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Criminal enforcement actions against physicians 'very aggressive'

Criminal convictions might be used as leverage to settle civil cases

The federal government has become "very aggressive" with enforcement actions against healthcare providers, according to **Mark J. Silberman**, JD, a partner at Duane Morris in Chicago. Silberman is a former state and federal prosecutor and former deputy chief counsel for the Illinois Department of Public Health.

Michael E. Clark, JD, LLM, special counsel in the Houston, TX, office of Duane Morris, says prosecutors looking at fraud and abuse "are far more willing to take on issues of medical necessity than they were in the past."

> *"Whom you choose to work with today, more than ever, is important."*

"They are questioning the motivation of physicians and arguing that they should be held criminally accountable for conduct that, in the past, would not have been considered fraudulent," says Clark.

As a federal prosecutor, Clark prosecuted a physician for prescribing an inordinate amount of methamphetamine hydrochloride. An expert witness testified that the inherent dangers of addiction were such that, when considered in connection with other less dangerous drugs, the prescribing of the drug was far outside the ordinary course of accepted medical practice. "The defense claimed the doctor had prescribed it for refractory depression and for weight control," says Clark. "The jury convicted the doctor."

Scrutiny invited

Physicians operate in such a heavily regulated environment, says Clark, "that not only is the threat of malpractice actions something to worry about, but perhaps more so are the exacting rules and regulations of federal and state reimbursement programs."

Even if one of the practice's vendors, not the practice itself, is being investigated for fraud, the practice likely will be asked to produce thousands of pages of documents, notes Silberman. "It can invite additional scrutiny, both from the government and from malpractice attorneys," he says. "Whom you choose to work with today, more than ever, is important,"

There is increasingly aggressive enforcement of fraud and abuse laws by regulators, prosecutors, and financially motivated whistleblowers, says Clark.

INSIDE

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This is also true for quality-of-care issues involving the physician's exercise of medical judgment, recordkeeping, and scope of practice, reports Silberman. He is seeing prosecution of physicians for discretionary decisions involving medical judgment, or, in the context of long-term care, the failure to coordinate care. "I've even seen one case in which criminal neglect was alleged for inaction," he says. "Obviously, the success of these prosecutions varies." *(See related story, p. 124, on criminal prosecutions for inappropriate opioid prescribing.)*

Prosecutors are increasingly seeking to convert allegations of abuse and neglect into criminal matters, adds Silberman. "The days where presuming an error was an honest mistake seem, to some degree, to have been replaced with a presumption of wrongdoing," he says.

Pending charges inadmissible?

If a physician is facing criminal charges, a malpractice attorney could use this situation to draw more attention to the case and raise public outrage over what's happened, says Silberman.

While a physician's conviction is admissible, most judges won't allow a pending charge to be introduced as evidence. For this reason, says Silberman, "most malpractice attorneys aren't going to go forward until a pending criminal case is resolved. But they can use it as leverage to obtain a settlement."

It's generally improper for attorneys to threaten the criminal process in order to settle civil actions, explains Clark. However, he says, "lawyers understand that convincing a prosecutor to move forward with criminal investigations or charges can 'up the stakes' for a defendant, to such a level that resolving the civil case becomes far more attractive."

Standard of care deviation

While most prosecutions of physicians who have committed acts constituting malpractice involve egregious circumstances, there are exceptions.

"This depends on factors such as the sophistication of the prosecutor's office involved," says Clark.

In some circumstances, there is such a gross deviation from the standard of care that the physician's underlying conduct fits the definition of criminal intent which results in significant harm to a person, says Clark.

"The involuntary manslaughter prosecution of Michael Jackson's personal physician, Dr. Conrad Murray, is a widely known example," says Clark.

In that case, the jury found that Murray's conduct in prescribing and delivering propofol, a powerful anesthetic, resulted in

Executive Summary

The government has increased enforcement actions against healthcare providers, including prosecuting physicians for quality-of-care issues, according to defense attorneys.

- ✦ There might be such a gross deviation from the standard of care that the physician's conduct fits the definition of criminal intent.
- ✦ Physicians have been prosecuted for discretionary decisions involving medical judgment.
- ✦ A physician who is improperly distributing controlled substances might face actions from the Drug Enforcement Agency and the United States Attorneys

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Jackson's death.

"In that regard, no doubt the jury was in part persuaded by one of the state's witnesses," says Clark. An anesthesiologist outlined 17 deviations from the standard of care, including some that he deemed "unconscionable" and "morally dubious."[1]

Indifference equals homicide?

Carelessness or indifference might suffice as the basis for negligent homicide in some jurisdictions. *(For more information on the burden of proof, see related story, below.)*

Ben A. Rich, JD, PhD, professor in the Department of Anesthesiology and Pain Medicine at the University of California — Davis Health System's School of Medicine, says, "[I]t is highly unlikely that a prosecutor would initiate such a prosecution, unless there was a demonstrable pattern of indifference that had resulted in the deaths of multiple patients."

The reason? Generally speaking, juries are favorably disposed toward physicians, says Rich. Multiple studies have shown that juries in malpractice cases are more likely to find for the defendant physician, even in cases in which independent reviewers found a departure from the standard of care.[2,3]

"If that is true in the garden variety malpractice case, it is even more likely to be true when a prosecutor seeks to impose criminal sanctions," says Rich.

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'Dramatically different' burden of proof required for criminal prosecution

Prosecutors typically act as 'lone rangers'

Criminal prosecutions of physicians for grossly substandard care almost invariably involve the death of multiple patients revealing a pattern of gross negligence or reckless indifference to patient safety, says **Ben A. Rich**, JD, PhD, professor in the Department of Anesthesiology and Pain Medicine at the University of California — Davis Health System's School of Medicine.

In an October 2013 case, a gastroenterologist was sentenced to life in prison after being found guilty of 27 charges, including unsafe propofol injection practices that resulted in one infected patient's death.

"The issue that is often, and properly, raised in the context of such prosecutions is whether the criminal law is the appropriate avenue by which to approach the physician's conduct," says Rich.

Rich says that prosecutors tend to operate as "lone rangers," disinclined to confer with medical boards or other regulatory bodies in determining whether to file charges. "They aren't known, however, to follow malpractice claim filings looking for egregious cases that are ripe for criminal prosecution," he adds. "It is important to keep in mind the two dramatically different burdens of proof."

Beyond a reasonable doubt

In a malpractice claim, the plaintiff's burden of proof is a mere preponderance of the evidence, meaning that the evidence is interpreted to show that it is more likely than not that the defendant physician's conduct fell below the minimally acceptable standard of acceptable care. "In stark contrast, the burden of proof in a criminal case is beyond a reasonable doubt," says Rich.

Most criminal prosecutions of physicians involve charges that a physician's conduct caused or materially contributed to the deaths of multiple patients, says Rich, and the burden of proof applies to each and every element of the crime. "First-degree murder requires proof of premeditation and intent, elements that would not usually be present in any physician-patient relationship, however dysfunctional," says Rich.

Most criminal prosecutions, therefore, are for one of the following:

• second-degree murder, which requires proof of a reckless act and grave indifference to human life;

• manslaughter, which doesn't require malicious intent;

• negligent homicide, which requires proof of carelessness or indifference to patient well-being.

"A notable exception is the prosecution of Michael Swango some years ago for multiple premeditated murders of patients," says Rich. "Ultimately, Swango plead guilty and accepted a sentence of life in prison in order to avoid the risk of the death penalty being imposed upon conviction."

Mark J. Silberman, JD, a partner at Duane Morris in Chicago, says that if criminal charges brought against a physician were upheld, "at that point, arguably, the job of the malpractice attorney would be done." Silberman is a former state and federal prosecutor and former deputy chief counsel for the Illinois Department of Public Health.

The reason? If the physician's criminal conduct was established beyond a reasonable

doubt, and the criminal conduct was related to the provision of care, then the fact that the physician failed to meet the standard of care is already established.

"Individuals may be aware of a malpractice case and pushing to make it a criminal case, and individuals may also be looking to also reframe those as allegations of malpractice," says Silberman. ✦

'Clear pattern' to successful prosecutions for improper opioid prescribing

The prescribing of opioid analgesics is a "target-rich" environment for criminal prosecution, says **Ben A. Rich**, JD, PhD, professor in the Department of Anesthesiology and Pain Medicine at the School of Medicine, University of California — Davis.

"Interestingly, the prosecutors in these cases tend to argue that the physician was acting outside the bounds of medical practice, dealing drugs for profit in the guise of medical practice," says Rich. "This is true of the case now pending in southern California against Dr. Hsiu-Ying `Lisa' Tseng." Tseng, a Rowland Heights, CA-based physician, is charged with second-degree murder in the deaths of three men and is accused of recklessly prescribing opioids to patients who had no medical need for them. The Drug Enforcement Administration says Tseng wrote more than 27,000 prescriptions over three years starting in January 2007.

Michael E. Clark, JD, LLM, special counsel at Duane Morris in Houston, TX, says prescription of controlled substances "has been, and remains, an area that will attract scrutiny by prosecutors." This scrutiny is particularly true if the pattern of behavior appears to be outside the scope of commonly accepted professional practice. "In many states, the legislatures have responded to concerns about pain management clinics by imposing special controls on them," says Clark.

Rich says that for this reason, physicians who treat patients with chronic pain have "a high level of concern."

"Nevertheless, there is a clear pattern to the physicians who have been successfully prosecuted." Here are commonly seen practices of physicians in these cases:

- maintaining very sparse or nonexistent medical records;
- routinely writing and refilling opioid prescriptions without physical examinations, follow-up visits, or assessments;
- failing to conduct any type of assessment of the risk the patient poses for addiction, abuse, or diversion of prescription medications;
- apparent indifference to whether the medication is controlling the pain and increasing the patient's ability to function.

Discretionary decisions by a physician using his or her professional judgment should not yield criminal consequences, argues **Mark J. Silberman**, JD, a partner at Duane Morris in Chicago and formerly a state and federal prosecutor and former deputy chief counsel for the Illinois Department of Public Health. "But prosecutors are looking at [a physician's discretionary decisions] in a multitude of ways," Silberman says. "'[Investigations] can cover the entire spectrum."

For example, a physician who is allegedly improperly distributing controlled substances might face actions from the Drug Enforcement Agency (DEA) and the U.S. Attorney's office. "In some cases, excess medication is looked at as improper billing, which can yield criminal consequences," adds Silberman. ✦

Florida chips away at peer review protection — Some providers are greatly exposed

Growing risk of peer review data used against physician defendants

Several federal laws, including the Health Care Quality Improvement Act and the Patient Safety & Quality Improvement Act (PSQIA), recognize the importance of encouraging open discussion regarding adverse medical incidents in order to create action plans to correct patient safety issues in the future. This open discussion is unlikely, however, if participants fear that documents created in the peer review process will be used against them later in litigation.

"The impact of subjecting these documents to litigation tends to be a stifling effect on candid discussions, or the creation of detailed documents in the first place," says **Samantha L. Prokop**, JD, an attorney at Brennan, Manna & Diamond in Akron, OH.

While most states have implemented statutes to protect peer review information, "some states, particularly Florida, have been chipping away at peer review protection," says Prokop. In 2004, Florida voters approved Article X, section 25 of the Florida Constitution, more commonly referred to as Amendment 7. This amendment provides that patients have a right to access any records made or received in the course of business of a healthcare facility or provider relating to any adverse medical incident.

"Plaintiffs in medical malpractice cases

have used this access provision to gather information regarding adverse incidents at hospitals or by providers, regardless of whether the incidents directly relate to the claim at issue," says Prokop.

Healthcare providers have been fighting to keep peer review information privileged, but Florida courts have upheld the validity of Amendment 7. " Recently, Florida courts have declared that Amendment 7 not only trumps the application of traditional statutory discovery protections, but also the Health Care Quality Improvement Act," says Prokop.[1]

Thus, healthcare providers are faced with the risk of having peer review data, processes, and information disclosed and used to their detriment in medical malpractice cases. "This leaves healthcare providers whose states do not have peer review protection greatly exposed," says Prokop.

She recommends that physicians join a patient safety organization (PSO) and transfer all peer review data to the PSO in accordance with the PSQIA and its implementing regulations. "One of the most important aspects of the PSQIA is that it affords Patient Safety Work Product protection from discovery by an outside party, particularly in malpractice cases," says Prokop.

"Best evidence plaintiff could have"

During malpractice litigation, the plaintiff's attorney often will attempt to obtain access to the peer review file. **Richard C. Kraus**, JD, an attorney at Foster Swift Collins & Smith in Lansing, MI, says, "Telling a jury that the hospital reviewed the defendant physician's care and decided there were standard of care breaches is the best evidence that a plaintiff could have. Courts are usually unwilling to allow discovery of the peer review committee's evaluation of a physician's performance when a plaintiff wants the information to prove negligence."

In contrast, courts may require disclosure of factual information in incident reports or witness statements obtained by a peer review committee. "The reasoning is that such reports or statements, particularly when prepared close in time to the incident, will be more accurate and reliable than deposition testimony months or even years later," says Kraus.

If a plaintiff alleges that a hospital negligently kept a physician on staff by failing to properly review his or her performance, the peer review file can be critical evidence. "Courts in various states have reached different conclusions about the discoverability of peer review materials," says Kraus.

The discoverability of peer review materials is commonly disputed in federal court cases. "A federal court is not required to apply privileges or protections created under state law," says Kraus. Depending on the nature of the case and the claimed justification for discovery, a federal court may require disclosure.

The most important factor is the applicable state law, according to Kraus. "Some states have very broad protections against disclosure or use of peer review materials; others are very restrictive," he says.

Courts usually view the peer review process as retrospective and focus on improving patient care in general or dealing with a specific provider's overall practice.

Because the care in a single case is unlikely to reflect a provider's overall practice, "courts are sometimes skeptical when peer review protection is claimed for review of a single case, particularly when there is some involvement by risk or claims management," says Kraus.

Executive Summary

Participants in peer review discussions after an adverse event occurs might fear that documents created during the process will be used against them later during malpractice litigation. While many states have implemented statutes to protect peer review information, some states are eroding this protection. To ensure peer review protection:

- ✦ Follow the hospital's or practice's procedures and policies.
- ✦ Limit access to the individuals directly involved in the process.
- ✦ Call in outside counsel if litigation is anticipated.

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'Ad hoc' peer review process is unlikely to result in protection

Some well-intentioned hospitals or physician practices carry out peer review on an "ad hoc" basis and select the best way to deal with a particular problem, says **Richard C. Kraus**, JD, an attorney at Foster Swift Collins & Smith in Lansing, MI.

"While that approach may be very effective from a clinical perspective, it is not likely to result in peer review protection," Kraus warns.

Physicians can consider these approaches to increase the likelihood that peer review materials will be protected:

• Understand the limits of peer review protection.

"The facts — what happened in a specific adverse event — are usually not protected," says Kraus. Rather, protection against disclosure and use in litigation is given to the evaluative process.

"The protection afforded to peer review is designed to encourage frank and candid review. It is not intended to protect against disclosure of adverse events," says Kraus.

• Follow the hospital's or practice's procedures and policies.

"The review has to be done by the right committee and for the right purpose," says Kraus. The peer review files should be separately and confidentially maintained. Only protected materials should be kept in the file.

"There is a mistaken belief that everything reviewed during the process is protected. That is not true," says Kraus. "Stamping documents as 'confidential' or 'peer review material' is not enough."

• Limit access to the peer review material to the committee and individuals directly involved in the process.

"The case law is not well-settled as to whether peer review is a 'privilege' that can be waived, like the physician-patient privilege," says Kraus.

Unless a hospital treats materials as confidential, however, it is unlikely that a court will accept a later claim of peer review protection.

• Call in outside counsel when a serious adverse incident occurs for which litigation is anticipated.

Samantha L. Prokop, JD, an attorney at Brennan, Manna & Diamond in Akron, OH, says, "Have the attorney conduct an investigation under attorney-client privilege." ✦

No legal duty to report concerns about impaired colleagues, but impaired physician risks 'reckless' allegation

Physicians' reluctance to report impaired colleagues has always posed a known barrier to prompt recognition of physicians who should receive medical and/or psychological or psychiatric care in order to ensure patient safety, says **Dan Groszkruger**, JD, MPH, principal of Solana Beach, CA-based rskmgmt.inc.

"This natural reluctance was reinforced when the Medical Board of California eliminated its 'diversion' program a few years ago," Groszkruger says. Physicians who sought voluntarily treatment were protected from disciplinary action, so long as they adhered to the program's rules.

"Unfortunately, the medical board concluded that the diversion program was not sufficiently effective to ensure the safety of patients under the care of impaired physicians in diversion, so the program was eliminated," says Groszkruger, who has represented physicians in licensing and disciplinary matters before the medical board. "The result has been even fewer reports of impairment, since lodging such a report could signal the end of the physician's ability to practice medicine and to earn a living, not to mention its relevance to medical malpractice litigation."

Knowledge of a colleague's impairment "puts a physician in a very difficult and possibly vulnerable position, legally," says Groszkruger. "When someone under a physician's care is harmed, lawyers tend to 'cast the net broadly.' Certainly, lawyers would sue anyone suspected to have had knowledge of impairment, but who neglected to report it."

Suit would be damaging and costly

Groszkruger says that absent unusual circumstances, such as if that physician directly supervises the impaired physician and is responsible to monitor his/her professional competence, there is no legal duty to report substance abuse, bizarre behavior, or other similar conduct to the authorities. Therefore, if a patient is harmed due to the impaired physician's malpractice, the other physician would normally bear no legal liability for damages. "This is not to say that a physician has no professional or moral and ethical duties in such a situation," he says. "Even though there may not be a clear legal duty to report, the physician should be guided by moral and ethical duties to protect the patient's safety."

Impaired physicians are a danger to themselves, patients, and possibly fellow physicians, says **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas.

"Legally, of course, an employer who has an impaired physician would also be sued for the negligent actions of the impaired physician," says Stimmel.

If a physician is treating the same patient as the impaired physician, a plaintiff attorney could allege that since a physician/patient relationship existed, the physician therefore had a duty to report the impaired physician and the employer, and possibly tell the patient of their concerns.

"A case against a colleague would be hard to win unless it was proven the colleague had 'actual' knowledge of the impairment, but you may still be sued,"

Executive Summary

A physician who becomes aware of another physician's impairment generally has no legal duty to report the concern, but plaintiff attorneys are likely to sue anyone suspected to have had knowledge of impairment who neglected to report it.

✦ Plaintiff attorneys may allege there is a duty if a patient/physician relationship exists or the physician is supervising the impaired colleague.
✦ An employer can be held liable for the negligent actions of the impaired physician.
✦ Evidence of impairment would be admissible if the impaired physician was sued.
✦ Impaired physicians might face allegations of recklessness resulting in punitive damages being imposed.

says Stimmel. "That type of lawsuit would be damaging to a reputation and costly."

Punitive damages possible

Regarding legal risks for the impaired physician, Groszkruger says that evidence of substance abuse or mental disorder, known to the physician who continued to practice, would be admissible on the issue of foreseeability.

"The knowledge of impairment would help to show that the physician was negligent or even reckless, by ignoring a known danger that his or her impairment could interfere with safe care," he says.

The most significant legal effect of such evidence would be an allegation of "recklessness" sufficient for an award of punitive damages.

"Punitive damages, by law, cannot be covered by insurance and must be paid by the reckless physician," he says.

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Patients' open access to medical records has the potential to decrease your legal risks

Some providers fear lawsuits, but patients are highly satisfied

"If this had been available years ago I would have had my breast cancer diagnosed earlier. A previous doctor wrote in my chart and marked the exact area but never informed me. This potentially could save lives."

This was one patient's response to the Open Notes system, an internally developed system used at Boston-based Beth Israel Deaconess Medical Center's. Open Notes not only allows patients to look at their electronic medical record, but also to make corrections by writing to the physician in the record.

"Suits often follow misunderstandings, especially when patients and families feel they have been left out of the communications loop," says **Jan Walker**, RN, MBA, an assistant professor of medicine at Harvard Medical School in Boston.

In a 2012 study of the OpenNotes system, of the 5,391 patients who opened at least one note and completed a survey, 60-78% of patients across the three participating sites who were taking medications reported increased adherence.[1]

Patients are able to review their record whenever they wish, which gives them the opportunity to spot errors in the record. "They call them to the attention of their providers for correction and maybe save errors down the road," says Walker, the study's co-first author. A patient might notice an allergy isn't recorded in the chart, for example, or that a recommended diagnostic test was never ordered.

Patients highly satisfied

Making the record more readily available through online access is likely to have minimal negative impact or have a beneficial impact on liability risk, says **Bryan Lee**, MD, JD, assistant professor in University of Washington's Department of Ophthalmology.

For example, a well-documented informed consent discussion that a patient can easily review online could prevent a claim alleging that the patient did not understand the risk, benefits, and alternatives to a procedure. If it's documented well online, the patient has the ability to review it multiple times and to gain a better understanding of the risks and benefits of the procedure before the surgery. "If there were a negative outcome, a patient can more easily go back to the chart after the surgery and confirm that this is something that was discussed, potentially decreasing the likelihood of hiring counsel and pursuing a possible malpractice suit," says Lee.

Still, some doctors fear that patients looking through their records will uncover mistakes, leading to more lawsuits.

"The Open Notes study has shown that patients are highly satisfied when given online access to their clinical notes," says Lee. "And we know from other research that patients who like their providers and experience greater transparency are actually less likely to sue." *(See related story, p. 128, on liability risks involving online access to records.)*

Executive Summary

Some physicians fear that giving patients complete online access to medical records, as does the Open Notes system at Beth Israel Deaconess Medical Center, increases liability risks. However, a recent study showed that patients are highly satisfied when given online access.

- ✦ Patients report increased adherence to medications.
- ✦ Patients can alert providers to errors in the record.
- ✦ A well-documented informed consent discussion accessible online could provide a defense to claims alleging that a patient wasn't informed.

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Expectation: Communication will come from the doctor

Where patients have access to their medical records online, it is important for physicians to filter what information is posted and when, says **Sharona Hoffman**, JD, LLM, co-director of the Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH.

"You don't want a patient to find a cancer diagnosis by logging on by themselves at midnight and seeing that up there," she says. "If it requires an explanation or is potentially upsetting, it requires a call, as in the old days."

Doctors at Cleveland Clinic post routine information on the MyChart patient portal (manufactured by Verona, WI-based Epic), but physicians still call with important test results or instructions. (For more information, see resource at end of this article.

Relying exclusively on MyChart would be dangerous, says Hoffman, "because patients may simply not check MyChart or may not understand the material that is posted. Therefore, they wouldn't receive information that they really need to have."

Think through the risks

Hoffman says physicians "have to think through the malpractice risks." If physicians don't communicate directly with the patient, they can't be sure he or she has the information, understands it, and knows what next steps to take.

"If treatment is adversely affected by insufficient communication, you could potentially face malpractice claims," Hoffman warns.

The question is how providers can reduce risks by improving communication with each other while actively involving the patient, says **Daniel O'Connell**, PhD, principle of the Communication Training Group, a Seattle-based firm that provides training to physicians.

> *"Information must flow across EHRs so as to be readily available ..."*

"For decades, we have relied on copies of consult notes and progress notes being mailed, faxed, or forwarded to other treating clinicians, when we are aware of their existence," he says.

The patient is now being included in the information loop. As electronic health records (EHRs) become even more widely used, and the concept of meaningful use extends to greater involvement of the patient, more patients will have access to their entire medical record, says O'Connell.

O'Connell says physicians should consider these approaches to decrease liability risks:

• Provide patients with readable glossaries of terms, recommended websites, and vetted sources of healthcare information.

"We would then expect that patients will become more active and sophisticated, both in managing their healthcare situations and in communicating efficiently and effectively with the multiple providers," he says.

Avoid information overload

• Recognize that information overload presents liability risks.

Physicians must use discretion in deciding the scope and timeliness of information sharing to prevent waste and potential patient harm, says O'Connell.

• Find ways to transmit information in ways that are "easily digestible" by patients, as well as busy clinicians and support staff.

"Information must flow across EHRs so as to be readily available for in-person, phone, and electronic interactions with the patient about their conditions," O'Connell says.

RESOURCE

• Epic's **MyChart** gives patients controlled access to the same medical records their doctors use, via browser or mobile app (for iOS and Android), including test results and upcoming appointments. For more information, contact: Epic in Verona, WI. Phone: (608) 271-9000. Fax: (608) 271-7237. Email: info@epic.com. Web: https://www.epic.com/software-phr.php. ✦

Treatment not medically necessary? Doctors facing more scrutiny from payers

However malpractice suits often allege failure to order test

Physicians are facing increasing pressure from payers to stop ordering tests deemed not medically necessary. Yet failing to order diagnostic tests can leave physicians legally vulnerable.

Many physicians are trying to cut back on unnecessary diagnostic tests, says **David P. Sousa**, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh. "This is particularly true in jurisdictions where there has been medical liability reform that gives physicians some protection," he says.

Jon M. Pellett, JD, an attorney of counsel with Barr, Murman, & Tonelli in Tampa, FL, says that when he represents physicians facing state licensing board complaints, he doesn't see many allegations against doctors for performing unnecessary diagnostic testing. "Usually the allegation is that they failed to do a test that they should have done, as opposed to doing more testing than is needed," he says.

Payers are looking at testing

Payers are looking much more closely at whether diagnostic tests are necessary, however.

"From a financial point of view, there is pressure to stop unnecessary testing," says Pellett. "What I'm seeing is an increase in questioning of medical necessity for doctors that are being more thorough than the programs would like them to be."

At the same time, physicians need to be thorough to protect themselves from liability. "In the malpractice world, it's the failure to order the test that usually comes up," says Pellett.

When a physician opts not to order a diagnostic test, the results of which can be determinative of a significant disease process or injury, says Sousa, it might be helpful for the physician to "state precisely in the medical record why the test was not ordered."

In one case, a 34-year-old year old man presented to an urgent care center with acute right upper quadrant abdominal pain. He was diagnosed with cholelithiasis and discharged on painkillers without lab work or imaging being done.

"The next day he went to surgery, where appendicitis was confirmed," says **Jonathan M. Fanaroff**, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

At the time of surgery the appendix was gangrenous, so one of the plaintiff's arguments was that the delayed diagnosis caused harm. The plaintiff alleged that a complete blood count and a urinalysis should have been done at the first visit. "The fact that [testing] was not done and there was no documentation about why it was not done hurt the defendant," says Fanaroff, adding that the case settled for $200,000.

Fanaroff says that if physicians believe that the risk of radiation from a CT scan outweighs the low likelihood of benefit in a particular case, that they should document this information specifically. "If there is no documentation in the record, and a physician claims as a defense after a lawsuit is filed that they were worried about radiation, a jury may not believe them," he explains.

Documentation that the physician followed published guidelines is also helpful, adds Fanaroff. The 2010 Centers for Disease Control and Prevention (CDC) guidelines for Group B Streptococcal (GBS) Disease, for example, state that when a full-term infant is born to a mother who had an indication for GBS intrapartum antibiotic prophylaxis and did not receive adequate intrapartum antibiotic prophylaxis, no lab evaluation is necessary as long as the infant is observed, well-appearing, and the duration of membrane rupture was more than 18 hours prior to delivery. *(To view the guidelines, go to http://www.cdc.gov/groupbstrep/guidelines/guidelines.html.)*

"If an infant meets those criteria, a provider could document that no lab work is needed based on the CDC Group B Strep guidelines," says Fanaroff.

SOURCES

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Executive Summary

There is increasing pressure on physicians from payers to stop ordering tests deemed not medically necessary, but failing to order diagnostic tests can leave physicians legally vulnerable.

✦ Payers are looking much more closely at whether diagnostic tests are necessary.

✦ If physicians believe the risk of radiation from the CT outweighs the low likelihood of benefit, they should document this belief.

✦ Documentation that the physician was following published guidelines that recommend against unnecessary testing can make claims more defensible.

Claims are alleging failure to monitor surgical patients: More providers sharing responsibility — and liability

A recent malpractice case named an orthopedic surgeon who had prophylactically placed a patient on antibiotics days before performing arthroscopic surgery to clean up scar tissue on the patient's ankle.

"The surgeon failed to appreciate that the patient had developed the early stages of Stevens-Johnson syndrome," says **Nan Gallagher-Auferio**, JD, Esq., an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ.

The plaintiff alleged that if a proper medical history been obtained and a thorough preoperative examination been performed, the surgery would have been aborted and the patient would have been sent to the hospital for immediate interventions to be performed.

"Here, the surgeon putting the patient under general anesthesia only intensified the adverse reaction of the syndrome, and the patient went into multi-organ failure in the lobby of the surgery center. She subsequently died," says Gallagher-Auferio, adding that the case was settled for $550,000.

In another case involving failure to monitor a patient, an anesthesiologist was sued after a patient developed disseminated intravascular coagulopathy in the post-anesthesia care unit (PACU) following removal of a malignant testicle at an outpatient surgery center.

"The anesthesiologist left the building without properly monitoring the patient's postoperative vital signs, and failed to respond to multiple pages from the PACU nurses," says Gallagher-Auferio. "The patient later died. The physician's conduct was indefensible."

Claims from communication lapses

Communication lapses are a frequently cited cause of medical malpractice cases, according to **Cindy Wallace**, CPHRM, senior risk management analyst at ECRI Institute, a Plymouth Meeting, PA-based organization that researches approaches to improving the safety, quality, and cost-effectiveness of patient care.

To protect themselves against these claims, Wallace recommends these practices:

- The surgical team should conduct a preoperative briefing to share information on the patient.

For example, the physician/surgeon and anesthesia provider should review the pre-anesthesia evaluation of the patient to discuss any known risks and the plan to minimize these risks.

- The physician/surgeon should ensure that the recovery team knows how to reach him or her, as well as a back-up contact, in case any questions or concerns arise.
- There should be an established process for handing off the patient from the surgical team to the recovery team.

"Standardized communication tools, such as the SBAR [Situation-Background-Assessment-Recommendation] briefing tool, should be used to clearly describe the patient's condition and key concerns and recommendations for the patient's recovery," says Wallace.

Risk of fragmented care

The responsibility for caring for postoperative patients is now being divided between more providers, reports **Hugo Quinny Cheng**, MD, director of the medicine consultation service at University of California, San Francisco Medical Center.

"Hospitalists are often asked to manage the 'medical' aspects of care in lieu of the surgeon," says Cheng. In some cases, the hospitalist serves as the attending of record for surgical patients, while the surgeon is a consultant.

"This shared responsibility allows each physician to focus their efforts on the areas they have the greatest expertise," says Cheng. "But it can also create risk if care becomes fragmented." For example, there could be uncertainty as to which provider is responsible for monitoring a specific issue, such as anticoagulation. "The surgeon and the hospitalist may each assume the other party is monitoring this, whereas in fact neither physician is doing so," says Cheng.

Another problem that can arise is the surgeon turning over care to hospitalists that lack adequate training or experience to deal with surgical problems. "The availability of hospitalists can untether subspecialists and surgeons from their responsibilities to closely follow their patients after surgery or to take call for emergency room patients," says Cheng.

Cheng says there is potential for the surgeon and hospitalist to be held liable in this scenario. If providers are going to divide up responsibilities, it's important to have a protocol in place that clarifies their roles, he adds.[1]

"Who will monitor and order anticoagulants? Who will monitor for bleeding and order transfusions?" says Cheng. "Even with protocols in place, however, there needs to be frequent communication between providers."

Reference

1. Cheng HQ. Comanagement: Who's in charge? *AHRQ Cases & Commentaries* [serial online]. June 2012. ✦

Executive Summary

Common allegations in malpractice claims involving surgical patients are failure to obtain a proper medical history, failure to perform a preoperative examination, and failure to monitor patients postoperatively. Ways to diminish risk include:

- ✦ Conducting preoperative briefings.
- ✦ Providing recovery teams with readily-available contact information for the surgeons and back-up contacts.
- ✦ Clarifying roles and responsibilities of all providers in a patient's care team.

Malpractice payouts increase for first time since 2003

Last year marked the first time since 2003 that there was an increase in the total medical malpractice payout amounts, as well as the total number of payouts, according to the 2014 Medical Malpractice Payout Analysis done by Diederich Healthcare, a Carbondale, IL-based provider of medical malpractice insurance. Here are some findings of the analysis, which is based on data from the National Practitioner Data Bank:

• Dollars in payouts grew to $3.73 million, which is 4.7% more than in 2012.

• California saw the largest year-over-year increase in payout money, with payouts up $51 million compared with 2012.

• When divided by patient type, most (45%) medical malpractice payment amounts were for claims regarding an inpatient case, while 38% of payouts were for claims involving outpatient cases.

• Most allegations (33%) pertained to diagnoses, but surgery (28%) and treatment (18%) also comprised considerable portions of payout money.

The top five states for medical malpractice payouts, per capita, were New York ($38.83), Pennsylvania ($24.76), New Jersey ($23.24), Maryland ($22.37), and Connecticut ($20.98). The bottom five states for medical malpractice payouts, per capita, were North Dakota ($2.96), Texas ($3.02), Wisconsin ($3.07), Mississippi ($4.15), and Indiana ($4.18)

"From 2003 to 2012, the total payout amounts had declined in each subsequent year, but 2013 brought a sharp change in this trend, with total payouts actually increasing from 2012 by $168 million, or 4.7%," says **Matthew Thompson**, JD, assistant vice president of the northeast region for Diederich Healthcare.

Additionally, 38 states experienced an increase in total payout amounts as compared to 2012. However, New York, the state that historically has had the highest total payout amount in the nation, experienced a decrease from 2012 of more than $73 million in payouts. "While it is too early to determine if this is the beginning of a new trend or simply an anomaly, we continue to monitor the data to see what 2014 brings," says Thompson.

Despite the payout amount increase in 2013, the total payout amounts and total number of payouts continue to be significantly less than the previous decade. The overall reduction has led to decreased malpractice insurance premiums for physicians and an increase in insurance carrier competition, says Thompson.

"This is good news for physicians wishing to maintain their independence through private practice and who are attempting to reduce a significant overhead cost: malpractice insurance premium," he says. ✦

COMING IN FUTURE MONTHS

✦ Update: How courts are interpreting apology laws

✦ Decrease legal risks when patients can't pay for care

✦ Risks when physicians transition from hospital employment

✦ How lawsuits can result from care of "difficult" patients

CME OBJECTIVES

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

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

CME INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below or 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 emailed to you instantly. ✦

CME Questions

1. **Which is true regarding criminal prosecution of physicians, according to Michael E. Clark, JD, LLM, special counsel at Duane Morris?**
   A. Carelessness or indifference cannot suffice as the basis for negligent homicide in any jurisdictions.
   B. Physicians cannot be prosecuted for discretionary decisions involving medical judgment under any circumstances.
   C. Evidence of a pending criminal case against a physician is always admissible.
   D. In some circumstances, there is such a gross deviation from the standard of care that the underlying conduct fits the definition of criminal intent which results in significant harm to a person.

2. **Which is true regarding protection of peer review information?**
   A. Courts cannot require disclosure of incident reports or witness statements obtained by a peer review committee.
   B. Depending on the nature of the case and the claimed justification for discovery, many federal courts have required disclosure of peer review materials.
   C. The facts of what occurred with a specific adverse event are always protected from disclosure.
   D. All documents labeled as "peer review material" are legally protected from disclosure.

3. **Which is true regarding a physician's legal duty to report an impaired colleague, according to Dan Groszkruger, JD, MPH, principal of rskmgmt.inc?**
   A. A physician who becomes aware of another physician's impairment has a legal duty to report the concern in all states.
   B. Physicians have no legal duty to report an impaired colleague, even if they directly supervise the impaired physician.
   C. Plaintiff attorneys are likely to sue anyone suspected to have had knowledge of impairment who neglected to report it.
   D. Physicians should not report their concerns about an impaired colleague through the peer review committee.

4. **Which occurred due to open access to medical records, according to a study published in "Annals of Internal Medicine"?**
   A. Patients reported more problems with adherence to medications.
   B. Patients were highly satisfied when given online access.
   C. Increased frequency of claims alleging failure to inform patients of results.
   D. Providers reported a significant increase in the number of patient complaints.

Physician Legal Review & Commentary

Expert analysis of recent lawsuits and their impact on physician risk management

Complications from treating broken ankle cause leg amputation and $9.1 million verdict

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News: The patient, a 35-year-old man, sought treatment for a broken ankle in October 2004 after an accidental fall. An initial physician at an orthopedic group began treating the patient, but pain continued, and the patient switched to a second physician. The patient's pain was located on the side of his foot near the little toe, which was deemed to be evidence of an unusual nerve disorder. The second physician performed surgeries. The surgeries led to multiple post-surgical complications and infections requiring multiple amputations and which ultimately resulted in the entire leg being amputated. The patient brought suit and claimed that the second physician failed to meet the standard of care. The defendant physician denied any wrongdoing. The jury awarded $9.1 million in damages against the physician.

Background: In this matter, the patient was a healthy 35-year-old public safety dispatcher working for a city. He sought treatment in October 2004 after falling on the steps while on his way to work, which resulted in a broken ankle. The patient went to a physician at an orthopedic group, who initially treated the injury, but this treatment was not completely successful. The patient continued to feel pain on the side of his foot near his little toe. This pain later was determined to be evidence of an unusual nerve disorder, which was apparently caused by the initial ankle fracture but not cured with the first physician's treatment. About a year after the injury, the patient changed doctors to a second physician who treated him from 2005 to 2009.

After the loss of his leg, the patient was devastated and unable to work, due to his disability.

This second physician began performing surgeries to attempt to cure the patient's pain. The surgeries initially proved to be unsuccessful, but the physician continued with the surgical plan and eventually amputated the little toe. However, this procedure proved unsuccessful as well, and in addition, the patient developed an infection after the first amputation. The physician then amputated the fourth toe, but the patient's pain continued. In July 2009, this second physician amputated below the knee, which again resulted in a post-surgical infection. This infection necessitated amputation of the remaining leg above the knee, but this surgery was performed in September 2009 by a different physician. Over the course of his four-year treatment, the second physician performed 12 surgeries on the patient, with multiple failures to cure the pain and multiple post-surgical infections that required additional treatment. After the loss of his leg, the patient was devastated and unable to work, due to his disability.

The patient brought suit, alleging that the physicians' actions fell below

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the standard of care, which led to the requirement of additional surgeries and which subjected the patient to infection. The patient sued the initial physician and the second physician. After a 15-day trial, the jury found the first physician not liable. The jury found that the second physician, who performed the 12 surgeries, did not adequately treat his patient and thus did not meet the standard of care required. The jury awarded a total of $9.1 million: $2 million for past pain and suffering, $2.8 million for past and future medical expenses and loss of wages, $4 million for future pain and suffering, plus an additional $350,000 to the patient's former wife for loss of services.

What this means to you: The primary issue in this case was to what degree, if any, the physicians were negligent for failing to meet the standard of care in treating the ankle fracture. The initial physician was found to have met the standard of care, but the second physician deviated from this standard. When dealing with multiple surgical procedures, there can be numerous complications inherent in surgery, and physicians must exercise caution before, during, and after the surgery to ensure their patient's health and recovery. One of the major issues in this case was the onset of multiple post-surgical infections that caused serious injuries in their own right and required additional surgeries to treat.

Infections are a serious and dangerous potential risk of surgical procedures. Any surgery that causes a break in the skin has the potential to lead to postoperative infection, called surgical site infection (SSI). According to the Centers for Disease Control and Prevention (CDC), chances for developing an SSI are about 1% to 3%. These numbers, given the potentially serious consequences of a SSI, warrant precautions to be taken place by physicians and healthcare facilities to ensure minimal infection. Most of these SSIs are minor and affect only the skin around the incision. Others, however, can be serious and life-threatening. MRSA (methicillin-resistant *Staphylococcus* aureus) is a bacterium that is resistant to many antibiotics and is potentially life-threatening, but many of these infections can be prevented by following CDC infection control guidelines. In general, physicians and hospitals have several techniques that might help prevent SSIs and MRSA. These techniques include cleaning hands and arms up to elbows with an antiseptic agent immediately prior to surgery; cleaning hands with soap and water or alcohol-based rub before and after dealing with each patient; wearing special hair covers, masks, gowns, and gloves during surgery to keep surgical sites clean; and focusing on keeping surgical sites, particularly the skin, clean with special soaps designed to kill germs. Surgeons should follow their hospital scrub-in and skin prep protocols, which are designed to reduce SSIs. Because SSI rates are tracked and trended by hospitals, physicians should afford extra care and precaution to lower their rates, as these are used for credential review and other peer review activities. For more information and guidelines regarding SSIs, visit the CDC at http://www.cdc.gov/HAI/ssi/ssi.html.

Given that the CDC has guidelines in place, physicians and healthcare facilities should be aware of these guidelines and be cautious to follow them. These guidelines are a great place to start, and following them provides a strong defense for physicians that they have followed the standard of care. However, physicians should not consider these a guarantee of protection against liability: going above and beyond the recommendations can offer further protection, so physicians should not consider these guidelines to be all that is mandated. Additional protections, beyond those recommended by the CDC, to ensure patient health might be warranted if other physicians in a similar situation would employ such protections.

Reference

Supreme Court of Erie County, NY. Case No. 011346/2010. Feb.5, 2014. ✦

Surgical complications from elective surgery result in $1.3 million verdict against physician

News: The patient, a 38-year-old woman, underwent an elective abdominal surgery, an abdominoplasty or "tummy tuck," which included liposuction of the abdominal flap, in June 2009. There were immediate problems with the surgery, including dark-colored drainage, clots, and painful burning sensations. The physician attempted to treat the wound area, but he didn't refer the patient to a wound care specialist, despite the patient's request. The wound became infected and worsened, and the patient did not improve until being treated at an emergency department at a different facility, which discovered a staph infection. The patient brought suit and alleged that the surgeon physician failed to meet the standard of care and caused the patient's serious physical injuries and economic loss. The physician denied all allegations of negligence. The jury awarded $1.3 million in damages against the physician.

Background: In this matter, the patient was a healthy 38-year-old woman who operated her own company, a home care and medical staff-

ing business. She claimed to be in her best shape, purportedly maintaining a regular workout schedule in which she jogged at least two miles a day, but she said she sought to give herself a treat. She underwent an abdominoplasty by the surgeon. The surgery immediately produced complications and problems for the patient. She experienced dark-colored drainage, clots, and painful burning sensations. Upon returning to the physician for postoperative checks, the physician cleaned the wound area without anesthesia and repeatedly prescribed ointment and pain medication, but these treatments did not treat the wound sufficiently. The patient requested multiple times to see a wound care specialist, but the physician did not refer her to one.

More than a month after the surgery, the patient's pain continued, and she repeatedly went to her physician seeking treatment. The wound likewise continued to worsen, and the physician deemed it infected, but he continued to fail to refer the patient to a specialist. Instead, the patient went on her own to an emergency department about eight weeks after the surgery, due to increased pain and the wound continuing to open and worsen. The emergency department sent her to a wound care clinic, which admitted her to the hospital for six days of treatment. During this treatment, it was discovered that the patient had a staph infection, which the original surgeon physician did not diagnose or treat during his time with the patient. Despite being discharged from the wound clinic, the patient still has recurring injuries based on the procedure. She has a large scarred area, which occasionally opens up, areas of deformed tissue around the surgical site, and suffers from frequent nightmares. Furthermore, she continues to take medication and sees infectious disease practitioners.

The patient brought suit and claimed that the physician failed to timely diagnose and treat the wound. She said this failure resulted in the area worsening and developing a serious infection and other symptoms and problems that persisted. The defendant physician denied all allegations of negligence. The physician stated that it was the patient's choice to have the surgery and that she was well aware of the potentially serious risks and complications of such a procedure, despite its elective nature. The jury deliberated for less than six hours and found that the surgeon was negligent and the patient was not negligent, which the surgeon had alleged in an attempt to defend by deflecting some of the fault from himself. The jury awarded the patient $500,000 for pain, suffering, scarring, disfigurement, and associated mental or emotional distress, $382,000 for lost wages, and $430,000 for lost future income, based on the fact that her personal business ultimately failed along with and because of her declining health.

What this means to you: Elective procedures have inherent risks associated with them, and these risks can be quite serious. Physicians must be aware of the potential complications of any procedure and, when counseling a patient, they must be cautious to inform the patient of such risks.

However, informing patients might not provide an ultimate defense from all liability. Even when physicians have patients sign consent forms, which should be done, they still must exercise the proper standard of care in performing any procedures and will be found liable if care falls below this level. Physicians must perform in accordance with similar professionals acting under the same or similar circumstances. Cosmetic surgeons performing elective procedures will thus be required to exercise the same level of caution that their colleagues would be expected to.

The issue for the physician in this case related to his postoperative care of the patient, rather than any negligence from the procedure itself. According to the American Society of Plastic Surgeons, there are several possible abdominoplasty risks, which include unfavorable scarring, bleeding, poor wound healing, blood clots, skin discoloration, persistent pain or swelling, and infection. These are known risks, and patients must be informed of the potential for these risks to occur despite the physician's best efforts to prevent them. In this case, the patient experienced several of these effects, the most serious of which was the infection that set in after the surgery. When dealing with such effects, physicians should be cautious and might consider referring patients to specialists who are better suited to handle specific injuries. Wounds that do not heal within normal timeframes can cause serious problems, and there are specialist physicians and clinics that are dedicated to wound healing and care. Failing to recognize the seriousness of a postoperative injury might constitute medical malpractice, when other physicians in the same circumstances would recognize the danger. Referring a patient to a specialist should be considered

Discussions with patients prior to surgery should include the following categories to fulfill the requirement of informed consent:

- the nature of the illness and natural consequences of no treatment;
- the nature of the proposed operation, including benefits and risks;
- common known complications, which should be discussed in detail with a description of what to expect during hospitalization and postoperative care;
- alternative forms of treatment, including non-operative techniques, which might have their own different benefits and risks.

Physicians must give patients all relevant information. The exact information given should be tailored to the specific needs and preferences of the individual patient. Physicians should be cautious to not overwhelm patients with too much information at one time. Information may be given in parts, as long as all relevant information is given. For more information, see the

American Medical Association (AMA) Opinion 8.08 regarding informed consent, found online at http://bit.ly/1giGCHW.

Physicians may make informed consent and release forms stronger by giving patients all relevant information in an easily understandable manner and by having multiple lines for signatures or initialing. Having a patient sign or initial each line, which contains important information, will make it more difficult for the patient to later deny that they were given such information. During litigation, patients might attempt to use the defense that they were not actually informed or that the document did not adequately confer the relevant information. Physicians will strengthen their position by going over documents with patients specifically and line-by-line, although this approach necessarily will take more time. The physician going over documents as opposed to a nurse or hospital staff member also might provide a better defense against patients claiming they were inadequately informed. Additionally, this process will give patients an opportunity to ask the physician any questions regarding the procedure.

Release forms offer physicians potentially strong protections if litigation arises, but they do not offer complete immunity. Physicians and patients might not be able to contract around basic negligence. A signature on the release form alone thus might not necessarily prove that a patient has given informed consent. Physicians must discuss the procedure and risks with the patient, who must understand this information; otherwise the mere signature alone may be irrelevant. Medical malpractice is governed by tort law; contract law thus has limited application, but it might offer some protection for physicians depending on the state in which a case arises. One leading case from California, *Tunkl v. Regents of the University of California* (60 Cal.2d 92, 383 P.2d 441, 32 Cal.Rptr. 33), established in 1963 that a release document that waives the patient's rights to recover from a hospital or physician for injury based on negligent acts is invalid based on public policy. The Supreme Court of California established a test for evaluating when contracts that relieve an actor of liability for his or her own negligence affect the public interest, and it expressed reservations about allowing such a release document because physicians and hospitals often have superior bargaining power. Thus, patients might be forced to sign release documents, or be unable to receive medical treatment.

Some critics have suggested reforming medical malpractice liability, trying to change the focus from tort law to contract law, particularly given the nature of the relationship in which patient and physician know each other and might form contracts before engaging in treatment. However, medical malpractice remains tort's territory, thus any type of release form or waiver cannot ensure complete protection for physicians.

Physicians should give patients accurate and realistic expectations for surgeries. Exaggerating the potential benefits of operations to coax patients to opt for surgeries might cause problems later if the operation does not live up to these benefits. Consent forms for elective surgery should particularly warn patients that even simple surgeries carry inherent risks, and physicians should warn patients that not everyone will get the results that they hope for. Physicians should be cautious and not guarantee such results, even if patients ask for guarantees. However, giving any such guarantee has no effect on a medical malpractice claim, as long as the physician provides the proper standard of care. That said, guarantees might raise legal contract issues, so it is best to avoid giving these guarantees in the first place.

Another concept raised in this case is that of comparative negligence. Comparative negligence may be used as a defense theory in cases in which the plaintiff is partially at fault along with the defendant. When both the plaintiff and the defendant are to blame for the injuries, the defendant might not be liable for the entire amount of the damages. Comparative negligence allows a defendant to reduce the reward against himself by proving that the plaintiff caused or failed to mitigate the injuries. Juries may make specific findings regarding percentages of fault, distributing to any and all parties. For example, a jury might find that the plaintiff was 30% at fault and the defendant was 70% at fault. In this case, the plaintiff would only be able to recover 70% of his losses, thus a successful physician proving that the patient caused some of the injury, for example by failing to follow postoperative procedures or re-injuring a wound, would be able to reduce the amount of damages. Physicians might consider raising these issues, depending on the facts of the case, when plaintiffs have done something to contribute to their own injuries. Note also that the precise mechanics of how comparative negligence works might vary significantly by state, and there are a few states that bar any recovery if plaintiff's negligence contributed to the injuries. It is important to work with experienced local counsel in such circumstances.

Finally, as discussed in the context of the previous case, infections are a potential risk of any procedure and can cause serious injuries. It is of the utmost importance that physicians recognize the signs and symptoms of infections to ensure that treatment is timely and to prevent further complications based on the infection. A delayed diagnosis or delayed treatment of an infection can be the basis for liability. Physicians should understand how to properly diagnose and properly treat infections. Following guidelines put in place by organizations such as the CDC might help physicians to treat their patients and avoid liability.

Reference

Circuit Court of Jackson County, MI. Case No. 11003545 NH 38. Feb. 18, 2014. ✦