overworked doctor" is coming up more often in medical malpractice litigation, says **Bruce H. Nagel**, Esq., an attorney with Nagel Rice in Roseland, NJ. "One of the recurring themes in our cases is, 'Has the doctor done a thorough and complete examination and spent sufficient

Executive Summary

Unsafe workloads that lead to patient harm occur at least once a month for 40% of attending physicians surveyed. Plaintiff attorneys are raising these issues in medical malpractice litigation:

- ✦ whether a thorough and complete examination was performed;
- ✦ if the doctor has spent sufficient time with the patient;
- ✦ the number of patients seen by the doctor.

time with the patient to discharge their duty?'" Nagel says. "We are always looking at timelines and the amount of patients seen by the doctor."

Jurors likely will sympathize when they learn the entire examination took only a few minutes after the patient waited for more than one hour to be seen, for example. "Some offices book patients for only six minutes," Nagel says. "The reality is that doctors are seeing more and more patients every day because the insurance carriers are under-reimbursing them."

Computerized charting makes it easy for the plaintiff's attorney to point out to the jury that the doctor only saw the patient for a few minutes, and this argument is often persuasive, reports Nagel. "You now have a very defined timeline. If the patient has to wait to be seen and then the doctor only sees them very briefly, that strikes a chord with most jurors," he says.

Juries won't sympathize with MDs

Plaintiff attorneys can argue that excessive workload was part of the reason a physician wasn't providing reasonable care, says **Steve Levin**, JD, an attorney with Levin & Perconti in Chicago.

"We have tried cases where what's really going is factory medicine," he says. "Patients are just being shuffled in and out of the office. If you are seeing too many patients in a specific period time, you cannot act as a reasonably careful doctor."

Levin has seen physicians and nurses candidly acknowledge being overworked and understaffed during depositions. "They will sometimes admit it and say they are doing the best they can with limited resources," he says.

Juries might sympathize with nurses forced by employers to care for more patients than they have time for. "We then gear the case toward the ownership or administration, as opposed to the direct care providers," Levin says. "But if physicians allow themselves to be in a situation where they were not able to provide care in a reasonable manner, a jury is going to hold that against them."

Reference

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Patient refused care? Lawsuit might not happen

After an elderly man was diagnosed with rectal cancer, his son alleged a delay in diagnosis. "He threatened to get a lawyer and sue the doctor for not ordering the proper diagnostic exams that would have detected the cancer earlier," says **Denise Shope**, RN, BSN, MHSA, ARM, CPHRM, a risk management consultant at RCM&D, a Baltimore, MD-based insurance brokerage firm.

When the medical record was reviewed, however, the physician had clearly documented that the competent patient had refused the colonoscopy exam on multiple visits to his primary care physician. "The doctor repeatedly had detailed his conversation in writing, and his patient knew of the risks," says Shope. "When the patient's son and his lawyer reviewed the medical record, the case and complaint fell silent."

If a case is dismissed or dropped early, and there is no payment or indemnity made on behalf of the defendant doctor, then there is no required reporting to the National Practitioner Data Bank, says Shope. "Obviously, the longer the case is in litigation, the more costly the case in terms of court fees, expert testimony, and attorney fees," she adds.

Shope says a well-documented informed consent or refusal of care, along with the patient's acknowledgement of receipt of educational materials, can make a plaintiff attorney reconsider pursuing a malpractice claim. "Plaintiff attorneys do not like to see non-complaint patients. It makes it more difficult to argue their case of negligence," she says.

Shope says an example of good documentation of informed consent would be the completion of a well-written standard informed consent form, along with a complete progress note indicating the purpose, risks, benefits, and alternatives to the proposed treatment or procedure. She says physicians should include these items in their documentation:

• A list of any educational materials provided to the patient or the patient's representative.

"This can be as simple as a one-page brochure, or as sophisticated as a DVD that patient watches in the physician's office or takes home to view," says Shope.

• Consent forms written in laymen's language.

"These should be easy to comprehend," says Shope. "A signed copy of the consent form can be provided to the patient or family representative."

• The fact that patients were provided with an opportunity to ask questions at the time of consent.

"The physician should offer the opportunity answer any questions or concerns at any time going forward," says Shope. "All of this should be captured in a well-written progress note in

the patient's medical record."

• The physician's explanation of the risks of the refusal and alternatives, along with the risks and benefits of the alternatives.

"The physician should never use disparaging remarks or comments regarding the patient's refusal of care," she says. "Labeling the patients as 'stubborn' or 'stupid' is not helpful and can be damaging if the record is ever presented to a jury."

Every competent adult patient has the right to refuse care, says Shope. The physician has the duty to inform and explain the diagnosis, disease, treatment options, risks, and benefits of the proposed treatments and procedures, and the risks and benefits of the alternatives, and will be held to the "reasonable and prudent" standard.

"Good documentation of this process can only help the physician in the event of litigation," says Shope. "It becomes difficult to defend the physician's actions when the record is silent to the informed consent or informed refusal process."

If a patient refuses the care recommended by the physician and subsequently has an adverse outcome as a result, it would be difficult to find a sympathetic jury to favor the patient/plaintiff, according to Shope. "Therefore, a plaintiff's attorney may not want to pursue the negligence claim against the physician, or at the least, may avoid the failure to provide an informed consent allegation," she says. ✦

Legal risks of social media are many — Look to guidelines

Physicians should take care in online communications including the electronic posting of information and the exchange of information via computers and phones, says **Lois Snyder Sulmasy**, JD, director of the American College of Physicians' Center for Ethics and Professionalism in Philadelphia.

"What happens online, stays online — forever," she says. A new position paper by the American College of Physicians and the Federation of State Medical Boards provides guidance on the use of social networking, blogging, online forums, cell phone photography, electronic searching, texting, and emailing. *(To view the guidelines, go to http://bit.ly/ZR5Xvt.)*

"Our goal is to help physicians provide the best care to patients and maintain trust in the patient-physician relationship and the medical profession," says Snyder Sulmasy. Potential liability risks for physicians include confidentiality, privacy and security concerns, risks associated with patient-physician relationships, informed consent and documentation issues, practice of medicine across state lines, and defamation, she says.

"State medical boards are looking at online activities closely," adds Snyder Sulmasy. "Online activities by physicians is an evolving area, and it could end up the subject of malpractice claims, just as it has become the subject of state medical board disciplinary actions."

A study in the *Annals of Internal Medicine* in January 2013 looked at behaviors such inappropriate contact with patients and use of patient images without consent.[1] It found that these and other online activities would lead board officials to perform investigations. A March 2012 research letter in the *Journal of the American Medical Association* (JAMA) found that in response to reports of online professionalism violations such as sexual misconduct and misrepresentation of credentials, 71% of state medical boards have held disciplinary proceedings.[2]

"Postings and emails create permanent records that can be forwarded and are discoverable, so attorneys may be looking at this in medical malpractice and other types of litigation," says Snyder Sulmasy.

References

1. Greysen SR, Johnson D, Kind T, et al. Online professionalism investigations by state medical boards: First, do no harm. *Ann Intern Med* 2013; 158(2):124-130.
2. Greysen SR, Chretien KC, Kind T, et al. Physician violations of online professionalism and disciplinary actions: A national survey of state medical boards. *JAMA* 2012; 307(11):1141-1142. ✦

Chart can deter lawyer from pursuing claim — Attorney will have 'nowhere to assert a claim'

Does a patient's chart include all tests and treatments, a full medical and social history and physical exam, differential diagnoses, critical thinking thought process steps, and medical justification for preliminary and final conclusions regarding treatment and diagnosis?

If so, this chart goes a long way to support compliance with the standard of care, says **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, principal of the Kicklighter Group in Tamarac, FL.

"When there are no omissions in the documentation in the steps of the process, often there is nowhere to assert a claim of omission or commission as a basis for a malpractice suit," she explains.

Full and legible documentation of the office practice record is just as important as the documentation in a hospital, ambulatory surgery center, or

other place of care, advises Kicklighter. "Documentation in a medical record should not have to be interpreted or deciphered as if it were a foreign language," she underscores. "The interpretation or deciphering could be done in error and could be the basis of a preventable injury or untoward outcome."

The fully documented, legible medical record is "the first line of defense, or the first giant step of the pitfall of lack of defense," says Kicklighter. "If it is not documented, then memory and usual and customary practice are what is relied on. That then leaves more room for the jury to decide on what they believe or not."

Your charting is not just a clinical record for the care of patient, says **Richard S. Lovering**, JD, a partner in the litigation group of Bricker & Eckler in Columbus, OH. It is potentially a trial exhibit several years from now to demonstrate that all healthcare providers complied with accepted professional standards, Lovering says. "Years later, after memories have faded and recollections differ, the chart will be the trial exhibit that will either incriminate or exonerate the practitioner," he says.

Here are risk-reducing strategies that could deter a plaintiff attorney from pursuing a claim:

• It is better to have documentation of an interaction, even if it is general in nature.

For example, "Discussed in detail risks and benefits of the procedure" is better than relying solely on an informed consent form or nothing at all. "This gives the provider the leeway to discuss routine, custom, and habit concerning informed consent discussions," says **Derek S. Davis**, JD, an attorney with Cooper & Scully in Dallas.

It is better, however, to be specific regarding timing of interactions, as this can become a pivotal issue if a bad outcome occurs, says Davis. In one case involving a doctor who took call over the weekend for one of his partners, the patient had received an epidural pain injection on a Friday. "The dispute boiled down to whether the patient called the doctor's on-call service on Saturday or Sunday," says Davis.

If the patient called on Sunday, the standard of care required the patient to be evaluated in the emergency department if she was still having pain in her back. The doctor testified that he received the call on Saturday and called a prescription into the pharmacy.

Unfortunately, the pharmacy records showed the patient picked up the prescription on Sunday, and the doctor only recorded in his records that the call came in "over the weekend." "We managed to track down the original prescription that clearly showed it was called in on Saturday and managed to convince the opposing attorney to drop the case," says Davis. "Precision in documentation is important."

• Physicians should be cognizant of the "audit trail" that is often being sought in discovery by plaintiff's counsel to document who charted, and when they charted, in an electronic medical record.

Most computerized medical records contain an automatic "audit trail" showing when medical records were accessed, what entries were made, when any changes were made, and whether any entries were erased.

"If the audit trail does not correspond with the timing, narrative, and sequence of events in the chart, the plaintiff's attorney will allege that the chart was altered or that the chart narrative is inaccurate," says Lovering.

Plaintiffs' attorneys will attempt to place late entries in the worst possible light, he warns. "To avoid the appearance of impropriety or worse, conspicuously date any late [written] entry," he says. "Note that the reason for any late entry is to accurately document the patient's care and condition."

• If an error was disclosed to the patient, physicians should document this process.

If there was negligence involved in the injury or untoward outcome, settlement negotiations can take place early on without a lawsuit being initiated, says Kicklighter, providing more indemnity payment directly to the patient.

"In addition, disclosure starts the statute of limitations running," she says. "Documentation of the disclosure meeting in the record can be influential when an attorney is considering the merits of a malpractice lawsuit." *(See related story, p. 140, on documentation of refusal of care.)*✦

Executive Summary

Good documentation can sometimes dissuade a plaintiff's attorney from pursing a claim. Include this information in the patient's chart:

- ✦ interactions with patients;
- ✦ the reason for late entries;
- ✦ the patient's refusal of care.

New approach to malpractice reform

A "Patients Compensation System," if implemented, would eliminate "jackpot justice" in Georgia and Florida, according to **Wayne Oliver**, executive director of Patients for Fair Compensation and former vice president at the Center for Health Transformation.

There are four pieces of legislation being considered in Florida and Georgia. Oliver reports that the Georgia General Assembly will be holding hearings to gauge public support for creating the system.

"Business leaders and hospital administrators are intrigued by the idea

Executive Summary

Patients for Fair Compensation is working with stakeholders in Georgia and Florida to replace the adversarial medical malpractice system with a no-blame, administrative system. Some possible benefits:

✦ More patients would be eligible for compensation.
✦ Physicians would be encouraged to disclose errors.
✦ There would be less motivation to practice defensive medicine.

of eliminating medical malpractice lawsuits as we know them," says Oliver. "Hospitals want to avoid the appearance of impropriety, and doctors want to practice without looking over their shoulders to ensure a trial lawyer isn't lurking in the shadows."

If a child presented with a broken wrist from a fall injury and without any other symptoms, the standard of care would be to get an X-ray of the wrist, says Oliver, but defensive medicine might make some physicians feel compelled to order a head magnetic resonance imaging (MRI) and full-body CT scan in this situation. "Physicians are ordering thousands of dollars of tests, not to add any treatment value or improve the potential outcome, but strictly to protect themselves from medical malpractice lawsuits," says Oliver.

Few legitimately injured patients receive any compensation at all, and those who do typically pay half to their attorney, adds Oliver. "If we were to design a system today that would help make patients whole after a medical injury, no rational person would design the tort system we have in place today," he says.

The Patient Compensation System would allow a physician who has committed an avoidable medical error to disclose it and help that patient navigate the system and obtain appropriate compensation, he explains, as follows:

• Once an error or avoidable medical injury occurs, a patient advocate would be appointed to help the patient navigate the administrative solution.

• The Patient Compensation System medical director would review the medical record and interview all relevant parties.

• If the medical director concludes that the error was avoidable, a panel of physicians would review the redacted medical record and determine if, in fact, the error was avoidable.

• If the medical review panel believes that the injury was avoidable, they would send the application to the compensation department for payment.

Caps aren't sufficient to address the problem because these don't stop physicians from being sued, according to Oliver. "Texas has done an excellent of addressing traditional tort reform, with caps," he says. "However, if you ask Texas physicians, 'Are you practicing less defensive medicine?' they will say no. The reason is they still get sued."

The Patient Compensation System would allow injured patients to receive compensation within weeks instead of years, he says, and would allow more patients to be eligible for compensation.

"Right now, trial lawyers tell us they are not taking cases unless there are economic damages in excess of $500,000, just because of the capital outlay that they have to invest to get a case underway," Oliver says. ✦

COMING IN FUTURE MONTHS

✦ Surprising facts on misdiagnoses suits

✦ Keep front office staff from getting you sued

✦ Stop risk-prone communication practices

✦ Why healthcare reform poses med/mal risks

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 should physicians do to reduce risks with electronic medical record documentation, according to Kathy Ferris, ARM, CPHRM, a healthcare risk management consultant at Physicians Insurance?
A. Avoid routinely validating patient history documented by previous providers.
B. Avoid using free-text entry in addition to system tools.
C. Confirm, correct, or update data automatically filled by the system.
D. Never switch the coding engine option "off."

2. Which is recommended to reduce legal risks when prescribing narcotics, according to Kathrine E. Fisher, JD, a partner with Yates, McLamb & Weyher?
A. Pain management contracts should not specify the risk of addiction.
B. Physicians should not check prescription monitoring databases for a specific patient more than once.
C. For each visit, physicians should chart why the medication was prescribed.
D. Physicians should not routinely obtain a copy of prior medical records.

3. Which is true regarding legal risks of advice provided by physicians during an "informal" encounter with a patient, according to Richard J. Wadas, MD, FACEP, president and chief medical officer at Emergency Resource Management?
A. Giving specific recommendations without documentation is appropriate as long as a physician-patient relationship already exists.
B. Physicians should not restrict advice to general terms if a patient/physician relationship already exists.
C. Prescribing a specific treatment plan outside the office can never be interpreted as establishing a patient/physician relationship.
D. Specific or personalized advice regarding a specific condition would likely be construed as establishing a patient/physician relationship.

4. Which is recommended regarding documentation, according to Richard S. Lovering, JD, a partner in the litigation group of Bricker & Eckler?
A. Discussions involving disclosure should not be referred to in the patient's chart.
B. When making a late entry, physicians should note that the reason is to accurately document the patient's care and condition.
C. No documentation of an interaction is better than vague documentation.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Family of boy, 12, who suffered fatal brain damage awarded $3.5 million after 2-hour transfer delay

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News: In 2002, a 12-year-old boy was taken to the emergency department by his mother after she found him screaming in pain and holding his head. The child was at the emergency department for more than one hour before the doctor examined him, at which time it was discovered the boy's previously implanted brain shunt was malfunctioning. As the hospital was incapable of treating the boy, transfer protocols to another hospital were initiated. The child, however, was not transferred for more than two hours, and the physician failed to re-examine him during that time. While the child awaited his transfer, his condition worsened. He suffered fatal brain damage, and he died three days later. The patient's mother sued the doctor and alleged that she failed to recognize the severity of her son's condition and timely arrange for his transfer to an appropriate facility. The jury awarded the mother $3.5 million in damages.

Background: A 12-year-old boy presented to the emergency department with his mother after she found him screaming in pain, holding his head, and appearing lethargic. The child had a history of significant developmental delays and required a brain shunt to drain excess cerebrospinal fluid from his brain. The child arrived at the emergency department and was examined by a nurse at 7:05 a.m. He was found to have stable vital signs. The nurse contacted the doctor at 7:30 a.m., and the doctor ordered pain medicine for the child. However, the doctor did not actually examine the child until 8:15 a.m., more than one hour after the child's arrival, and 45 minutes after the physician was advised of the child's status.

While the child awaited his transfer, his condition worsened. He suffered fatal brain damage, and he died three days later.

Upon examination, it was determined that the child had a malfunctioning brain shunt. The doctor began transfer protocols, because the hospital did not have appropriate neurosurgical personnel to treat his condition. The doctor also contacted the emergency department doctor at the receiving facility and the child's regular neurologist and neurosurgeon. The doctor then went on to treat other patients, as she apparently did not realize the severity of the child's condition. Although the child's condition continued to deteriorate, the doctor did not return to reassess him. The doctor claimed that she was not told by the emergency department nurse of the signs of severe deterioration. The child was not transferred to another facility until 10:20 a.m., more than three hours after his arrival at the hospital. When the child finally arrived at the receiving hospital, he suffered respiratory arrest. His brain was damaged beyond repair. He died three days later.

The child's mother thereafter

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

commenced a lawsuit against the doctor. She alleged that the doctor failed to timely recognize the severity of the child's condition, which resulted in excessive delay in his treatment and ultimately his death. It was argued that the doctor should have realized the severity of the child's condition and arranged for quicker transfer. If the child had been timely transferred to an appropriate facility, then excess cerebrospinal fluid would not have built up in his brain, and he would not have suffered fatal brain damage.

The defendant doctor contended that she provided appropriate medical care to the child and had complied with the applicable standard of care. Defendant further argued that the child was still in stable condition when he arrived at the receiving hospital and was still treatable at that time. However, plaintiff was able to contradict this argument through the testimony of the child's grandmother, who testified that the child's deterioration happened about five minutes after arrival at the receiving hospital. Defendant's creditability was further damaged when she contradicted her prior deposition testimony at trial and blamed the discrepancies on plaintiff's counsel's "threatening" demeanor while questioning her at the deposition. Plaintiff was able to disprove this contention through the testimony of stenographer who took the deposition and an audio recording of the deposition.

The jury found that the defendant doctor deviated from the standard of care in failing to timely transfer the child and awarded his mother $3.5 million.

What this means to you: In hydrocephalus, there is a buildup of cerebrospinal fluid (CSF) around the brain and spinal cord. This buildup of fluid causes higher than normal pressure on the brain. A shunt, usually placed when hydrocephalus is diagnosed, helps to drain excess cerebral spinal fluid and relieve the pressure in the brain. If the shunt stops working or otherwise malfunctions, the fluid will begin to build up in the brain again. Too much pressure, pressure that is present too long, or pressure that accumulates too fast will damage the brain tissue, as was seen in this case.

According to the summary, this child arrived at the emergency department and was examined by a nurse at 7:05 a.m. He was found to have stable vital signs. A child of 12 years old, with a prior history of shunt placement and presenting with complaints of severe headache and lethargy should, at the minimum, have a full set of vital signs taken that would include a blood pressure, pulse, temperature, and respirations. In this case, we do not know from the facts if all of these vital signs were taken. Because infection, as well as obstruction, is a frequent complication of shunt placement, the vital signs would give the caregivers a better indication of a differential diagnosis. In cases of increased intracranial pressure, an increase in blood pressure (hypertension) as well as a decrease in heart rate (bradycardia), known as Cushing's response, is commonly seen when there is pressure on the brainstem.

It was argued that the doctor should have realized the severity of the child's condition and arranged for quicker transfer.

The nurse contacted the doctor at 7:30 a.m., 20 minutes after the first encounter, and the doctor ordered only pain medicine for the child without an initial exam. What is not mentioned in the summary is why the nurse delayed in informing the emergency department physician of the critical information regarding the patient's presenting symptoms and history of shunt placement unless, of course, she did not recognize the gravity of the situation. This situation was clearly an emergent one and needed to be addressed immediately. In fact, the doctor did not examine the child for more than one hour after the child's arrival and 45 minutes after she was advised of the child's status, thus precious time was wasted. Had the physician had access to this important information, and assuming that she was aware that time is of the essence in these cases, the physician could have changed her overall assessment and treatment plan for this patient.

Although the hospital did not have the appropriate neurosurgical personnel to handle this case in house, most hospitals do have a CT scanner. If this critical diagnostic test, a CT scan of the head, had been ordered, it would have given the emergency department physician valuable information to better evaluate the severity of the patient's condition. A shunt series, which is simply an X-ray that examines the full length of the shunt to reveal any blockages or disruptions, also would confirm a diagnosis.

Additionally, according to the summary, the emergency department physician did contact the patient's neurologist and neurosurgeon; however, there is no mention of what information was relayed to them and, in turn, what advice was given to the emergency department staff. As the patient's private physicians and experts in their field, did they not also have an obligation to visit and evaluate the patient and possibly expedite the transfer to the receiving hospital? Our summary is silent on this matter.

It does not appear, from the information presented in the summary, that once the patient was deemed appropriate and waiting for transfer, frequent vital signs and neurological checks were performed or that the emergent nature of this child's illness was appreciated. We can assume that if adequate assessments had been performed in a timely and accurate fashion, the patient's deterioration would have been more readily identified and, ideally, his critical situation handled immediately.

The lack of escalation and communication of critical information between the nurse and the physician, as well as a lack of critical patient monitoring, are the salient issues in this case. It appears that performance of diagnostic tests, which are considered the standard of care, to determine this diagnosis also were lacking.

As such, the overall credentials and level of assessment skills of both the nurse and emergency department physician should be evaluated to determine if they are up to par with their job function and responsibilities as emergency department practitioners. If not, appropriate measures of remediation should be taken to ensure patient safety.

If the root cause of this case was a knowledge deficit in the timely recognition and treatment of a life-threatening neurological condition, then an educational opportunity in the way of a grand rounds conference or other informational forum on this topic for the emergency department staff should be a required corrective action.

Reference

JAS MA Ref. No. 271396WL, 2012 WL 6799935 (Mass.Super. Oct. 22, 2012). ✦

Woman awarded $5 million when failure to test results in bilateral leg amputations

News: In 2008, a female patient presented to the emergency department of a local hospital with severe pain in her feet and legs. After examination by a physician's assistant (PA) and written approval from the emergency department physician, she was diagnosed with cellulitis and discharged home. Later the same day, the patient was found unresponsive in her home and rushed back to the emergency department. Following diagnostic testing, she was found to have blockages in the arteries of her lower legs, requiring amputation of both legs below the knee. The woman sued the physician, the physician's assistant, and their employer, and she claimed that they failed to timely diagnose the arterial blockages and prevent the amputation of her legs. The jury awarded the patient $5 million.

Background: A 61-year-old female patient was brought by ambulance to a local hospital due to severe pain in her feet and legs, which also were cold to the touch. She was examined by the physician's assistant, who discovered that the patient had a diminished distal pulse, bilateral leg soreness, leg pain, and leg redness. The defendants contended that a venous Doppler ultrasound examination indicated that the patient had no blockages in the veins of her legs. The patient, on the other hand, claimed that no such tests were performed. The patient was diagnosed with cellulitis and discharged home about noon, with a prescription for antibiotics and pain medications. She also was told to place ice on one of her legs.

... the physician was mainly unresponsive and simply poked his head into the room and said, "We don't admit people for cellulitis."

The patient and her family complained that she never got to see a doctor and begged for her to be admitted to the hospital. However, the physician was mainly unresponsive and simply poked his head into the room and said, "We don't admit people for cellulitis." This interaction is the only one the physician had with the patient, although he signed off on the diagnosis and recommended discharge.

About midnight that night, the patient was found unresponsive in her home by family members. She was brought back to the emergency department and, following diagnostic tests, was determined to have blockages in the arteries of her lower extremities. As a result, both legs had to be amputated below the knee.

The patient thereafter sued the physician, the physician's assistant, and their employers for medical malpractice, and she claimed that they failed to timely diagnose and

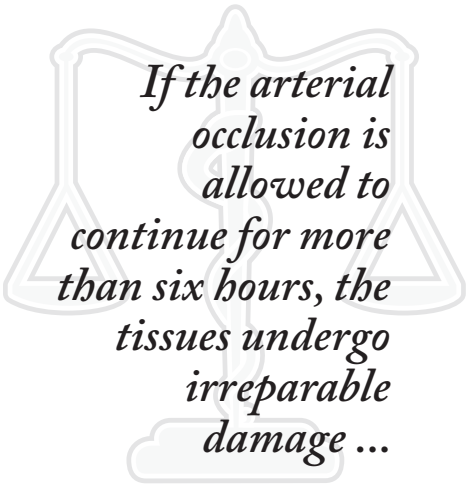
treat her arterial blockages. She argued that her legs would not have required amputation had she been properly diagnosed and the blockage timely discovered. She contended that had either of two simple tests been conducted within six hours of her arrival that morning, her legs could have been saved.

Defendants argued that they did not deviate from the standard of care in their treatment of plaintiff. They maintained that when she first arrived, acute venous problems were ruled out by a normal venous ultrasound and an acute arterial problem was ruled out by the presence of pulses, thus leaving infection as a result of cellulitis being the most likely cause of the plaintiff's complaints. Defendants asserted a major change in plaintiff's condition took place later that night following her discharge, which resulted in a cardiac arrest from a lack of blood pressure and pulse. Such conditions were not present or foreseeable during the initial visit.

The jurors returned a verdict in favor of plaintiff and awarded her $5 million. The jurors applied the standard of care of ordinary negligence and not gross negligence, as required under Georgia law when a physician or healthcare provider is providing "emergency medical care." The jury determined that the patient did not receive "emergency medical care" because she was in stable condition during her initial visit, despite having been treated in the emergency department.

What this means to you: The causes of occluded arteries are numerous and may include long-standing peripheral arterial disease (PAD). Some risk factors for PAD include diabetes, smoking, and hypertension. Symptoms of peripheral arterial disease may include cool/cold feet to touch, pain in the legs, or loss of pulses in legs or feet. A simple diagnostic test done in these cases is a Doppler study that confirms the presence or absence of pulses in the lower extremities.

Because PAD is a widespread disease of the arteries, the presence of PAD in the lower extremity arteries is a strong indicator that there is also PAD in the arteries of the heart and brain. PAD has two major complications associated with its presence: limb complications such as nonhealing wounds, ulcers, gangrene, and loss of a limb, and risk for stroke and/or heart attack.



If the arterial occlusion is allowed to continue for more than six hours, the tissues undergo irreparable damage ...

The information above sets the stage for the case at hand. This patient presented with classic symptoms of PAD: extreme pain in her lower extremities and feet that were cold to the touch. Despite the claim by the emergency department staff that appropriate testing to evaluate an occlusion was performed, the wrong test was performed. Herein lays the crux of this case.

The physician assistant performed a venous Doppler study instead of an arterial Doppler study. The arterial study is performed using the same Doppler machine, but the transducer device is placed in a different area of the leg to better capture atrial blood flow. Had this study been performed in the emergency department, it was possible that the article occlusion would have been diagnosed and treated in a timely fashion.

Additionally, a physician never properly assessed this patient, nor did he complete an adequate history and physical. The patient was never queried regarding a condition called intermittent claudication that presents as pain in the leg and feet while walking and indicates lack of blood flow to the legs. Instead of completing a comprehensive history, physical, and diagnostic testing, the emergency department staff incorrectly diagnosed the patient with cellulitis. Because redness and pain in the extremities are frequently seen in both conditions, arterial occlusion can, to the untrained eye, be mistaken for cellulitis. At a minimum, the patient should have been seen by a consulting surgeon to determine a definitive diagnosis.

If the arterial occlusion is allowed to continue for more than six hours, the tissues undergo irreparable damage, as was seen in this case. Needless to say, had the staff been more astute to this vascular emergency, they would have acted more aggressively in their overall treatment plan. However, once the patient was discharged and ultimately returned approximately 12 hours later in critical condition, the permanent damage was done.

The issues in this case are the lack of an adequate history and physical and the failure to recognize a vascular emergency. Comprehensive education on the signs and symptoms of vascular emergencies would be required for the emergency department staff. Also, there was a lack of PA supervision, and the hospital's policy on PA supervision might need to be revisited and reinforced.

Reference

2012 WL 6136433 (Ga. State Ct., Sep. 24, 2012) 2010-C-13313-4. ✦