

# Professional Liability Handbook

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The *Professional Liability Handbook* is an educational offering from the AAO-HNS Professional Liability Committee. It is designed to inform otolaryngologists about professional liability perils inherent in daily practice and risk management ideas to address some of them. Important points - some identical - are cited by several contributors; the repetition is intentional for emphasis and education. This handbook is intended neither as legal advice, nor as a substitute for the counsel of your own attorney.

# Professional Liability Handbook

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## Where are Otolaryngologists Most Vulnerable to Liability Claims?

Keith McReynolds, MD  
East Valley Otolaryngology Consultants  
Mesa, Arizona

It is always informative to look back on the previous experience. The following is extracted from the Physician Insurers Association of America Data Sharing Study. This is the accumulated liability claims data on otolaryngologists from 27 physician founded medical liability insurance companies. The data covers 1985 to 1999 and is from 49 states.

### Four Most Prevalent Misadventures

	# Closed Files	# Paid Files	Indemnity Paid	Avg. Indemnity Per Paid File
I. Improper Performance	1047	431	\$65,564,013	\$152,114
II. Error in Diagnosis	375	114	\$29,225,469	\$256,364
III. Failure to Supervise or Monitor a Case	106	62	\$10,214,831	\$164,755
IV. Performed When not Indicated or Contra-indicated	92	37	\$5,155,074	\$139,326

**Comment:** As expected, improper performance of surgery is the most common successful claim. However, errors in diagnosis result in higher payments per case. Now look at the most common procedures in each of the diseased categories.

### Improper Performance in Order of Prevalence

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
A. Sinusitis	39	\$11,123,899	\$285,228

Operative procedures on paranasal sinuses  
Operative procedures on nose

Diagnostic procedure involving paranasal sinuses

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
B. Deviated Nasal Septum	24	\$3,097,455	\$129,061

Operative procedure on nose, nasal bones, or nasal cavity

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
C. Tonsillitis	22	\$2,001,719	\$90,787

Operative procedures on tonsils and adenoids

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
D. Diseases of Upper Respiratory Tract, Pharynx, Larynx	30	\$2,883,181	\$96,106

Operative procedure on nose  
 Operative procedure on paranasal sinuses  
 Operative procedure on larynx and trachea  
 Diagnostic procedure on larynx and trachea

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
E. Plastic Surgery desire	8	\$551,050	\$68,881

Operative procedure on nose  
 Operative procedure on skin and skin grafts

Comment: Surgical and diagnostic procedures on the paranasal sinuses and nose dominate the claims paid in several disease categories. Now a look at when errors of diagnosis are most likely to lead to claims.

**Errors in Diagnosis in Order of Prevalence**

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
A. Malignant Neoplasm of Larynx	12	\$3,900,935	\$325,078
Diagnostic interview, evaluation or consultation Diagnostic procedures involving larynx or trachea Operative procedures on larynx and trachea			

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
B. Malignant Neoplasm of the Pharynx	11	\$1,701,123	\$154,648
Diagnostic interview, evaluation or consultation. General physical examination			

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
C. Malignant Neoplasm of Tongue	7	\$615,000	\$87,857
Diagnostic interview, evaluation, or consultation. Operative procedure on tongue			

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
D. Benign Neoplasm of the Cranial Nerves	7	\$1,555,833	\$222,262
Diagnostic evaluation of hearing Diagnostic interview, evaluation or consultation			

Comment: Errors in diagnoses resulted in indemnity payments of almost 30 million dollars.

Malignant tumors of the larynx, pharynx, and tongue and acoustic neuroma were the most common conditions resulting in errors.

**Failure to Supervise or Monitor Case**

Condition	#Paid Files	Total Indemnity Paid	Avg. Indemnity Paid Per File
A. Malignant Neoplasm of Larynx	4	\$1,589,999	\$397,500
B. Intracranial and Intraspinal Abscess	5	\$962,499	\$192,500

Comment: Failure to supervise or monitor a case resulted in more than 10 million dollars in paid indemnity. There were only a few files in each category. These two conditions stood out because 90% of claims resulted in payments which were substantial.

**Surgery Performed When not Indicated or Contraindicated**

There were no trends in number of cases, but surgery on the paranasal sinuses and middle ear, inner ear, and mastoid were the most expensive.

**Final Comment:** As this date includes cases over a 15 year period, it probably underestimates our current liability costs. The types of claims and their relative costs should help us direct our risk management efforts.

## **Tips on Avoiding Malpractice Claims**

John H. Issacs, Jr., MD  
Department of Otolaryngology  
University of Florida  
Jacksonville, Florida and Gainesville, Florida

### **Introduction**

Many states require CME credits in risk management. Many of the tips here are from the Florida Physician Office Guide for Risk Management put out by the Florida Physicians' Insurance Company and the Florida Medical Association. Many of the physicians reading this will be familiar with these items. This is intended as a brief review. Obviously, avoidance of malpractice is an ongoing educational and clinical effort.

### **Office**

Your relationship with your patient begins with your office. Your personnel should be courteous. The office should be clean and tastefully decorated. Most importantly, the patient should not have to wait. The staff should also be professional and patients should not be able to hear phone conversations or other conversations dealing with other patients or personal matters.

The examining rooms should be private and nicely appointed. I took an informal survey of otolaryngologists several years ago to see whether or not they closed the doors to their examining rooms

and about half did not. This preference seems to be mostly the result of their training. ENT patients do not disrobe in most cases and many departments keep the doors open. Obviously, the doors should be closed if personal questions are being asked or if the patient disrobes for any reason, i.e., to listen to the chest in a patient with possible bronchitis or pneumonia. As a rule, I always have a nurse in the room when examining a female patient with the door closed. I will sometimes have a nurse in the room for the entire exam as well as the history if I feel the patient is in any way inappropriate or peculiar. This last is a judgment call gained by experience. A nurse in the room sometimes allays some of the patient's fears.

As part of the history one should routinely request all pertinent old records and so note in the chart. Even if the records are not obtained, your effort is important.

Records should be legible, either neatly written or typed. Typed records look more professional. Records are one of the most important aspects of defense in a malpractice case. They should never be altered after the fact. They can be updated and changed when mistakes have been made. However, any changes should be dated and initialed. It is possible to date ink so it is sometimes possible to date the ink used to make the notation. It is very harmful to a malpractice case if a notation dated "July 1" used ink that was not available until August 1. Medical records should have a good, appropriate history and physical. Allergies should be clearly noted.

If an x-ray machine is used in the office, there should be a "Pregnancy Sign."

If a procedure is performed, consent should be obtained and clearly marked in the records. There should be time for the patient to ask questions.

All prescriptions should be legible. There have been significant malpractice awards against physicians whose patients received the wrong medication because their handwriting was not clear on the

prescription.

There should be a mechanism for follow-up for lab results, particularly abnormal results. I do not hesitate to use registered mail for important communications to the patients if I cannot contact them by phone. Even if this fails, the documented effort should be helpful.

Missed follow-up appointments should be documented and, if there is evidence of a severe problem, additional follow-up is indicated. There should not be a long delay in follow-up appointments and emergent and urgent patients should be worked into the office in a timely fashion. Your office should not be so busy that there are undue waits for visits and that there is no room for an occasional emergency or urgent case.

Drugs used in your office should be clearly labeled and replaced before they become outdated.

The phone will be the most common manner the patient will probably use to contact you or your office. There should be a record of all phone conversations placed into the patient files whether it is a call from the patient or by your office informing the patient of a need for a follow-up appointment (there should be a method of reminding patients to come back should they miss their appointments, i.e., follow-up on cancer patients). Your conversations with the patient should be recorded in the chart. This is frequently a problem if you talk to the patient when you are on call or not in your office. However, every effort should be made to summarize these conversations and place them in the record.

The person who answers the phone in your office should be qualified to do so. They should not offer medical advice unless qualified. Hold time should not be excessively long, possibly less than two minutes. There should be enough phone lines so the patients can get through to your office. The answering service should be efficient and courteous, also.

If you share call with another physician, that physician should be qualified to provide coverage for your patients. Patients should be informed when another physician will be covering for you, particularly hospital inpatients. You should be available preferably by a beeper system or cell phone when you are on call. I would suggest a system that allows for documentation of pages to you. My personal experience is that nurses will often note that they paged the physician when the physician never actually received the page (paged wrong doctor and did not page correctly).

Remember, in general, you do not have to take care of everybody who walks into your office (certain contracts may require that you take care of a particular patient). If a patient seems peculiar or if you have “bad vibes” about the situation, you do not have to accept them as a patient. This is something that physicians right out of training are not always cognizant of because they are eager to establish their practice with new patients. Also, because as a resident they had to take care of every patient assigned to them.

You are also allowed to say that a specific case is beyond your expertise. Remember, if you honestly feel a patient may be litigious or unhappy with the result of your proposed surgical procedure or medical treatment, you are allowed to state the simple fact, “I don’t think I can help you” or “I don’t think I can improve your nasal breathing.” Some patients will not be helped by any physician or surgeon.

With an established patient, if you wish to discontinue their care you have to give adequate notice, usually in writing via registered mail, and usually with 30 days notice to allow them time to find another physician. Obviously, this is not always an option if you have been contracted to care for this particular patient.

## **Hospital**

If you have a hospitalized patient who is not doing well, it is appropriate to ask for help. It is clearly in the patient's best interest to get additional help if the patient is doing poorly and there is any question about your ability to handle the problem. It is far better to seek another medical expert's opinion before a plaintiff's attorney seeks one to examine a bad outcome.

## **Patient Relations**

As a general rule open lines of communication with the patient and/or the patient's family are beneficial if things are not going well. Things that make patients or their families angry tend to instigate or precipitate malpractice suits. Most families are willing to understand that you may have made a slight error in judgment, but they will be very upset if they feel you are untruthful or are trying to cover up. Also remember when you are talking to the families that a bad outcome is something that you have warned them about in the consent and is not necessarily an indication that you have done wrong. Be up-front with them about it and tell them we have had this bad outcome and that we are going to do our best to handle it in the best way possible (of course, having the complication clearly listed on the operative permit beforehand is quite beneficial, particularly if a suit does come about).

## **Other Concerns**

Some malpractice suits are the result of billing problems. Be sure your patients understand your fee, etc., beforehand. If there are billing problems and you do use a collection agency, be sure you have the

oversight to directly approve, on a case by case basis, any action before the collection agency sues the patient.

Other areas of risk management not addressed here are obligations to report problems with biohazardous material, office safety, and compliance with various other governmental regulations including access for patients with disabilities.

I have also not addressed all that is involved once a malpractice case has been instituted. Certainly, your lawyer should assist you in this area. It may be beneficial to have your own lawyer in addition to the insurance company's lawyer. Your own lawyer should not have to do much, but he should be there to defend your interests. In one malpractice case involving six physicians, the plaintiff offered to settle in a wrongful death case for about \$300,000. The defense attorney's feeling was that this could be negotiated down to \$200,000. The insurance company felt that the case was defensible in court and refused to settle. Each of the individual physicians' lawyer wrote the insurance company and told them that they should settle for this amount. The reason for this was if physicians lost and the judgment was over the coverage provided by the insurance company, the argument could then be made that the insurance company was responsible for the excess over their coverage because the settlement offered was within the limits of the coverage. The insurance company in turn fought the case in court and won. Had they lost and there had been a "runaway settlement," the company probably had its own coverage for this type of situation.

## **Summation**

In summary, treating the patient with respect and honesty, keeping lines of communication open and having very good records are the foundation of preventing malpractice suits and defending them when they

do occur. In addition, keeping up to date on the latest advances in medical care and providing top quality care are also pertinent and necessary.

There is a large body of data, both in the literature as well as in web sites, dealing with medical malpractice. What follows is a partial list. I have not listed state medical societies, however, this is one resource that should also be accessed. Most have some information dealing with malpractice in their particular states.

SELECTED RESOURCES FOR RISK MANAGEMENT  
FOR THE  
THE PROFESSIONAL LIABILITY COMMITTEE

1. *“The Florida Physicians Office Guide For Risk Management,”* published by the Florida Medical Association and The Florida Physicians’ Insurance Group.
2. *“Legal Medicine,”* by S. Sandy Sanbar, Alland Gibofsky, Marvin Fireston, and Theodore LeBlang, published by Mobsley/ The American College of Legal Medicine.
3. *“A Reference Tool for Risk Management,”* published by FPIC, Jacksonville, Florida. (CliffRapp, FPIC, 1000 Riverside Avenue, Jacksonville, Florida 32204, 800-741-3742)

The web sites: [www.hosprract.com](http://www.hosprract.com), [www.cpicm.com/news/advisor.htm](http://www.cpicm.com/news/advisor.htm),

[Jama.ama-assn.org/issues](http://Jama.ama-assn.org/issues), [www.mcandl.com](http://www.mcandl.com), [www.medmal.com](http://www.medmal.com), [www.pronational.org](http://www.pronational.org),

[www.FACS.org](http://www.FACS.org), and the site for the American Medical Association.

## **Adverse Outcomes and Difficult Patients: Survival Strategies**

Thomas M. Kidder, MD  
Medical College of Wisconsin  
Milwaukee, Wisconsin

### **Adverse Outcomes**

Practice long enough – and for many of us it doesn't take long! – and you and your patients will encounter adverse outcomes and complications. These occurrences may result from the disease process itself, or they may happen during the course or as a result of treatment. In our litigious society there is a penchant for assigning blame or guilt for every adverse event, whether or not the true cause is known. Furthermore, it is accepted that a monetary award is the way to compensate for a real or perceived injury.

Two inherent characteristics of all biologic systems are variability and unpredictability. Humans and their diseases are very complex biologic systems and subject to these vagaries. Some of the complications and adverse outcomes that we encounter are unforeseeable and not preventable; others are. As physicians and surgeons, we can to some degree influence the events, or at least the fallout from those events, in both categories.

With respect to surgical procedures, there are three times when we can be proactive in both helping our patients to cope with adverse events and in reducing our own risk of being sued: before,

during, and after the operative procedure.

## **Before**

Our initial and any follow up contacts with our patients should establish a relationship of mutual concern, respect and trust. Taking the time to listen and thoughtfully address a patient's complaint, and then to formulate and communicate to the patient, in terms the patient can understand, a plan that is medically/surgically sound and in the best interest of the patient will go a long way to build confidence and trust in your capability as a surgeon. An explanation of your diagnosis, its prognosis and ramifications with and without treatment, and why you are proposing a particular treatment or operation is crucial to get your patient to "buy into" your recommendation. The better the patient understands these elements in the medical decision-making process, the more likely he or she will be to comply and to have a realistic expectation regarding outcomes and potential risks. During your informed consent dialogue, you must inform the patient about risks or potential complications that might occur, especially any which might have catastrophic consequences irrespective of their rarity of occurrence. Document that you provided informed consent and include the essentials of your conversation in the medical record. A detailed discussion of informed consent is beyond the scope of this article; it is mentioned because it is one of the key elements in defusing retaliation toward the surgeon should a complication or adverse outcome occur.

If you know that an office visit will include recommending a surgical procedure, you may want to suggest that your patient have a spouse or other family member(s) come along. This may obviate the need for going through your explanation more than once, it's an opportunity to mention important

preoperative and postoperative instructions to enhance compliance, and it gives the patient and family a chance to ask questions regarding the surgery, postop care and restrictions. Inviting a family member helps build rapport before the day of surgery.

## **During**

See that the operation you propose and perform has justifiable indications, and that the operation is suited to the patient and his/her disease. This seems very basic and common sense, but defending a case wherein a complication arose out of an operation that had undocumented or questionable indications may not be successful. Be sure that your skills and the abilities of your support staff (e.g., anesthesiologist, surgical assistant, ICU staff), as well as your surgical armamentarium, are equal to the task – i.e., don't take on a task which you or your institution can't handle. Specialists are generally held to national standards of practice, certainly so for elective cases. In addition to exercising skill and good surgical judgment during the case, it is important to dictate your operative report in timely fashion, including operative findings and, especially, indications justifying your decision to operate.

## **After**

Should a complication or adverse outcome occur, it is essential that the surgeon stay involved and not distance himself/herself from the patient and family. Though your inclination is to avoid an unpleasant situation – it's human nature – your wisest course of action is to stay on top of the situation, make yourself available to the patient and family, return phone calls, request needed consultations, provide frequent follow-up visits, and reassure the patient that you will work together to ameliorate the

situation. Keep the patient and family informed; be forthright but don't blame yourself or someone else for what happened. Frequently, when the dust settles and the issues are examined more objectively, no one is found to be at fault. Some of the worst things you can do when an adverse event occurs are: abandon or avoid the patient and his/her problem; become angry at the patient or family when they ask questions; and, blame yourself or some other involved person for what happened.

Notifying your liability insurance carrier or your risk management office about an adverse event or complication which has potential medicolegal implications is always advisable and may even be required by your contract. You should not be penalized or stigmatized by doing this, and such early notification will help set the stage for an effective defense should it become necessary.

### **The “Difficult Patient”**

I hesitate to use this term because it implies the physician is biased or judgmental in his/her overall impression of a patient. I'm not referring here to the patient with a difficult or complex medical or surgical problem. The “difficult patient” comes in many flavors: the noncompliant patient, the “doctor-shopper”, the demanding patient, the VIP, the patient with unrealistic or exaggerated expectations, the untruthful patient, the patient who is seeking secondary gain, the patient with untreated paranoia or bipolar disorder, the patient who is seeing you against his or her will (e.g., at the insistence of an attorney or family member), the drug seeker – any one of these or others may present themselves in your office. The stage is often set for conflict even before the patient enters your office, and you may have no early warning signs that you are treading on a minefield when you interact with such individuals.

While you cannot control the actions of such patients, you can and must control yourself.

Employ the same skills of history taking – esp. careful listening -- and examination that you employ for all your patients. Do so in an empathetic, non-confrontational manner. Provide clear explanations of what you're doing, why you're doing it (e.g., flexible laryngoscopy, etc.), and your assessment and recommendations. These are basics, and you should not deviate from them, especially when dealing with a challenging patient.

Even if you feel anger, it's important not to exhibit anger toward the patient. For some individuals, anger is a way of life – every interaction for them is confrontational and adversarial. It's crucial that you not return anger for anger; it not only impairs your function as a physician, but society in general and juries in particular do not hold in high regard doctors who “lose their cool”. The blustery, cantankerous patient is often anxious and fearful. His or her initial reaction to you or your staff may be colored by previous negative experiences with health care professionals.

Being cordial and not showing anger does not mean that you must accede to unreasonable requests or demands. Agreeing with manipulative patients who pressure you to write prescriptions for controlled substances, want you to condemn the care they've received from other physicians, or expect you to certify disability that you feel is unwarranted, is not only totally inappropriate but it could trigger scrutiny and sanctions of your practice by regulatory agencies. Practicing medicine is not a popularity contest; you can make your point and remain firm in your decision, even if the patient is unhappy, threatens you or storms out of your office. But in doing so, it is very important that you not become visibly angry.

In addition to your conduct in the presence of the patient, there are a few other things you can do to protect yourself in such situations. As in real estate where location, location, and location are the top three

considerations, paramount among your protections when dealing with the “difficult patient” are documentation, documentation, and documentation. This aspect of practice has been emphasized in many contexts, and well it should be. In documenting these encounters it is especially important to be thorough, complete and non-judgmental – never, ever make disparaging remarks about anyone in your chart notes. Try to dictate into your report any noteworthy comments the patient makes; I usually take notes while the patient is relating the history, jotting down any phrases that I think might be important, then I dictate them into my consultation note. Along with the essential details, perhaps the most important element in your record is your medical decision-making: why you chose to make a particular recommendation or follow a certain course of action. Even if your treatment plan diverges from a generally accepted standard of care, there may be good reason why you chose that option, and it’s extremely helpful if you explain it in your note.

If you anticipate a difficult patient encounter, it may be helpful to have a member of your office staff, a resident or medical student, present in the exam room with you. The same goes if the patient wants to have a relative or companion present in the exam room; there should be few reasons for not allowing this. Providing the patient with written informational material, using audiovisuals, or having members of your office staff supplement what you’ve told the patient will all reinforce your image as a competent, caring professional who made every effort to do the best for his/her patient.

Finally, there are times when a patient-physician relationship is beset by irreconcilable differences and should be terminated. It is not always easy to determine when a patient-physician relationship has been actually established, but, generally, when the doctor meets with the patient and performs an examination, it is reasonable to assume that the relationship exists.

While a patient always has the right to terminate such a relationship at anytime and without notice, the physician cannot just walk away from his duty toward the patient without incurring the liability of abandonment, yet he or she may legally and ethically sever the patient-physician relationship by carefully taking certain steps to do so. This process may vary, depending on the locality in which you live, but your state medical society is an excellent resource if you are anticipating taking such action. Your state society can usually provide you with the necessary forms and information for legally severing your relationship with a patient. In general, you are usually required to provide written notice to the patient, delivered by registered or certified mail with return-receipt-requested. You must give the patient reasonable time (usually 30 days) to find alternate medical care, indicate that you will be available to provide emergency care during this interim period, and offer to transfer copies of records to his/her new physician once you receive signed authorization.

Interacting with a “difficult patient” is not a pleasant part of any medical practice, yet it is a reality of caring for patients. Taking short-cuts (as we are sometimes prone to do, especially when we’re caring for health professionals or VIP’s) and diverging from our usual, routine method of practice can prove to be disastrous. Not being compulsive and attentive to details, failing to document (despite the fact that the medical record may someday prove to be our strongest ally in defending against a lawsuit), and exhibiting anger toward a patient – these are behaviors which we all need to constantly work on eliminating from our daily repertoire.

## **Discontinuation of the Physician-Patient Relationship**

May Y. Huang, M.D, FACS

Once a physician- patient relationship is established, the physician has an obligation to continue to provide care for the patient until the relationship is terminated. Abandonment refers to the failure of a physician to provide necessary medical care to a current patient without adequate justification. Although physicians may withdraw from this responsibility, they must provide adequate notice of their withdrawal so that the patient can secure another physician.

For an abandonment claim to succeed, the patient must usually demonstrate several key elements. A physician-patient relationship must have been established. The patient expected the physician would provide the necessary medical care. The physician failed to perform his duty to provide continuing care. The patient was injured as a result of the abandonment.

A patient commonly perceives that a relationship has been formed when he or she consults with the physician for treatment, usually at the first visit. However, a relationship may also have been created anytime medical advice or confidential information is conveyed. This may apply to telephone contact, electronic communication or curbside consultation. Except in emergency situations, a physician can limit the purpose or duration of the relationship when it is established if this is clearly communicated to the patient and documented in the medical record.

An Independent Medical Examination is an isolated assessment and is a limited physician-

patient relationship. Performance of an Independent Medical Examination does not obligate the physician to treat the patient or monitor his/her condition over time as in the traditional fiduciary role of the physician.

In general a physician can choose his or her patients, however, a physician's discretion to provide services to a particular person has limitations. A physician cannot refuse to provide services to a patient merely because the patient belongs to a certain group. One cannot refuse to treat on the basis of the patient's sex, race, religion, ancestry, national origin, or physical disability (discrimination); this includes patients who are positive for HIV. The right to terminate may also be limited by a managed care or capitation contract. The third-party payer may need to be consulted for transfer of care of capitated patients.

Under certain circumstances termination of the relationship may increase the physician's exposure to charges of abandonment. For example, the physician should not end the relationship in the acute phase of treatment or diagnostic evaluation. Termination should be avoided if care of the patient cannot be transferred to another similar provider in the area because the physician is the only source of a particular type of medical care or "the only game in town". If there are no other similar physicians in the area, then termination may also incite an antitrust lawsuit. Physicians should be cautious when terminating the relationship with a patient who may have difficulty finding alternative care, such as an indigent patient. Physicians are considered to have an ethical obligation to treat the indigent. It is generally recommended that the patient be given as much time as possible to find alternative care and assistance in locating other sources for care.

Reasons for termination of the physician-patient relationship that are usually considered

appropriate:

- non-compliance with treatment or recommended care
- failure to make and keep follow-up appointments
- refusal to pay reasonable fees for services when able to do so
- non-compliance with office policies and procedures
- behavior that is dangerous or offensive to other patients or personnel
- verbal abuse of office personnel
- threats of violence

The physician also has a duty to maintain a safe office environment. Physicians should document the problems that lead to termination and the efforts to resolve the problems.

The physician can terminate the physician-patient relationship without creating liability for abandonment. If the situation for termination is appropriate and acceptable, termination should be formally and properly completed to prevent charges of abandonment. The physician should provide a written notice of termination to the patient which provides adequate time and opportunity for the patient to obtain care from another physician. The letter should be sent by certified mail with return receipt requested.

Important elements of the written notice include the following:

1) Effective termination date:

Generally a minimum of 10 working days is adequate notice of termination, 30 days in some states, unless the patient has fired the physician or already assumed care elsewhere;

2) Reason for termination:

This is not required.

3) Interim care until termination date:

The physician will remain available until the effective termination date.

4) Assurance that the patient is medically stabilized:

5) Patient responsibility:

Remind the patient that follow-up should be pursued and that continued medical care is now their responsibility.

6) Provision for continued care:

The patient may be directed to sources for continuing care such as local medical societies, nearby hospital medical staffs, or community resources. A list of alternative physicians qualified to treat the patient's condition may be provided to the patient. Specific referrals to another provider, however, may be perceived as dumping.

7) Authorization for release of medical records

Offer to provide a copy of the medical record (for the patient or for the patient's new physician) by enclosing a blank authorization form to be mailed back to the office.

If the patient is seen for emergency care after notice of termination, the physician should treat the patient until stabilized. In case it may be unclear whether the relationship has resumed, it is safest to again provide written confirmation of the termination of the relationship.

Consultation with your risk manager or attorney may be advisable for each individual situation.

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## **Hazard Inherent in the Internet: Don't Let Wired Mean Ruined**

Matthew L .Howard, MD, JD  
Ukiah, California

Great concern has been raised about potential risks arising from new communications technology: telemedicine, email, the web, and computerized medical records. The potential benefits include increased market share through web advertising, patient access to information twenty-four hours a day, and eased communications through e-mail. Although some of the concerns are well grounded, for the most part these new technologies are legally merely extensions of the older technologies represented by television and telephones. The rules that will apply to the newer technologies will be outgrowths of the older. Rather than consider the forms of communications technology therefore, the best means for analyzing the liability potential is to consider the situations in which liability might arise.

### **Advertising on the Web**

Advertising on the web, most frequently for physicians in the form of a web site which provides information and by implication advertises the expertise of the physician in the management of the medical conditions discussed, operates under the same rules as television or print media advertising. Liability will arise where the advertising misrepresents facts, makes claims not supportable by sound scientific evidence, or induces harmful patient behavior. Web sites that provide strict factual information about

medicine conditions, and straightforward practice related information, will thus not create a problem.

Sites that provide before and after photography of cosmetic surgery patients, testimonials from satisfied patients, comparison between the practice and others with similar techniques, are more likely to create a problem.

### **Personal Jurisdiction**

When suits are filed, the traditional rule is that the plaintiff (the person bringing the law suit because of claimed injury) must file in a court located where the defendant lives or works. A citizen of Los Angeles, injured in a motor vehicle accident in Chicago by a person who lives in Indiana, will normally be required to file the suit either in Chicago (site of the incident), or in Indiana (residence of the supposed wrongdoer). The Los Angeles resident cannot sue in California, and then expect the defendant to travel from Indiana and the police to travel from Chicago in order to testify. Where lawsuits based on commercial or medical injuries are involved, the courts have said the defendant must have “purposefully availed himself” of the legal protections of a jurisdiction, and must have had more than “minimal contact” with the jurisdiction before he can be sued there. The same rule applies in medical malpractice situations. Patients may travel long distances to obtain medical care at a tertiary center. A suit arising from such care is filed in the jurisdiction where the medical center is located.

Therefore a web site that merely entices a person to travel to the physician’s practice for care would probably not establish such jurisdiction in the plaintiff’s state. On the other hand, a web site that provides specific medical advice, allows for the purchase of goods, or results in prescription drugs being provided to the out of state resident, may result in a physician being required to defend suits in any

jurisdiction where injury occurred. This is the same rule that applies to print media or television.

## **Telemedicine**

Potential problems arising from telemedicine include questions of licensing and the same issues of jurisdiction. Several states have revised their laws to specifically state that telemedicine is not permissible where advice is being provided to persons resident in other states unless the physician is licensed in that state. Such rules will certainly restrain telemedicine expansion. Providing specific advice to patient via email or other electronic means may also raise jurisdictional issues. Current law would not allow an out of state patient who had established care by attending at a physician's office to establish jurisdiction in the distance state consequential to a telephone call for advice, or even series of calls. Jurisdiction would remain in the state where care was initiated. We should expect the same rule to apply to other electronic means, including advice rendered by e-mail. What we should expect and what will actually happen, as the courts deal with these issues is not necessarily the same thing. Caution is indicated.

## **Confidentiality of medicine records**

Confidentiality is mandated by both ethical and legal concerns. While people may regale their friends with accounts of their gall bladder operation, there are many aspects of medicine care that they keep secret. Release of such information unintentionally may imperil professional licensure and may precipitate suits for invasion of privacy. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for strict control of medicine records to prevent unauthorized release. The

final regulations have not been released but are expected to provide for substantial financial penalties for failure to comply.

More and more medical groups are establishing computerized medical records, some a summary of care and others full text office notes. To facilitate physician use, these may be available to practitioners through off site computer access. As recent headlines have demonstrated, no degree of cyber sophistication suffices to guarantee that unauthorized persons will not obtain access. If the Defense Department and Microsoft cannot assure the confidentiality of their sites, it is likely that Lower Slobbovia Medical Group will be even less successful. Physicians may well be liable for breaches of confidentiality under these circumstances, both under the state law and under HIPAA. Courts will likely weigh the advantages to patients against the risk of disclosure, which may be a function of the sophistication of the Medical Group's defenses. The California Medical Association has created an "electronic subsidiary" called MedePassSM which is intended to meet HIPAA's strict confidentiality and security rules. Presumably other sources will become available as well. As is often the case, it will pay to spend extra for the state of the art protections.

Whether using email for communication, Web advertising to build a practice, computerized medical records accessible for remote sites, or any of the other variations on the new technology, it is essential to maintain protections against unauthorized access and to avoid incurring liability for malpractice in a state other than your own or liability for practicing medicine without a license by creating the appearance of practicing medicine in another state.

## **Civil Litigation: Stages of a Lawsuit**

Myron W. Yench, Jr., MD, FACS  
Department of Otolaryngology-Head and Neck Surgery  
Charette Health Care Center  
Portsmouth, Virginia

### **Introduction**

This chapter will focus on the civil litigation process, specifically the stages of a lawsuit. It will try to familiarize the physician with this process by taking the reader from conception of the plaintiff's complaint through the trial. This chapter is not intended to be construed as legal advice, it is merely an overview. Any legal concerns should be addressed to an attorney.

### **Prefiling**

A medical malpractice claim begins when the plaintiff discovers that he has been wrongfully injured and decides to seek just compensation through the judicial system. The plaintiff seeks the advice of an attorney and, in turn, the attorney interviews the potential client to determine if it is prudent to accept the case and proceed. At this early stage of the lawsuit, gathering information can be quite difficult given the fact that the court isn't involved and the defendant won't willingly relinquish information that will aid the plaintiff in his case. Consequently, a private investigator may be hired by the attorney to assist in this pre-claim discovery

process in determining if the plaintiff's complaint is substantiated and worth pursuing. Information is also obtained from public records while the defendant is usually not aware that this process is being conducted. There is a statute of limitations on medical malpractice claims which differs from state to state. Most states have a discovery rule that states that the statute of limitations begins once the plaintiff discovers that he/she has been wrongfully injured.

After the plaintiff's attorney has investigated the claim and feels that there is a case, he/she may contact the defendant to inform them of the pending lawsuit or may file suit and the defendant is informed through formal legal process. Prior to this initial contact the defendant may not even be aware that litigation is pending. At this point the defendant should contact his/her attorney and insurer. The defendant should consider all options because if a claim is settled (payment made by an insurer) it will need to be reported to the National Practitioners Data Bank (NPDB). Negotiations for settlement continue, often to the day of trial.

## **Filing**

Filing a complaint notifies the court that the plaintiff is commencing litigation against the defendant. This also gets the court involved in the case. First of all, the plaintiff's attorney must file the case with the proper court and to ensure this three criteria must be met: personal jurisdiction, subject matter jurisdiction, and venue.

### ***Personal Jurisdiction***

Personal jurisdiction is a geographical limitation on the place where a plaintiff may bring suit against the defendant for a particular claim. Personal jurisdiction is a personal privilege of the defendant and relies on

the relationship between the defendant and the state where the suit is filed (forum state). The defendant has to have a relationship with the forum state in order to be sued there. According to *Hanson v. Denckla* (357 US 235 (1958)), the defendant must purposely avail itself of the privilege of conducting activities within the forum state, thus invoking the benefits and protections of its laws. In other words, the defendant has to make a deliberate choice to conduct business or otherwise relate to that state in a meaningful way before suit could be filed against him/her in that state. Without getting into too much detail here's an example of personal jurisdiction. Let's say Dr. X who lives, practices, and advertises only in State A treats Patient Y who lives in State B. Patient Y decides to sue Dr. X and files a claim in State B. This doesn't meet personal jurisdiction requirements because Dr. X didn't purposefully avail himself to State B, though he treated Patient Y from State B, he made no effort to attract that patient to his practice; he never advertised in State B. Now had Dr. X advertised or otherwise tried to draw patients from State B then he could have been sued in State B. Also, if Dr. X enters the jurisdiction of State B he may be subject to service of process and then subject to suit in State B termed "gotcha" jurisdiction.

### ***Subject Matter Jurisdiction***

Subject matter jurisdiction deals with the court's authority to hear certain types of cases. Not all courts can hear all types of cases. For example, some courts only hear probate cases while others hear a broader range of cases and still others, like federal courts, hear cases arising under federal law.

### ***Venue***

Venue is defined as the proper (or a possible) place for the trial of a lawsuit because that place has some connection with the events that have given rise to the lawsuit. Venue is considered a personal privilege of the defendant, thus it restricts further where a plaintiff may bring suit. A full discussion of venue is beyond

the scope of this chapter.

## **Pretrial**

The pretrial phase commences once the plaintiff's attorney files pleadings with the court. The plaintiff's pleading, called either the complaint or original petition, sets forth the reasons for the complaint and also the facts that support the plaintiff's claim for compensation (prima facie case). The defendant's pleading is called the answer (this will be discussed later in the chapter).

### ***Service of Process***

Service of process is the initial notice to the defendant that a lawsuit has been filed against him/her. These papers are served to the defendant or his/her appointed representative, in person. There are a number of rules governing this process and improper service can lead to dismissal of the lawsuit.

### ***Responding to the Complaint***

The defendant can either answer the complaint or file a motion to dismiss the case. The defendant has a time limit (usually 20 days) to respond or an entry of a default judgment will be made.

## **Answer**

The answer is the defendant's response to the plaintiff's complaint; it states his/her position (defense) on each of the allegations (claims) within the complaint, trying to disprove the plaintiff's prima facie case. The defendant may also assert affirmative defenses or counterclaims. For example, a counterclaim could be filed if the plaintiff owes the defendant money for services rendered.

## **Motion to Dismiss**

Instead of answering the complaint, the defendant can file a motion to dismiss (pre-answer motion).

Reasons for filing such a motion include:

1. Lack of personal or subject matter jurisdiction
2. Improper venue
3. Insufficiency of service of process
4. Failure to state a claim upon which compensation may be granted

## **Discovery**

Discovery is the process by which both parties obtain information from each other and non-party witnesses through several devices overseen by the court. Discovery is the longest portion of the lawsuit and the rules governing it are very liberal. Information that may be inadmissible in court is discoverable as long as there is a chance it will lead to admissible evidence. Privileged information, such as attorney-client relationship, attorney work product, and non-testifying expert, is not discoverable. Of course, there are exceptions to this rule.

### ***Types of Discovery***

- 1. Requests for admission:** This is a request to the opposing party to either admit or deny that a given set of facts or statements are true.
- 2. Physical and mental examinations:** This allows the defendant to obtain an independent medical examination of the plaintiff.
- 3. Interrogatories:** These are written questions sent to any person who is a party to the lawsuit.

It is most effective for obtaining basic background information. The answers are edited by the attorney so that they are technically correct and provide the requested information, but little speculation. If the question is slightly ambiguous it will be sent back for clarification.

- 4. Deposition by written questions:** These resemble interrogatories but may be sent to any person (party or non-party). In contrast to interrogatories, parties may object to a question or request that additional (cross) questions be asked (similar to cross-examination). These questions must be answered in the presence of a third party (process server or notary public) to ensure that the answers are properly sworn.
- 5. Oral depositions:** This is the taking of sworn testimony from a witness (party or non-party) through the use of oral questions. Witnesses can be subpoenaed to appear. Parties to the litigation have the right to be present and question the witness through their attorney. The witnesses are sworn in and the deposition is recorded. The deposition gets the witness “on the record” so that if his/her testimony changes at trial, the deposition can be used to impeach that testimony. The witnesses are also cross-examined at the deposition.
- 6. Requests for production:** This is a written order directed at parties to a lawsuit for the production of certain documents to be presented to the requesting attorney.
- 7. Subpoena duces tecum:** This directs non-parties to a lawsuit to produce documents or other tangible evidence for the deposition. In most states a subpoena for a medical record should include a signed release by the patient

The discovery phase shows both parties the strengths and weaknesses of their cases, thus encouraging settlement. Most lawsuits do settle prior to the start of trial. Also, after discovery a motion to dismiss or a

motion for summary judgment may be requested.

### ***Summary Judgment (pre-trial motion)***

Summary judgment occurs when judgment is made by the court in favor of the defendant or plaintiff without a trial. Such judgment is appropriate only if the evidence before the court shows undisputed facts and that the moving party is entitled to judgment based on those facts. If there are any disputed facts then the motion will most likely be denied and the case will proceed to trial or settlement. Summary judgment is supported by affidavits, depositions, admissions, admissible documents, and answers to interrogatories.

### **Trial**

The case moves to trial if either settlement is rejected or motion for summary judgment is denied. There are many rules that deal with evidence, witness, etc., and a thorough discussion is beyond the scope of this chapter. However, there are two motions that will be discussed: directed verdict and judgment notwithstanding the verdict (j.n.o.v.).

### ***Directed Verdict (pre-verdict motion)***

This is now called “judgment as a matter of law” and is entered when there is no legally sufficient evidentiary basis for a reasonable jury to find for the non-moving party (Federal Rule 50 (a)). In other words, the judge has the authority to rule in favor of either the plaintiff or defendant prior to the case going to the jury, if the evidence is such that any reasonable jury could not side with the non-moving party. The majority of the time the defendant is the one requesting a directed verdict. The request is made after the plaintiff’s evidence is presented and, if denied, then again after all evidence is presented. The directed verdict tries to prevent a judgment based on emotion instead of the facts.

### ***Judgment Not Withstanding the Verdict (post-verdict motion)***

Also referred to as “judgment as a matter of law,” j.n.o.v. is where a judge can overturn the jury's verdict especially if the jury acted irrationally and in disregard of the evidence in reaching the verdict for the non-moving party. This motion is requested when the evidence heavily favors the moving party, such that a reasonable jury should have sided with the moving party, but the judgment is in favor of the non-moving party. The prerequisite of raising this motion is that a pre-verdict motion (directed verdict) must have been requested at the close of all the evidence. Another prerequisite is that the motion has to be filed within 10 days of the entry of judgment (jury's verdict). Similar to the directed verdict, this motion tries to ensure a judgment based on the facts instead of emotion.

### ***New Trial***

The losing party may file a motion for a new trial within 10 days from entry of judgment.

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*This chapter was intended to familiarize the reader with the stages of a lawsuit. This is by no means a thorough review of civil litigation but merely an overview of what can be expected.*

**Note: The opinions and/or assertions contained within are those of the author and are not to be construed as official or as reflecting the views of the Department of the Navy, the Department of Defense, or the AAOHNSF.**

## **What to do Until the Lawyers Arrive**

Matthew L. Howard, MD,JD.  
Ukiah, California

Physicians are usually quite aware that an incident has occurred which may result in a suit. The paralyzed face after parotidectomy, the dead ear after stapedectomy, a death after tonsillectomy, are such catastrophes that no reasonable physician could doubt a suit is brewing. In other instances, the physician has no warning that a patient perceives him/herself as having been injured until suit is filed, or until notice of pending suit is filed in those states that require it.

Because the two situations differ, the following discussion of what to do until the lawyers arrive is divided into three sections. The first section deals with general comments on ways to prevent suits and defend them when they occur. The second section deals with actions you, the physician should, and should not, take when the catastrophe occurs. The third section deals with actions you should, and should not, take when the first warning of a suit is the service of papers.

## **Creating a Legally Competent Practice**

As a prudent physician, you will have instituted personal and office management processes which are always in place and working to lay the groundwork for defense of a suit later. You may further benefit from the resulting atmosphere of competence, accuracy and readiness which will prevent some suits from being filed when the unhappy patients prospective attorney observes that the common weaknesses seen in other offices are not present in yours. Therefore, you **should take** the following steps (not necessarily in any particular order of importance):

1. Ensure that office notes are accurate by dictating notes in the patient's presence, thus giving the patient an opportunity to correct errors. Although a suit defense will rarely hinge on the minor errors which creep into routine history taking, this issue has arisen in malpractice suits. The attention to accuracy and detail evidenced by such a system shows the patient that he or she is dealing with a competent, attentive professional. If you are an employee of an organization that does not provide for dictation, you should do your best to convince the managers that it is an investment well worth making. Dictation software may be available. There are few things worse than being faced at trial, five years after the office visit, with a three foot by five-foot enlargement of your own handwriting, and being unable to translate it.

2. Ensure that laboratory findings are tracked by instituting a system of follow-up. Your system should provide that you review and initial all reports before filing. Post-cards or other means to inform patients of results are very useful.

3. Ensure that patients keep recommended consultation appointments, and obtain recommended tests, by establishing a tickler file for reminders. Either the consultants office or the laboratory or X-ray facility should be questioned when results do not return to the office to determine if the patient kept the

appointment. Alternatively, the patient can be contacted. It is not necessary for you to make these calls personally. Documentation in the patient file should state the day and time of the contact or attempted contact. If a message is left on an answering machine, or with a family member, it should be noted. Letters warning of possible consequences of failing to keep such appointments should be sent by certified mail with the return receipt filed in the patient's chart. You should personally review the charts of all patients who fail appointments in your office also, entering a notation as to whether follow-up calls or letters are needed.

4. Prescribe medication in writing, with clear handwriting. Your system should ensure that a duplicate prescription is retained and you must have a system for recording telephone and after-hours prescriptions. A simple method is to keep a prescription pad handy and write the prescription as you dictate it to the pharmacist, then file the written prescription in the patient chart. Alternatively, you can have an answering machine in your office on which you leave messages for your staff about after-hours prescriptions so they can enter the information. Telephone prescriptions should be reserved for after hours and emergencies.

5. Record all telephone messages, no matter how trivial. Whether this is done by written entry into the patient file, with a telephone log, or with message slips entered into the patient file, is a matter of choice. Let us suppose that a suit hinges on whether or not you responded to a series of calls from the patient concerning post-operative hemorrhage. The patient claims the calls were made. You remember no such calls. If you can produce five years of telephone logs in which every call ever received during office hours has been recorded, a competent plaintiff's attorney may realize that no reasonable jury is going to believe that this patients calls were the only ones not recorded. The conclusion will be no calls

about the hemorrhage were made. As a result the suit will never be filed. Perhaps the telephone log shows that you did receive the calls but did not respond to them. The insurance company now understands that the focus should be on reasonable settlement, rather than defense. In both instances, justice has been well served.

6. Obtain a truly informed consent through an educational process which makes the patient aware of drug side effects and precautions, the risks and side effects of procedures, the risks of not carrying out recommended procedures or taking recommended drugs, and the alternatives available. Remember that it is your job as the physician to obtain the informed consent. You may use nurses, videotapes and written materials to provide the basic educational material, but you must review it yourself with your patient and answer any questions.

7. Enforce an ironclad rule that no chart is copied in response to a request for records without your approval. Further, notations should be entered in the file when charts are copied and for whom. You may have early warning of a suit by receiving a request for record copies from a university medical center or a law firm. Signed releases from the patient should be kept as a permanent part of the record. In almost all states, it is unprofessional conduct to refuse to copy a file because an account is overdue or because a suit has been threatened.

### **What To Do When a Catastrophe Occurs**

Few things can match the feelings of depression and despair, which follows realization that a major error has occurred, or a major injury has been caused. If you are the surgeon who has been carefully performing a mastoidectomy and you suddenly realize you are looking at the snake-eyes of an

already destroyed lateral semicircular canal, or the cut end of a facial nerve, you will have feelings of despair not understandable except by those who have been there. It is essential that in this state of mind, you do nothing, neither immediately nor in the weeks following the event that will harm a later malpractice defense. It is equally essential that you do certain things, which will aid your defense.

1. Do not let guilt control your actions. It is entirely understandable that a conscientious physician caught in this circumstance may wish to confess all to the patient and the patient's family. It is critical that the physician be truthful and forthcoming without admitting guilt. The patient must be told that the facial nerve, to use that example, has been injured during the surgery. Prospects for treatment should be discussed with the patient. Will you re-explore the mastoid to perform a graft and anastomosis? Will you refer the patient elsewhere, perhaps to a university program, for further treatment of the complication? These are proper matters for discussion. A bold statement that "I goofed", or some similar comment hurts you without furthering patient care. The existence of the error is not proof without more that you are liable. Perhaps circumstances are such that despite the presence of the injury, the proper standard of care was in fact met. A physician stressed by having to explain the disaster to patient and family is in no condition to make the judgment for him or herself at that moment. If rational evaluation later does confirm serious physician error, responsible insurance carriers will negotiate a settlement. The settlement process is not assisted by a physician confession on the table in the conference room.

2. Don't abandon the patient. It is very difficult to see Mrs. A come into the office week after week with her paralyzed face, or dead ear, to listen to her complaints and to deal with her anger. Too many physicians react to this situation by trying to shunt the patient aside. Even if medical care has

reached the stage that a normal follow-up appointment in two months would be appropriate, weekly visits without charge should be continued. You are responsible for providing emotional support, reassurance, and guidance for further therapy, if any. Even where it is medically appropriate to start spacing out post-surgical visits, it is not good medical-legal practice to do so. Continuing to make oneself available announces to the patient and to the world, “I did nothing wrong here, and I take responsibility for my patients”. Ask yourself how a jury will respond if told by the patient, “He took my sutures out and then he said he would see me in a year. I felt totally abandoned and rejected”. If the patient, through anger or out of concern for your competence, chooses to go elsewhere, so be it. Appropriate letters should still be sent offering to continue care and reminding the patient of necessary follow-up.

3. Write a narrative summary of the case. Your insurance carrier will ask that you prepare a narrative of your care of the patient beginning with the first patient contact, so do it now. Such a narrative should be prepared in as much detail as your notes and your memory allow. You should explain the rationale for the decisions you made and why you did not take an alternate path. For example, your patient has been diagnosed with nasopharyngeal carcinoma. You have been treating her for otitis media with effusion, but have never performed nasopharyngoscopy nor obtained X-rays of any type. Set down your reasons for the treatment program you adopted. Do this as soon as you realize there is a problem, and it will not matter if your memory on some points becomes fuzzy later. File this, and all correspondence you receive from your insurance carrier or attorney, in a separate file stored in a locked drawer of your desk or some other location where it will never be mistaken for part of the patient’s file.

4. Notify your insurance carrier. Most insurers require such notification at the earliest practicable time or they may decline to provide coverage. Follow their instructions.

5. If it appears that there may be multiple defendants in a subsequent lawsuit, and if someone else who may be sued has the same insurance carrier that you have, consider hiring your own attorney to supervise and respond to your questions. That attorney's fee, which will be paid by you, will be unimportant when compared to the peace of mind you will get by being reassured that the insurance company's hired attorney is really keeping your best interests in mind. Most states have a rule that where two defendants have the same insurance carrier, and there may be a conflict between them (as when surgeon blames anesthesiologist, and anesthesiologist blames surgeon), the carrier must provide separate legal counsel to each defendant. The personal attorney recommended above is useful even where the insurer has provided individual counsel.

6. If the catastrophe occurred in surgery, be sure the operative note is dictated in a timely fashion. Take more time than usual and put in detail. In particular, if there are any extenuating circumstances which explain the event, and which do not look like self-serving excuse making, include such material in the operative report.

### **What to Do When the Suit is a Surprise**

The author of this article once had the unpleasant surprise of receiving a 90-day notice of intent to sue, a procedural requirement in California. The notice claimed failure to diagnose lung cancer in a timely fashion, and was a prelude to a wrongful death suit by the patient's surviving spouse. Receiving such a notice should trigger the first action by the physician.

1. Review the patient file. In the case cited above, the record showed that the patient had been seen for hoarseness of recent onset and that physical examination showed a paralyzed left true

vocal cord. A chest film performed the same day showed what was presumably a mediastinal mass. Still on the same day as the initial consultation visit, the patient had been walked over to the office of a neighboring thoracic surgeon, who had within three days arranged for bronchoscopy and then CT-guided needle biopsy to establish the diagnosis. In other words, the suit would have been groundless. A narrative report to the plaintiff's attorney, reviewed and approved by the insurance company's attorneys before it was mailed, persuaded the plaintiff's attorney to drop the idea of a suit.

But supposing review of the patient file had revealed serious gaps, either in the care provided or in documentation of the care. The otolaryngologist accused of failing to diagnose a cancer of the larynx will deeply regret notes which read "normal larynx" and will wish that every pertinent negative had been individually recorded. In the real world, essentially every suit filed reveals some weakness in either care or documentation. These are not usually issues critical to the case, but they can be as critical as the failure to note pertinent negatives during laryngeal examination where the subsequent suit claims failure to diagnose in a timely fashion. The physician is then tempted to revise his/her office notes after the fact. **DON'T DO IT!** Sophisticated document examiners will uncover late corrections and revisions more often than not. The resulting perception of guilt and cover-up can destroy an otherwise excellent defense. Once record alteration has been uncovered, an otherwise defensible case will no longer be defensible. Further, in most jurisdictions, alteration of records is an offense punishable by revocation of one's license.

The same warning applies to hospital records. The plaintiff's attorney will usually have obtained a copy of hospital records before filing the suit. Alterations in the hospital record are then obvious to anyone who compares the records. Some insurance companies are putting disclaimers in their policies

stating that while a defense of a malpractice case will be provided, any judgment will not be paid where physician alteration of records contributes to the judgment against the physician. As a consequence, not only will the physician's license be at risk, but his/her financial well being also.

2. Write the narrative summary, notify your insurance carrier and consider hiring your own attorney, all as already outlined above.

### **Further Points to Remember**

Remember that not even the worst catastrophe necessarily means there will be a suit. On at least one occasion, a child has died during bronchoscopy for a foreign body with the parents resisting all efforts by family members encouraging them to sue. The parents felt that the physician had given them the information they needed to give an informed consent, and they had such rapport with the physician that they believed he truly had done everything possible.

Remember that even when a suit results, the physician usually wins. True malpractice occurs when physicians have demonstrated arrogance, incompetence and greed, which leads to enormous jury awards. Good physicians doing their best have been "struck by lightning." But the majority of suits involves issues on which reasonable people could disagree. In such circumstances, juries tend to give the physician the benefit of the doubt.

Once a suit is filed, do not call the patient unless they have continued under your care. It is very rare for a patient to continue care with a physician against whom a suit has been filed, but it does occur.

Once suit is filed, communications to the patient should only go through the patient's attorney, and should always be cleared by the physician's attorney. Whether the communication is a heart-felt, "How

could you do this to me?" or a more substantive matter of care or something about the suit, any such communication can be construed as an attempt to improperly influence or intimidate the patient. Don't do it.

Finally, don't turn away from your natural support system. If you are married, or have a significant other, that person should be a source of emotional support in times of crisis. Whether you rely on your partner, someone from the clergy, or just a good friend, remember that emotional stress during suits is a major problem for almost all physicians who have been sued, or who expect a suit because of events. Don't take your problems out on your partner or your children. Divorce is substantially higher for physicians who have been sued, and the undersigned believes that drug, alcohol and domestic abuse are higher as well.

I am sure that there are those who are so stoic by nature or so thick-skinned that the stress of a suit rolls off them like the proverbial water from a duck's back. I suspect the majority suffers more than they would like known. For many other physicians, a suit is a life-altering event on a par with marriage, death of a loved one, or a major illness. Following the steps outlined above at least ensures that the physician will have taken actions to strengthen his or her defense, and avoided taking actions which might harm the defense.

## **The National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank**

Myron W. Yench, Jr., MD, FACS  
Department of Otolaryngology-Head and Neck Surgery  
Charette Health Care Center  
Portsmouth, Virginia

### **Introduction**

The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) are national, centralized information data bases intended to collect and distribute information about health care practitioners (NPDB, HIPDB), suppliers (HIPDB), and providers or health care entities such as hospitals, HMO, PPO, etc. (HIPDB) to those eligible to receive such information. These data banks are closed to the general public and strict criteria have to be met in order to report to or receive information from them. Violation of the confidentiality laws that apply to the data banks can result in monetary fines. The NPDB collects information about medical malpractice settlements, adverse licensure, privileging, and professional society membership actions and medicare/medicaid exclusions while the HIPDB collects information related to fraud and abuse in health insurance and health care delivery. The reporting and querying criteria vary for both and each will be discussed in detail. Finally, a practitioner can query either data bank about themselves and are encouraged to do so.

## **NPDB**

The NPDB became operational in September 1990 and is intended to improve the quality of health care by acting as a centralized information clearinghouse. The NPDB collects and releases certain information related to professional competence and conduct. It functions as a means of preventing incompetent practitioners from moving from hospital to hospital or state to state without being detected. The term practitioner includes physicians, dentists, nurses, audiologists, physical therapists, and other allied-health professionals. The NPDB was established by Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*. The intent of Title IV is to encourage hospitals, state licensing boards, and other health care entities to identify and discipline those who engage in unprofessional behavior and restrict the ability of incompetent practitioners from moving from state to state without disclosure of previous activities. Part A of Title IV provides immunity under federal or state law for those who participate in the professional review process. Responsibility for implementation of the NPDB resides within the Department of Health and Human Services (HHS). The information contained in the NPDB is intended to supplement, not replace, a comprehensive and thorough review of a physician's professional credentials. It's also intended to alert a health care entity or state licensing board that there may be a problem with a particular physician's professional competence or conduct. Information contained in the NPDB is confidential and released only to those whom can query the data bank (will be discussed later). The information released to queries is also confidential. The NPDB is closed to the general public, as the Freedom of Information Act doesn't apply. Violation of confidentiality can result in monetary penalties.

## ***Querying the NPDB***

Reports given to those that are eligible to query the NPDB include: medical malpractice settlement information and adverse licensure, clinical privileging, and professional society membership actions.

The following are authorized to query the NPDB:

1. Hospitals **must** query when a physician applies for privileges and every 2 years on all members of the medical staff or those holding privileges at that hospital. Hospitals are not required to query on interns or residents unless they are appointed to the medical staff or granted clinical privileges to practice outside the parameters of their formal training program (example: moonlighting). Hospitals are required to query on physicians wishing to add or expand existing privileges and on applications for temporary privileges.
2. Health care entities (examples: HMO, PPO, nursing homes, rehab centers, group practice, etc.) that provide health care and follow a formal peer review process.
3. Professional societies that follow a formal peer review process.
4. Physicians may query about themselves only, at any time.
5. State licensing boards or Boards of medical examiners.
6. Medical malpractice payers **may not** query at any time.
7. Plaintiff's attorney or a plaintiff representing him/herself may query under the following circumstances:
  - a. A medical malpractice action/claim must have been filed by the plaintiff against a hospital in a state or federal court or other adjunctive body.

- b. The physician on whom the information is requested must be named in the action/claim.
- c. Evidence has to be submitted to the Department of HHS demonstrating that the hospital failed to submit a mandatory query on the named physician. This evidence is not available through the NPDB, but is obtained through discovery in the litigation process.

There are limitations on the use of NPDB information in that the information on the physician can only be used with respect to a legal action/claim against the hospital and not against the physician.

- 8. Any person or entity requesting aggregate information which doesn't identify a particular physician.

A fee of \$20 is charged for self-query. This can be accomplished by either calling or writing the NPDB. The phone number is: 1-800-767-6732

Address: NPDB

PO Box 10832

Chantilly, VA 20151

### ***Reporting to the NPDB***

The following entities must report to the NPDB:

- 1. **Medical malpractice payers** (any entity that makes a payment for the benefit of a physician).

They must report when a lump sum or the first of multiple payments is made and the report must be submitted within 30 days from the date the payment was made. Medical malpractice payments are limited to the exchange of money and must be the result of a written complaint or claim demanding monetary payments for damages. A refund fee is only reportable if it results

from a written complaint or claim (Ex: filing a cause of action based on the law of tort) demanding monetary payment for damages. The claim must be based on a physician's provision of, or failure to provide health care services. The malpractice report is also submitted to the state licensing board. According to NPDB regulations "*A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred*". Payments made for residents and/or interns must be reported; however, payments made on the behalf of medical students are **not** reportable. A payment made for a claim against a health care entity that doesn't identify an individual is not reportable; however, a payment made for a claim against a professional corporation or other business entity that is comprised of a single physician is reportable only if the payment is made by the corporation or business entity. Payment of a medical malpractice claim from the physician's personal funds is not reportable.

The report to the NPDB includes the following:

- a. Name of physician
- b. Amount of payment
- c. Name of hospital with which the physician is associated
- d. Description of the acts or omissions upon which the claim was based.
  - i. patients age at time of event
  - ii. sex of patient
  - iii. patient type: outpatient vs inpatient
  - iv. initial event on which claim was predicated: diagnosis/procedure

- v. subsequent event: occurrence that precipitated the claim
- vi. description of damages resulting from the initial and subsequent events
- vii. standard of care determination

A payment is not reportable if the defendant physician is dismissed from the lawsuit prior to settlement or judgment; however, if the dismissal results from a condition in the settlement, then the payment is reportable. Example: Physician in a lawsuit agrees to payment as long as his/her name doesn't appear in the settlement. This is reportable.

Payment based entirely on oral demands is **not reportable**.

2. **Health care entities:** must report adverse clinical privileging actions within 15 days from the date the adverse action was taken or clinical privileges voluntarily surrendered.

Actions that **must** be reported include:

- a. Professional review actions that adversely affect a physician's clinical privileges for a period of more than 30 days. Such actions include: reducing, restricting, revoking, denying, or suspending privileges. Also included is a health care entity's decision not to renew privileges based on a physician's competence or conduct. Adverse actions such as censures, reprimands, or admonishments are **not** reportable.
- b. Acceptance of a physician's surrender or restriction of privileges while either under investigation for possible incompetence or unprofessional behavior or in return for not conducting a review action or investigation.
- c. Revision to any action such as reversal of a professional review action, reinstatement of privileges, etc.

Actions that are **not** reportable include:

- a. A denial or restriction based upon the physician not meeting a health care entity's established threshold eligibility criteria for a particular privilege.
- b. Physician who voluntarily restricts or surrenders clinical privileges for personal reasons.
- c. Suspension of clinical privileges for administrative reasons.
- d. Physician denied medical staff appointment or clinical privileges because of over manning.
- e. A proctor assigned to a physician to assess professional competence, however, the physician doesn't require the proctor's approval for treatment decisions.

Finally, a summary suspension is **reportable** if it's:

1. In effect for more than 30 days
  2. Based on incompetence or unprofessional behavior
  3. The result of a professional review action taken by a health care entity.
3. **State licensing boards:** must report adverse actions within 30 days of that action.

**Reportable actions include:**

- a. Denial of an application for renewal related to incompetence or unprofessional conduct.
- b. Licensure disciplinary actions related to incompetence or unprofessional conduct such as revocation, censure, suspension, reprimand, probation or surrender.
- c. Licensure disciplinary actions taken by a state board based upon a disciplinary action related to incompetence or unprofessional behavior taken by another state board.
- d. Licensure disciplinary actions taken by a state board based on the physician's

deliberate failure to report a licensure disciplinary action taken by another state board when requested.

- e. Fines and other monetary sanctions when accompanied by other licensure disciplinary actions.
- f. Revisions to adverse licensure actions such as reinstatements.
- g. Notify Dept. HHS if aware that a health care entity failed to report adverse actions it has taken against a physician.

**Non-reportable actions**

- a. Denial of initial application for license.
  - b. Fines and other monetary sanctions not accompanied by licensure disciplinary actions.
  - c. Voluntary surrender of a license for personal reasons.
  - d. Licensure disciplinary actions imposed with a *stay*, pending completions of specific actions.
  - e. Monitoring of a physician for a specific period of time unless such monitoring is a restriction of a physician's license or is considered a reprimand.
4. **Professional Societies:** Must report professional review actions related to incompetence or unprofessional conduct which adversely affect membership. Actions not based on the above are not reportable. For example, adverse actions taken against a physician for advertising practice, fee structure, etc. are **not reportable**. The action must be reported within 15 days from the imposition of that action.
5. **Medicare/Medicaid Exclusion:** As of March 1997, these reports were added under

agreement with the Health Care Financing Administration and the Office of the Inspector General.

6. **Military:** When a claim is settled with a payment, the case is forwarded to the Bureau of Medicine and Surgery (BUMED) for review. If, after review, the Chief, BUMED determines that the payment of a medical malpractice claim was for the benefit of a health care practitioner, a report in the name of the practitioner must be forwarded to the NPDB.

Monetary penalties are imposed on those who don't adhere to the above reporting policies (\$11,000/violation).

***What happens when a report is submitted to the NPDB?***

Once a report is submitted to the NPDB, it's recorded as written, word for word, from the reporting entity. The NPDB does not change any wording. After the report is recorded a copy is sent to the reporting entity for review to ensure its accuracy. The physician also receives a copy of the report and should carefully review it. If the physician disagrees with the report then a couple of options are available. The first is to submit a **statement** which gives the physician a chance to tell his side of the story. This statement is limited to 2000 characters including spaces and punctuation, so one needs to be succinct and to the point. This can be submitted at any time, there is not a time limit. This statement will then become part of the NPDB report and will be disclosed to all those who query and sent to those who queried in the past.

An example would be if a resident were named in a suit but not listed on the original report, then the resident could submit a statement indicating that he/she didn't have ultimate control over the decisions being made.

The second option is to **dispute** a report. A physician can dispute either the accuracy of the report or if

it was submitted in accordance with NPDB regulations, but can't dispute it to protest a decision by his/her insurer to settle a claim or appeal the underlying reasons for an adverse action. The physician has **60 days** after receiving the NPDB report to dispute it. The dispute process starts with the physician contacting the reporting entity and also notifying the NPDB that a dispute is being initiated. The dispute notification becomes part of the NPDB report and is disclosed to all those who query and sent to those who queried in the past. The physician then tries to resolve the dispute with the reporting entity. The outcomes of the dispute process are as follows:

1. The report is corrected to the satisfaction of the physician
2. The report is voided
3. The reporting entity declines to change the report
4. The report is corrected, but not to the physician's satisfaction

If the reporting entity either declines to change the report or it's not corrected to the physician's satisfaction, the physician can request that the Secretary of the Dept. of HHS review the matter. Again, this avenue can't be used to protest a decision by his/her insurer to settle a claim or appeal the underlying reason for an adverse action. The Secretary will determine if the report needs to be corrected, voided, dismissed, remain as is, or beyond the scope of Secretarial review. Though the Dept. of HHS doesn't have a formal appeals process, it will review a physician's written request for reconsideration of the Secretary's decision. The outcome of such a review will be to either affirm the prior decision or issue a revised finding. Finally, if a report is corrected, revised, or voided, the NPDB will notify all past and future queries in addition to the physician and reporting entity.

## **HIPDB**

In addition to the NPDB, there is a new data bank called the Healthcare Integrity and Protection Data Bank (HIPDB) which started collecting information on health care providers (health care entities such as a HMO, PPO, group practice, hospital, etc.), suppliers, and practitioners in Fall 1999. The purpose of the HIPDB is to combat fraud and abuse in health insurance and health care delivery through the use of a centralized information database, similar to the NPDB. The HIPDB supplements the NPDB.

The *Health Insurance Portability and Accountability Act of 1996* (Public Law 104-191), which is Section 1128E of the Social Security Act, directed the Secretary of the Dept. of HHS acting through the Office of the Inspector General and US Attorney General to establish the HIPDB. Similar to the NPDB, the HIPDB is confidential, closed to the general public, and incorporates the same immunity provisions.

Information contained in the HIPDB includes the following:

1. Civil judgments against health care providers, suppliers, or practitioners in Federal or State court related to the delivery of health care items or services, excluding medical malpractice civil judgments and settlements in which no findings of liability have been made.
2. Federal or State criminal convictions against health care providers, suppliers, or practitioners related to the delivery of health care items or services.
3. Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners.
4. Exclusion of health care providers, suppliers, or practitioners from participation in Federal or

State health care programs.

5. Any other adjudicated action or decision (official action taken by a Federal or State governmental agency or health plan against a health care provider, supplier, or practitioner, that adheres to the basic guidelines of due process) based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service. This includes but not limited to the following: reduction or suspension in pay, reduction in grade, orders by an administrative law judge, civil monetary penalties or assessments, restrictions from participating in Federal or State governmental contracts or programs. Clinical privileging actions are excluded.

Entities eligible to **report** and/or **query** the HIPDB include the following:

1. Federal and State governmental agencies
  - a. Department of Justice
  - b. Department of Health and Human Services
  - c. Any Federal or State agency that administers or provides payment for the delivery of health care services. Example: Department of Defense, Department of Veteran's Administration.
  - d. Federal and State law enforcement agencies and law enforcement investigators; States Attorneys General.
  - e. State Medicaid Fraud control units
  - f. Federal and State agencies responsible for the licensing and certification of health care providers, suppliers, and practitioners. (Ex: DEA, State Medical Boards)
2. Health Plans (defined as a plan, program, or organization that provides health benefits whether

directly or through insurance, reimbursement, or otherwise). Examples include the following: plans funded by Federal and State government such as Medicare, Medicaid, Bureau of Indian Affairs, Department of Veteran's Administration; HMO; PPO; insurance companies; private health plans, etc.

3. Self-query
4. Person or entity requesting aggregate information which doesn't identify a particular person or entity.

The reporting entity has 30 days to file the report, and similar to the NPDB, fines will be imposed on those that don't report (\$25,000/violation). There is a new integrated reporting/querying system that will be used to report and/or query both data banks called the NPDB-HIPDB Integrated Querying and Reporting System (IQRS). Finally, the dispute process is similar to that of the NPDB. Self-query is available for a fee of \$20.

#### **References:**

[www.npdb.com/guidebook](http://www.npdb.com/guidebook)

[www.npdb.com/HIPDB/h-welcome](http://www.npdb.com/HIPDB/h-welcome)

**Note: The opinions and/or assertions contained within are those of the authors and are not to be construed as official or as reflecting the views of the Department of the Navy, the Department of Defense or the AAOHNSF.**

## **Tips on Compliance with Federal and State Mandates**

Dennis D. Diaz, MD, FACS  
Central Penn Ear, Nose and Throat  
Carlisle, Pennsylvania

**Fraud as per Medicare—“an intentional deception or misrepresentation which the individual knows to be false or does not believe to be true, and the individual is aware that the deception could result in some unauthorized benefit to him/herself or some other person.”**

**Abuse as per Medicare—“payment for items or services when there is not legal entitlement to that payment, and the physician has not knowingly and intentionally misrepresented the facts to obtain payment.”**

Nearly every aspect of a physician’s practice is subject to state and federal laws and regulations, including the manner in which a physician is licensed to practice, conduct business and establish and maintain relationships with patients, other health care professionals and institutions.<sup>1</sup> The federal government wants every practice to set up internal or external auditing systems. Complying with these federal and state mandates is a time-consuming part of contemporary medicine that most

physicians wish would go away.

Compliance is a complicated matter that has economic and legal risks for physicians. In an effort to provide guidance for the development of a compliance guidance plan, the Office of the Inspector General issued a long, wordy document in the Federal Register. The goal of this guidance is to provide a tool to strengthen the efforts of health care providers in preventing and reducing impropriety. According to this document, many physicians have expressed an interest in better protecting their practices from audits for erroneous or fraudulent conduct through the implementation of an office compliance program. As a secondary benefit these programs can “also benefit physician practices by helping to streamline business operations.”<sup>2</sup> A simple and streamlined interpretation of this document is as follows:

Learn the rules

Follow the rules

Double-check your work

Make a mistake? Admit it. Make a refund.<sup>3</sup>

That’s it. Pretty much my work is done. But there is more. Physicians should familiarize themselves with this comprehensive process to comply with this government demand or face the potential consequences of a dreaded audit. The Office of the Inspector General believes that the majority of physicians are honest and share their goal of protecting the integrity of Medicare and other federal health care programs.<sup>4</sup> All health care providers have a duty to ensure that claims submitted to federal health care programs are true and accurate. The development of a voluntary compliance program and active application of compliance principles will go a long way toward achieving this goal.

A good, effective voluntary compliance plan provides internal controls and improved medical record documentation. A well designed compliance program can:

1. minimize billing mistakes
2. reduce chances of an audit by HCFA or OIG
3. speed and optimize proper payment of claims
4. avoid conflicts with the self-referral and anti-kickback statutes
5. provide evidence of good faith attempt to bill appropriately. This in turn leads to improved billing practices, which can result in improved revenues. Incorporation of compliance measures into a practice should augment the ability of the physician to provide quality patient care and should not be at the expense of patient care. An effective compliance plan sends an important message to employees of a physician's practice by encouraging employees to report problems to the practice and improves procedures for prompt and thorough investigation of erroneous or fraudulent conduct. Most important, it reduces the practice's potential liability.

The basic framework for any voluntary compliance program consists of seven basic elements. These seven elements provide a solid basis upon which a medical practice can create a compliance program. Full implementation of all components may not be feasible for some practices but as a first step, physician practices can begin by incorporating those components which, based on the practice's specific history, are most likely to provide an identifiable benefit.<sup>5</sup> The extent of implementation will depend on the size and resources of the practice and each practice should incorporate each component in a manner that best suits the practice.

The seven basic elements are:

1. written standards of conduct, policies and procedures
2. designation of a compliance officer and or committee
3. development and implementation of physician and employee training
4. a mechanism for employees to report claims
5. a system to respond to allegations and enforcement of disciplinary action against violators
6. audits and other risk evaluation techniques to monitor compliance
7. investigation and correction of systemic problems and non-employment of sanctioned violators

The following is a brief description of the seven elements of a compliance plan. If you need comprehensive coverage of this topic read the Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practice in the Federal Register. It's a lengthy read but not a bad one especially with a cold frosty Foster's beer by your side. For a "just the facts, ma'am" as well as an excellent review presented in an easy understandable manner of what you need to know to get started in developing a practice compliance plan, I recommend Conomikes Reports, Vol. 19, No. 5, November 1999 and Vol. 19, No. 6, December 1999/January 2000. A compliance manual by Conomikes may be purchased from AAO-HNS at (1-703-836-4444).

1. Written Standards of Conduct, Policies and Procedures

The plan should state the practice's mission, goals and ethical principles relating to compliance. Written standards and procedures are a central component of any compliance program and should include a comprehensive set of billing and coding procedures. The practice's expectations with respect to billing and coding, patient care, documentation and payer relationships should be made clear to practice employees in the form of a code of conduct. It should clearly articulate the specific procedures personnel should follow when submitting claims.

Identifying risk areas (coding and billing, documentation, improper inducements, kickbacks and self-referrals, reasonable and necessary services) can serve as an important checklist of what an auditor would be reviewing. Coding materials and resources should be readily available to staff. This would include current CPT and ICD-9 books and Medicare Carrier bulletins. Training and education requirements of billing and coding staff should also be included along with mechanisms for claim submission processing and credit balances.

## 2. Compliance Officer or Committee

To administer the compliance program, the practice should designate someone who is responsible for overseeing the compliance program. This person serves as the focal point for compliance and carries out the planning, implementation and monitoring of the compliance plan. This can be an individual, group of individuals or out-sourced with a designated liaison to maintain continual interaction with the out-sourced compliance officer.

## 3. Physician and Employee Training

Essentially, training is for everyone and education is an important part of any compliance program. There are three basic steps for setting up educational objectives:

1. determine who need training in coding, billing and in compliance
2. determine the type of training that best suits the practice's needs
3. determine when the education is needed and how much each person should receive.<sup>6</sup> All

employees and physicians should attend an annual general session on compliance. This training should highlight fraud and abuse statutes, coding requirements, claims submission processes and marketing practices. Attendance by all staff including physicians should be mandatory. Everyone should sign a statement confirming an acknowledgement of practice compliance training. Coding and billing staff should receive additional training specific to their activities including coding requirements, claim development and submission processes, legal sanctions for submitting deliberately false or reckless billings, proper documentation of services rendered among others. Physician practices can also provide a source of continuous updated billing standards and procedures by making publications or government documents that describe current billing policies available to its employees.

#### 4. Reporting Claims and Developing Open Lines of Communication

In order to prevent problems from occurring and to have a frank discussion of why it happened in the first place, physician practices need to have open lines of communications. An open line of communication is an integral part of implementing a compliance program. Open communication depends on confidentiality and non-retaliation policies. The compliance officer must develop and record

the procedures of communication with the lead physician of the practice. These must be regular and direct. Questions and responses should be documented and dated. They also help as training materials and revisions to policies and procedures.

#### 5. Responding to Detected Offenses and Developing Corrective Actions

Violations of the practice compliance program, significant failures to comply with applicable federal law and other types of misconduct threaten a practice's status as a reliable, honest, trustworthy provider of health care. When the practice determines it has detected a possible violation, the next step is to have a corrective action plan and determine how to respond to the problem. The practice should develop monitors and warning indicators such as significant changes in the types of claim rejections, unusual usage pattern of CPT-4, HCPCS or ICD-9 code utilization among others. The compliance program should provide for full internal assessment reports of detected violations. If the physician practice ignores reports of possible illegal activity, it is undermining the very purpose it hopes to achieve by implementing a program. In instances involving individual misconduct, the standards and procedures might also advise as to whether the individual involved in the violation either be retrained, disciplined or, if appropriate terminated. Discipline policies should be developed for physicians, managers and employees. Physicians, managers and employees should be well trained in the consequences of non-compliance and particularly willful non-compliance.

#### 6. Auditing and internal monitoring

Practice monitoring is accomplished through regular auditing of the billing and claims submission

process. This evaluation includes not only whether the physician practice's standards and procedures are current and accurate but also whether the compliance program is working. An audit is an excellent way for a physician practice to discover, if any, problem areas exist and focus on the risk areas associated with this. Audits should focus on the most important risk factors: improper coding, inadequate or illegible documentation and routine use of undocumented superbills, charge tickets, etc. The practice's self-audits can be used to determine whether (1) bills are accurately coded and accurately reflect the services provided as documented in the medical record, (2) documentation is being completed correctly, (3) services or items provided are reasonable and necessary and, (4) any incentives for unnecessary services exist.<sup>7</sup> For your first chart audit you may wish to engage a coding consultant to show you how to do an effective audit. Thereafter you could perform then internally. Don't set tough goals for audit frequencies. The OIG has no specific guidelines. An annual audit, for each provider, should be adequate. Audits are based on reasonable samples and 6-10 charts per provider is a good starting point. Audits serve at the basis for making changes to improve compliance. One of the most important components of a successful compliance audit protocol is an appropriate response when a problem is identified. This action should be taken as soon as possible after the date the problem is identified.

## 7. Response Plan and Corrective Actions

If any violation of law is determined in the course of any audit or investigation, the compliance officer is responsible for a timely and positive response to the infraction. These steps might involve changing procedures to assure that the problem does not recur, as well as returning overpayments the

practice received. It is suggested that any communication resulting in the finding of non-compliance should be documented and should include the date of the incident, name the responsible party, name of the person responsible for taking action and the follow-up action taken. It is important to rebill any claims improperly coded and submitted, refund any overpayments as soon as possible and take disciplinary action with the offenders. The physician practice may seek advice from its legal counsel to determine the extent of the practice's liability. Consult an attorney who is familiar with health law before self-disclosing errors and overpayments. Part of the training and education should include protocols of what to do if an investigator shows up at your practice. This information should be included in your compliance manual and copies given to each employee. External audits are not solely the province of Medicare. Any third party payer has that right.

## **Final Comments**

The United States Department of Health and Human Services and the United States Department of Justice have identified the detection and elimination of health-care fraud as a top priority for federal enforcement.<sup>8</sup> The Health Insurance Portability and Accountability Act of 1996 (HIPAA), giving money and power to the Office of Inspector General and FBI for fighting fraud, was signed into law on August 21, 1996 by President Clinton and went into effect January 1997. Within the Act's anti-fraud provisions is the Medicare Hospital Insurance Fund which gives the Office of Inspector General and the FBI self-perpetuating funding and expanded powers to investigate and prosecute health care fraud and abuse at every level of public and private health care. Not only will this account receive substantial new appropriations but will also receive all penalties, fines and other recoveries from the

resulting investigations, prosecutions and settlements. This provides investigators with an obvious incentive to increase the scope and frequency of their investigations and prosecutions.

All health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other federal health care programs are true and accurate. By implementing an effective compliance program, physician practices can help prevent and reduce fraudulent or erroneous conduct in their practices. Compliance programs not only help reduce or prevent fraudulent or erroneous claims but they may also show that the physician practice is making a good faith effort to submit claims appropriately.<sup>7</sup> Along with a compliance program, educate yourself about the requirements of state and federal health-care programs and the fraud and abuse regulations. Learn what the red flags are and stop waving them. Having a compliance plan is not mandatory and does not guarantee effectiveness but it may decrease the risk of violating a law and may reduce the penalties and sanctions if a violation occurs.<sup>9</sup>

You can have professionals create or assist you in the development of a compliance program or you can do it yourself. For the do-it-yourselfer I recommend the Practice Compliance Kit from Conomikes Reports. I found this compliance plan workbook for medical practices full of excellent, practical and helpful information. It is a wonderful guide for getting started in developing a compliance program. It is not enough to just create a compliance program. There must be an on-going evaluation process with periodic reviews and monitoring as well as feedback and disciplinary consequences for not being in compliance. While having a plan can reduce risks it is better to have a limited plan that is observed rather than a comprehensive plan that is not followed. You should strive to keep the plan as

simple as possible. Remember, the only thing worse than having no compliance plan is to have one you do not follow.<sup>10</sup> All staff and all physicians must be involved. The physician has the ultimate responsibility to fully comply with all applicable statutes and regulations and needs to be alert to any changes. The adoption and application of the compliance program does not absolve the physician from this responsibility.<sup>11</sup> Your compliance officer or physician should be familiar with attorneys who are experienced and capable in this arena of law. Remember to consult with appropriate legal and medical professionals experienced in health-care matters if you find yourself the target of an investigation.

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## **Professional Liability Insurance/Making the Right Choices**

Joseph B. Carter, MD, FACS  
Department of Otolaryngology-Head and Neck Surgery  
MetroHealth Medical Center  
Cleveland, Ohio

### **Introduction**

As Otolaryngology – Head and Neck Surgeons in today’s litigious climate, each of us is statistically likely to be sued at least once. Professional liability insurance (i.e. Malpractice insurance) is an important, necessary, and expensive commodity that can help protect you, your assets, and your professional reputation. Choosing the right policy and professional liability carrier can be a difficult and time-consuming process. Physicians need to understand coverage (and non-coverage) issues and recognize that the up front policy cost, while always a factor, is not the only consideration upon which to base a policy purchasing decision. Physicians should thoughtfully examine and consider the amount of coverage, type of coverage, and the insurance carrier in choosing their coverage. Care should be taken to avoid the temptation to purchase on price alone, to economize on the exposures to be covered, or the total coverage amount. Policies should be adequate not only for traditional professional liability exposures but also for today’s expanded liability.

## **Choosing a Professional Liability Carrier**

Medical professional liability insurance is a cyclical business. Over the past twenty-five years there have been several cycles of availability and affordability crises interspersed with periods of new companies entering the market and attempts by these carriers and some established carriers to increase or protect market share by under-pricing premiums. These practices have led to significant periods of instability and some spectacular failures in the professional liability insurance industry. Criteria therefore to consider in evaluating a carrier first and foremost include size, financial strength, experience, history, and rating by independent insurance rating organizations. The larger the company and the stronger its financial resources the better able it is to carry out its mission. Financial strength can be determined by reviewing annual financial statements, looking at total assets, amount of surplus, premium to surplus ratio, and profitability. In general, stronger companies have larger surplus and smaller premium to surplus ratios. Investigate whether professional liability is the carrier's main product or a sideline and how long the carrier has been in business, particularly in the professional liability sector. Specialized and "sufficient" experience is best (minimum 10 years). Independent insurance rating organizations, e.g. A.M. Best, are an important source for evaluating the financial stability of various carriers. These ratings are useful, but are not the only financial index you need to examine. Get data on claims-paying ability, and how the company has allocated its assets. You should also check with your state department of insurance regarding both the carrier and agent.

Additional factors to consider in choosing a carrier include: reputation, legal defense philosophy,

and knowledge and experience with local courts, judiciary and defense attorneys. Determine how your defense attorney is selected and whether you have the right to refuse that selection. Ask for the names of lawyers who do work for the carrier. Beware of the “Name game.” Just because the insurance company uses lawyers who work for a particular firm doesn’t mean those lawyers are experienced at medical malpractice defense. Discussions with colleagues can be helpful regarding their satisfaction with the company’s responsiveness, representative availability, information and support, and in the event of suit, legal representation and aggressiveness and philosophy of claim defense. Also of importance are the policy’s features and premiums as well as the company’s underwriting criteria for termination, cancellation, non-renewal and surcharges.

### **Policy Basics**

Insurance policies represent a contracted relationship and each party has responsibilities and obligations to the other. While the particulars of each policy will differ and should be understood clearly, the basics usually include the following. The insurance company accepts financial responsibility on behalf of the insured for payment of any judgment or settlement up to a specific monetary limit in return for a fee (premium). In addition the company is responsible for investigating a claim, negotiating a settlement, and defending the insured. Premiums are determined by the type and scope of practice, location, limits of liability desired, and the company’s underwriting philosophy and criteria.

The physician must notify the carrier as soon as a claim is made or suspected (i.e. You should not fear a penalty for early reporting, early notification aids in early evaluation and preparation). The physician also has the duty to cooperate with the insurance company and assigned defense attorneys,

candidly and in good faith discussing all aspects of the case. Failure to do so may void coverage.

Many, if not most, policies stipulate that the company may, by the terms of the policy, have the right to settle a claim without your consent. It may be possible, though expensive, to add a “Consent to settle clause”, requiring the company to obtain your consent for any settlement. In many cases it may not be necessary (or possible) to add this clause as the companies desire to work with their insured’s and only rarely invoke this provision. The track record and reputation of the company should be considered in this regard and the advice of your personal counsel should be obtained.

Particular attention should be paid to the scope of practice definition in the policy. Premium rates vary by “risk” as assessed by each company for the types of procedures performed. Accurate and realistic profiles of your practice should be reflected in your representation to the insurance company to assure complete coverage.

There are two major types of policies available at the present time, “Occurrence” and “Claims made”.

Occurrence policies cover incidents that happen during the policy period without regard to when they are reported. Occurrence policies therefore provide protection for each policy period indefinitely, e.g. an occurrence policy purchased in 1998, covers any claim arising from your professional activity in that year, regardless of when it is reported.

Claims made policies require that the incident must have occurred *and* have been reported while the policy was in force. Thus a claim made policy purchased in 1998 only covers an incident arising from treatment in 1998 if the policy has been kept in force by renewals through the time the claim is filed. Once the policy has been terminated, coverage no longer exists. If further coverage is desired

for claims not yet reported at the time of policy termination, an “Extended reporting endorsement” or “Tail” must be purchased. If employment, policies, or insurance companies are changed, care needs to be taken to insure that no gaps occur in coverage by either purchasing the “tail” or “prior acts” coverage. Extended reporting endorsements cover incidents that occurred while policy was in force but were not filed until after the coverage was cancelled. Some carriers allow extended reporting endorsements to be earned if the policy is in force for a specified period (e.g., 5 years), or policyholder becomes disabled, retires, or dies.

Prior acts coverage gives retroactive coverage for those events that may have already occurred but have not yet been reported such as for new employees where an extended reporting endorsement has not been purchased, or where there is inadequate prior coverage, e.g. previous carrier goes bankrupt, etc.

In addition to traditional professional liability coverage, professional liability carriers may offer a number of enhancements to their basic policies. These include:

*Corporate coverage*, to protect the assets of the corporation in addition to individual coverage.

*Employee coverage*, which may be necessary for employees involved in patient care.

*Medical waste protection*, for indemnity from liability of those responsible for disposing of medical, hazardous, and other waste generated by your medical practice.

*Defense coverage for professional conduct review*, for State boards of registration, commissions, etc.

*Defense coverage for allegations of sexual misconduct.*

*Billing errors and omissions*, Usually an additional premium is charged for coverage of defense costs, civil judgments, settlements, and investigations in light of the Government's aggressive enforcement of fraud and abuse provisions of Health Insurance Portability and Accountability Act of 1996 against allegations of billing errors, coding errors, up-coding, etc.

*Directors and officers liability*, arising from physician officers and directors of a business acting on behalf of the business. Physicians who perform such a role should be sure the entity provides D&O coverage. Otherwise, though this is usually not provided by a professional liability policy, it can be purchased separately.

It is important that you examine and understand exactly what is and is not covered. The policy should be reviewed in detail by you, your attorney, and by an insurance professional to maximize coverage and minimize overlap with other policies (general liability etc.). It is also wise to retain indefinitely a copy of all your insurance policies, as they may be necessary at some point in the future to prove prior coverage. As with all critical documents you should consider keeping copies in a safe-deposit box or with your attorney.

### **How much is enough?**

There is no clear consensus on how much coverage is "enough". Minimum coverage is frequently determined by the local marketplace and the requirements of hospitals and other health care institutions. Also each practitioner and each practice must determine adequate coverage based on their local circumstances. The majority of physicians insured by the Physicians Association of America carry

\$1M/\$3M. This denotes a \$1 million limit per claim and \$3 million dollar total for all claims per year (note these limits represent dollars available for settlement and are not influenced by the cost of investigating and trying the claim). There is a trend to increase coverage to the \$2M/\$6M level but there is some debate that this may just add to the spiral of increasing awards and settlements, though even this level may be wholly inadequate in some venues. The amount of coverage should be periodically reviewed for adequacy.

### **Summary**

Professional liability insurance is an important investment for you and your practice. Due diligence should be taken in selecting the proper carrier and coverage. Utilize professional help. Your accountant, attorney, insurance agent, and financial advisor can and should assist you in selecting the coverage you need.

The proper amount and type of coverage and good representation by a financially strong, responsive, reputable company will serve you well in the event of a claim.

## **Guidelines for Medical Expert Witnesses**

Neil O. Ward, MD, FACS (ret.)  
American Academy of Otolaryngology-Head and Neck Surgery  
Alexandria, Virginia

America's adversarial legal system requires the services of medical expert witnesses in court cases alleging medical malpractice. It would be rare indeed that the jury or the judge would have sufficient medical expertise to decide such cases without the assistance of an expert medical witness. Patients who have been injured by maladroit doctors deserve the assistance of a medical expert, as do physicians who have been wrongly accused of "malpractice".

A problem arises because the court has wide latitude in defining a medical expert witness. The court assumes that opposing counsels have assessed their witnesses' credentials to support or refute the plaintiff's allegations and are assured the expert's testimony will be able to convince the jury likewise. This lack of credentialing for medical experts on the basis of training, practice and experience could be addressed by professional organizations.

A potential expert witness who reviews the case and does not support the plaintiff's allegations will not be retained (and in all likelihood remain anonymous to the defendant). Once selected, the medical expert will be coached and rehearsed on what counsel believes is the most effective testimony.

Physicians and surgeons are accustomed to being quizzed or reviewed in medical settings such as clinical pathological conferences or monthly morbidity and mortality sessions. But the courtroom is not a conference hall and the goal is not medical education but economic compensation. It is an unfriendly environment in which fortunes and reputations can be lost on a perception as much as on a point of law. The medical expert witness undoubtedly will be asked to answer briefly (often “yes or no, doctor?”) offering little opportunity to explain complexities. Pressured to offer an opinion the witness must respond truthfully, his/her personal opinion based on fact and acknowledging that other opinions exist, if they do.

The American Association of Neurological Surgeons (AANS) has pioneered efforts to establish guidelines for medical expert witnesses. They have also withstood legal challenges to their activity in reviewing and registering the testimony of medical experts suspected of inaccurate, unscientific, inexpert, and/or unfair statements in depositions or court. Upon determination of such testimony, and after due process, a few “expert” witnesses have been expelled from the AANS, thus diminishing their status as “experts”.

Pending approval of standards by the AAO-HNS Board of Directors and the establishment of a medical expert witness registry, it would behoove all otolaryngologists who might be induced to testify on the behalf of a patient or a colleague to review the AANS guidelines:

1. “Expert” testimony should reflect not only the opinions of the individual but also honestly describe where such opinions vary from common practice. The expert should not present his or her own views as the only correct ones if they differ from what might be done by other otolaryngologists.

2. An expert should be a surgeon who is still engaged in the active practice of surgery (preferably board certified in the same specialty as the litigant) or can demonstrate enough familiarity with present practices to warrant designation as an expert.
3. The otolaryngologist expert witness should champion what is believed to be the truth, not the cause of one party in the dispute.
4. The otolaryngologist should not accept a contingency fee as an expert witness.

Perjury is a criminal offense but individuals are guaranteed the freedom to bear witness as a constitutional right not qualified by being informed or impartial. “Hired guns” who offer biased testimony unfounded in fact or for a contingency fee may be prosecuted also, but the more cost-effective and efficient method of dealing with itinerant witnesses is to discredit them by expelling them from their professional organizations.

The AAO-HNS membership will have the opportunity to vote on this issue as bylaws will need to be amended to assure the protection of due process to those accused of unethical behavior.

Whatever the outcome, otolaryngologists who agree to be medical expert witnesses would be well-advised to follow the tested AANS guidelines.