

Managing the risks of practicing telemedicine

By Eric T. Berkman

Telemedicine – the practice of physicians using technology to consult remotely with patients or other doctors – is a growing field that has the potential to reduce health care costs while making it more convenient to treat patients who cannot easily access the right doctor in person.

But legal and medical experts say that any physician or medical group that considers adapting telemedicine in a practice must be aware of possible liability traps and know how to manage the risks.

Telemedicine comes in a variety of forms, ranging from videoconferencing and communication over customized Internet channels to good old-fashioned telephone and e-mail contact. (See “Telemedicine as usual: advice for old-fashioned telephone use” on page 16.)

And it offers plenty of benefits.

“It has a lot of potential for managing chronic diseases,” such as diabetes or hypertension, said Kevin M. Pho, a Nashua, N.H., internist and publisher of KevinMD.com, one of the most widely read medical-affairs blogs. “These aren’t conditions where you necessarily have to see a patient face-to-face all the time, and you can do a lot of patient management via videoconference, the phone or e-mail.”

It’s also useful for patients who are homebound because of health issues or live in remote locations hundreds of miles from a specialist or even a doctor, said Roy Schoenberg, chief executive officer of American Well Sys-

tems in Boston, which produces customized Internet platforms that enable patients (and doctors) to connect with a physician on demand.

“This is a completely new way of doing health care,” said Schoenberg, who is a physician himself. “It really doesn’t matter whether you’re in downtown Boston or in rural Maine surrounded by snow and ice. You have immediate access to the same health care professionals.”

Observers expect the field to explode once Medicare and more insurers begin reimbursing for services that aren’t conducted in person.

Even if reimbursement doesn’t happen, anyone who delves into telemedicine needs to be sure to address areas of potential risk, said Anne Huben-Kearney, vice president of risk management at ProMutual Group, the commonwealth’s biggest medical liability insurer.

Here are six areas that physicians engaging in telemedicine should address:

- **Privacy, security and patient confidentiality**

Privacy and security are the two biggest telemedicine-related concerns for professional liability insurers and patients, says Huben-Kearney.

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Negotiating the best possible hospital employment offer

By Jane Pribek

Negotiation 101 isn’t included in the medical school curriculum.

But maybe it should be. As more and more physicians seek employment in hospitals and hospital-owned medical groups, they are finding themselves bargaining the terms of employment contracts.

Many physicians who’ve been extended offers believe they should just sign on the dotted line of the hospital’s employment contract and hope for the best.

So says Boston attorney William Mandell, who has participated in hundreds of negotiations between hospitals and physicians, on both sides of the table.

“I spend a good chunk of my time trying

to educate physicians as to why that mindset is not an accurate read on the current situation for physicians in every specialty who are looking into becoming employees,” said Mandell, a partner at Pierce & Mandell.

“It doesn’t have to be a big ‘legal thing,’” said Troy, Mich. attorney David Haron, who typically represents physicians or providers other than hospitals at negotiations. “Most experienced

lawyers can go over a contract in an hour or two, and give the client some bullet points.”

Then the client can decide if he or she wants the lawyer to be involved in negotiations, or just take that list into the hospital meeting, said Haron, a partner at Frank, Haron, Weiner & Navarro.

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Are you hospital employee material?
— page 12

Loss-of-chance lawsuits aren’t on the rise, legal experts report

By Christina Pazzanese

Physicians in Massachusetts aren’t being sued frequently for negligently diminishing patients’ chance of surviving a serious medical condition – despite a ruling by Massachusetts’ highest court two years ago opening the door to these claims.

The “loss of chance” theory aims to hold a doctor responsible for a reduction in a patient’s statistical chance of survival or chance of avoiding becoming disabled.

Loss of chance can arise in a variety of contexts, including failure to call for emergency help, failure to promptly admit or transfer a patient to a hospital, failure to perform surgery and failure to prescribe cancer treatment.

In 2008, the Massachusetts Supreme Judicial Court declared that patients with a less than 50 percent chance of survival who were harmed by a doctor’s negligence are

entitled to seek damages for the lost opportunity to obtain a more successful medical outcome. Previously, under an “all or nothing” rule, physicians were released from liability, no matter how flagrant the negligence, if a patient had a less than even chance of survival.

But lawyers say that the ruling has not led to the kind of dire consequences for physicians that some first feared when *Matsuyama v. Birnbaum* and a companion case, *Renzi v. Paredes*, came down.

At the time, Peter C. Knight, an attorney at Morrison Mahoney in Boston who represented the doctor in the *Renzi* case, wrote that the doctrine was a “vast and sweeping new tort” that would “open the door to actions in all areas of tort-seeking damages.”

In an amicus brief supporting the physician, the Professional Liability Foundation called recognizing the “loss of chance” the-

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The heart of compassionate care

Tears filled Carol Schwartz's eyes during the video of Kenneth B. Schwartz's final months of life.

What mother wouldn't cry? Her 40-year-old son, a health care attorney at Mintz Levin in Boston, died 15 years ago after a 10-month battle with lung cancer.

The difference for Carol, though, was she wasn't alone watching that video. She was surrounded by 2,000 people at the 15th Annual Dinner of the Schwartz Center for Compassionate Healthcare – the brainchild of her

son that keeps her going in his absence.

Ken Schwartz outlined a plan for an organization that would strengthen relationships between patients and caregivers by teaching health care providers how to administer compassionate care, something he realized was incredibly important while he was fighting cancer.

And today, he would be amazed at what that organization has become.

At the center's inception, the concept that physicians could be taught compassionate care, that bedside manner was more than just a personality trait, was revolutionary. And yet now it is widely accepted, and a culture of teaching compassion continues to spread to hospitals and caregivers across the country and the world.

With Schwartz Center programs in countless hospitals in the United States and abroad, compassionate care is becoming the rule rather than the exception.

Teaching compassion, Carol said, starts with the belief that people, particularly those in health care, understand there's more to their jobs than crossing items off a checklist.

"I believe in people's possibilities, in a central core of optimism and in helping people see the possibilities in themselves. I have modeled that," Carol said, from her table at

Editor's Note

the dinner. "I have always been a cockeyed optimist, a joy-loving, joy-giving person. I have a true feeling that people can step up to

the plate and hit home runs."

Carol, who was a social worker for 32 years, reflected on her family and its passion for the medical profession.

"There is something about the calling of medicine that for me was holy. I had a feeling about medicine all my life," she said. "My dad, my brother and so many people we knew were dedicated and cared about people and their illnesses.

And her son found a way to emphasize the care in health care. For that, Carol takes a little bit of credit.

"I know I had an influence on him," Carol said. "I have a devotion to and a compassion for so many people in my life and they for me. I believe in trying to transform their lives, trying to turn them into more productive, more joyful lives."

It's that joy, mixed with pride in her son, that balances a mother's grief and sense of loss.

"I am humbly proud of Kenny, my baby," Carol said. "Ken was not about himself; he was about his causes. Every year, I come here and this is my proudest moment."

— Reni Gertner, MPH



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Keeping your Medicare enrollment up-to-date



By Emily B. Kretchmer, Esq.

Over the past two years, the Centers for Medicare and Medicaid Services (CMS) has instituted wide changes to the Medicare enrollment process that must be implemented by physicians – or they could risk claims being denied or a loss of billing privileges for a period of time.

CMS sees these heightened enrollment requirements as another way for the government to fight fraud within the system.

In a time when reimbursement is declining each year, payment methodologies are being restructured and accountable care organizations (ACOs) are starting to take shape, every claim matters. From implementing National Provider Identifiers (NPIs) to creating an electronic enrollment system, Medicare now requires health care providers to stay on top of the enrollment process and periodically update their information to ensure that they continue to be in good standing with the program and receive payments.

There are three major changes to the enrollment process that CMS has made in since January 2009. Physicians and their practice managers and/or billers must be aware of the following changes and respond to them:

- **Physicians must update Medicare with practice and enrollment changes.**

Physicians must update Medicare with changes in a practice location, ownership interest or adverse legal action within 30 days of the change.

All other changes to a physician's Medicare enrollment must be made within 90 days. Failure to timely notify Medicare could result in a physician losing billing privileges for up to one year.

- **The amount of time allowed for back-billing Medicare is reduced.**

As of January 2009, Medicare allows physicians who are enrolling in the program to back-bill for only 30 days prior to the "effective" date of their application. Previously, physicians could submit claims as far back as 27 months.

Medicare defines the "effective" date as either the date a physician filed an application that the Medicare contractor ultimately approved or the date the physician began furnishing services at a new practice location, whichever is later.

The "filing" date is defined as the date the Medicare contractor receives a signed Medicare enrollment application where all information is complete and the contractor is able to process the application. If the application is incomplete, the Medicare contractor will deny the application.

In the case of an application submitted using CMS's online Provider Enrollment, Chain and Ownership System, known as PECOS, the filing date is the date the contractor receives: 1) a physician's electronic enrollment application and 2) a physician's certification statement signed with an original signature and mailed to the Medicare contractor.

This means that physicians and their management team must prioritize Medicare enrollment in the credentialing process in order to capture all of the Medicare revenue that the physician is entitled to for his/her services.

- **Certain physicians must enroll through the online system.**

As of July 6, 2010, physicians who order or refer patients to durable medical equipment and home health services, as well as those who refer patients to specialists and/or to laboratory and imaging services, must be enrolled online in PECOS. (CMS has not defined the term specialist in this context.)

Physicians must enroll in PECOS as individual providers and not through their group practices. Failure to enroll online, even if the physician has previously enrolled in the program, can result in denial of claims and payment for these services.

CMS created this online enrollment system as an alternative to the paper enrollment process. PECOS will allow physicians, non-physician practitioners and provider and sup-



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plier organizations to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file or check the status of a Medicare enrollment application.

As the PECOS system has been rolled out, there has been a great deal of confusion in the provider community.

Originally, PECOS enrollment was required only for physicians and suppliers who order or refer patients to home health and durable medical equipment services. However, through its authority under the Patient Protection and Affordable Care Act, CMS decided to require a broader subset of physicians to enroll online, including those who order or refer patients to specialist, laboratory and imaging services.

This change to the enrollment process was announced in May 2010 and created concern across the provider community. Physicians feared that they would not have sufficient time to complete the enrollment process by July 6, 2010, and that as a result, they would be subject to denial of claims.

CMS listened and agreed not to automatically reject claims for providers not yet enrolled in PECOS for the time being. This, however, will most likely change in 2011.

To enroll in PECOS, physicians should take the following steps:

- 1) Go to PECOS at: <https://pecos.cms.hhs.gov>.
- 2) Use the same username and password that the physician used to obtain an NPI to log in and complete the electronic enrollment.
- 3) Print, sign, date and mail the two-page certification statement as instructed.

To help physician practices navigate the new requirements of the Medicare enrollment process, the American Medical Association and the Medical Group Management Association partnered to develop a new online toolkit. The toolkit is free to members of both groups and is accessible through their websites.

In New England, physicians can obtain provider enrollment information on NHIC's website at <http://www.medicarenhic.com>. NHIC serves as the Medicare Administrative Contractor of Medicare Part B services. **MMLR**

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Listening In

The news beat of the medical profession

MHA to ban hiring of smokers in 2011

The Massachusetts Hospital Association will institute a ban on hiring smokers starting Jan. 1, according to WBUR.

A ban on hiring smokers to be police officers or firefighters has been in place in Massachusetts since 1997. The MHA hopes to become a model as employers get more involved in their employees' health care.

The association says that refusing to hire employees who use tobacco of any kind is an extension of its no-smoking policy in and around the office.

Police and fire departments across the state stopped hiring smokers in 1997 as part of a pension system overhaul.

A ban on hiring or firing



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smokers would be illegal in 29 states and the District of Columbia, according to the National Conference of State Legislatures. That's one reason the practice has not become more common, said Leonard Sanicola of World at Work, a nonprofit human resources research group.

MMS adopts new policies

The House of Delegates of the Massachusetts Medical Society adopted several resolutions at its interim meeting in December.

The delegates voted to advocate that any legislation based on the recommendations of the Massachusetts Special Commission on the Health Care Payment System allow for the existence of Accountable Care Organizations, along with other innovative approaches to health care financing.

MMS physicians also adopted a position that decision-making regarding the pre-authorization of payment for medically necessary services and treatment is the de facto practice of medicine, and that individuals involved in those reviews should be held liable in malpractice actions stemming from delay and/or denial of care.

In addition, MMS agreed to explore increasing a fund to encourage the expansion and retention of primary care physicians and creating an effective debt-relief program; to train providers in protecting children from bullying; to work collaboratively with other organizations to advocate for legislation removing tobacco products and advertising from public view; and to engage in advocacy and education about the adverse public

health effects of gambling and related addictions.

Milton's ER makes most improved list

Milton Hospital's emergency room has been named one of the top 10 most-improved ERs in the country, according to The Patriot Ledger.

Press Ganey, a South Bend, Ind.-based health care consulting firm, awarded Milton Hospital's ER with a 2010 Top Improver Award based on a survey of patients over a two-year period. The 107-year-old hospital is affiliated with Beth Israel Deaconess Medical Center in Boston.

The latest improvement to Milton occurred in 2008 when state-of-the-art emergency facilities were built. One of the results has been a \$1.2 million increase in revenues from outpatient care attributable to emergency room visits.

Hospital President Joseph Morrissey said the hospital's recent success has been passed on to workers, who received a 3-percent pay hike, their first raise in two years.

The hospital, which has a \$65 million budget, employs about 600 people. Most patients come from Milton, Quincy, Braintree, Randolph, Canton, Hyde Park and Dorchester.

Data breaches cost industry billions

A new report claims that hospitals are suffering from data breaches in the rush to adopt electronic health records by 2011 so they can cash in on government incentives, according to eWEEK.com.

The benchmark study, conducted by privacy and data-management research firm Ponemon Institute and sponsored by security consulting firm ID Experts, revealed that hospitals are leaving themselves vulnerable to \$6 billion per year in costs from data breaches industry-wide.

For the study, Ponemon Institute interviewed 211 senior-level managers at 65 health care organizations.

Reasons for data breaches include poor management of data access, lack of encryption, loss or theft of devices and failure to shred documents.

The costs of a data breach stem from notification of government authorities and the media as well as from litigation.

Of the health care facilities surveyed, 69 percent had insufficient policies and procedures to thwart a data breach and detect the loss of patient data.

AMA offers patient feedback product

The American Medical Association has partnered with an outside firm to offer a resource that allows physician practices to get individual patients' feedback and analyze the data to identify ways to increase patient satisfaction, according to American Medical News.

The product, RealTime, is being offered in partnership with South Bend, Ind.-based Press Ganey, which has created other patient-satisfaction tools and surveys.

Physicians who use the product would collect patients' e-mail addresses and then ask patients upon check-in to complete an online survey about their visit. The survey is e-mailed almost immediately after the visit.

RealTime includes personalized "dashboards" that break down survey results and list patients' comments. The information can be compared with de-identified data from other practices.

Physicians would receive quarterly reports breaking down the data, including blind comparisons to other practices using the product and analyses of what drives satisfaction rates.

The product costs \$65 per physician per month for AMA members and \$85 per month for nonmembers, plus a \$100 set-up fee for any physician.

Poll: Compassionate care can save lives

The vast majority of patients and doctors believe that compassionate health care can make a difference in whether a patient lives or dies, according to a new poll commissioned by the Schwartz Center for Compassionate Healthcare at Massachusetts General Hospital.

While most patients and doctors agreed that compassionate health care makes a difference in recovery, an overwhelming majority – 81 percent of patients and 71

percent of doctors – said they believe it can make the difference between life and death.

Some basic elements of compassionate care in the study included showing respect for patients and their loved ones; treating patients as people, not a disease; conveying information in a way that is understandable; and listening attentively to patients.

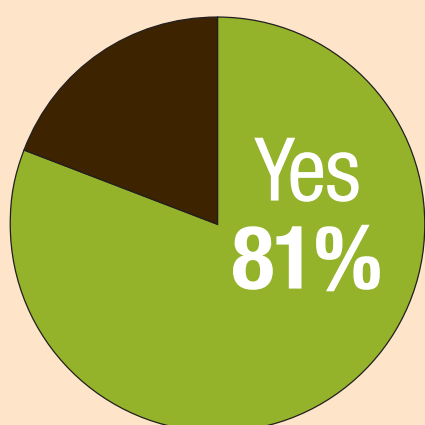
When asked whether the U.S. health care system pro-

vides compassionate care, only 53 percent of patients and 58 percent of doctors said yes.

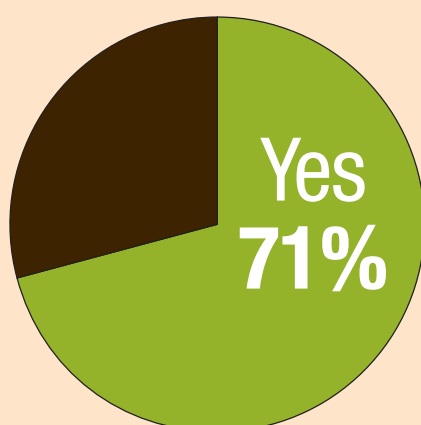
The Schwartz Center survey was conducted by Martila Strategies and Braun Research among 800 patients who had been hospitalized for at least three days within the past 18 months and 500 physicians who spend at least some of their time taking care of hospitalized patients.

Does compassionate health care make a difference in recovery?

Patients

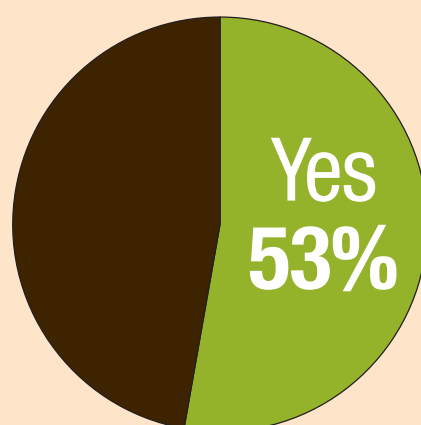


Doctors

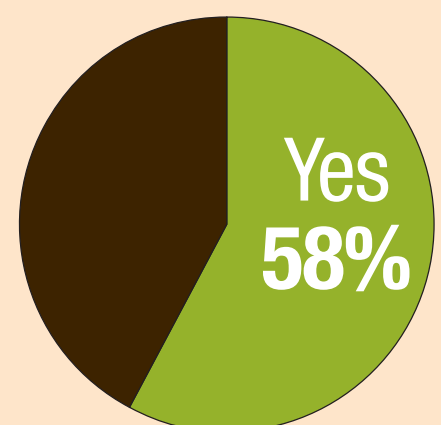


Does the U.S. health care system provide compassionate care?

Patients



Doctors



Most docs still tied to industry vendors

The percentage of doctors reporting financial ties to medical-product manufacturers has dropped over the past six years, but the vast majority of doctors still have some type of financial relationship with makers of drugs and medical devices, Modern Physician reports.

According to researchers at Massachusetts General Hospital's Mongan Institute for Health Policy, the percentage of physicians reporting financial ties to medical-product companies dropped to 84 percent in 2009 from 94 percent in 2004.

The study, which appeared in the Archives of Internal Medicine, surveyed nearly 1,900 physicians in seven specialties.

Among doctors reporting relationships with industry vendors, roughly 64 percent said they received drug samples and 71 percent acknowledged accepting food and beverages from product manufacturers. Around 14 percent said they received compensation for providing professional services.

The authors said that the percentage of doctors accepting compensation or items of worth from manufacturers has decreased in every category measured by the survey since 2004.

Association adopts policy on Internet use by doctors

The American Medical Association has adopted a policy aimed at helping physicians maintain a positive online presence and preserving the integrity of the patient-physician relationship.

The policy encourages physicians to use privacy settings to safeguard personal information and content to the fullest extent possible on social networking sites.

It also recommends that doctors routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and content posted about them by others is accurate and appropriate.

The policy directs physicians to maintain appropriate boundaries of the patient-physician relationship when interacting with patients online to maintain privacy and confidentiality; consider separating personal and professional content online; and recognize that actions and content posted can negatively affect their reputations and may even have consequences for their medical careers.



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Bills, Rules & Regs



From Beacon Hill

More patients going to emergency rooms

A growing shortage of primary care physicians is making it tougher for Massachusetts residents to see a doctor and forcing them into emergency rooms, according to a report presented to the State House by legislators and public health advocates.

In its biennial report that studies health care trends in the state, the Massachusetts Health Council found that in 2009, Massachusetts emergency room doctors reported 40 percent more patient visits than the average ER physician in the U.S.

The American Hospital Association found that the number of emergency outpatient visits was 19 percent higher in the state than in the rest of the country, according to the report.

Approximately 10 percent of those surveyed said that they did not have a personal health care provider, and 7 percent said they could not afford to see a doctor. The gap widened among different races and ethnic groups, with 8 percent of whites, 17 percent of blacks, 15 percent of Asians and 23 percent of Hispanics saying they did not have a doctor.

Children fared better than adults on access to health care, with nearly all children, regardless of race, ethnicity or family income, seeing a doctor regularly.

In a positive trend, Massachusetts ranked ahead of the nation in preventive screenings. The report also found that smoking is declining, the number of new cases of HIV/AIDS is decreasing, and the high school drop-out rate is down.

Voters have approved single-payer system

Non-binding ballot questions testing voter sentiment on single-payer health systems passed in all 14 Massachusetts House districts where they were offered in the November elections, according to the Massachusetts Campaign for Single Payer Health Care.

Campaign officials announced that their question passed in 78 of the 80 communities in which voters considered it, including five districts that backed Republican Scott Brown in January's U.S. Senate special election.

Campaign officials said the results showed that "the goal of improved and expanded Medicare for all is supported by a diverse range of communities across the state."

Similar questions passed in 10 House districts in 2008 and the campaign, which counts about 50 single-payer supporters in the state Legislature, hopes to use the election results to build their case for legislation next session.

Single-digit premium rate hikes approved

Patrick administration insurance regulators have signed off on over 300 premium rate increases for health insurance carriers, giving blanket approval to a catalogue of rates for the start of 2011 that limits increases to an average of less than 10 percent for consumers.

The rate approvals come seven months after the Patrick administration rejected 235 of 274 rate filings in April 2010 that the Division of Insurance found to be "unreasonable or excessive," with some carriers applying for base rate increases of up to 34 percent.

Average base rate increases ranged from 2.9 percent to 9.9 percent for the most recent filing period, although some customers will pay more after insurers work in factors such as the age of a company's workforce and the industry type.

After the Division of Insurance denied the increases and capped rates at 2009 levels, insurers sued the state but lost a bid for a court injunction to prevent the caps from taking effect.

The companies eventually prevailed through administrative appeals, though most settled with regulators in agreeing to keep base rate increases to single digits for one year.

Disclosure data available online

Massachusetts has become the first state to offer a comprehensive public database disclosing details of the financial relationships between pharmaceutical and medical device companies and doctors, hospitals and other prescribing providers.

Pursuant to the 2008 Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct, the data is now available for public download at www.mass.gov/dph/pharmamed.

The code applies to pharmaceutical and medical device manufacturers that employ or contract with any person to sell or market prescription drugs or medical devices in the state.

Physicians' financial relationships with drug and medical device companies from the end of 2009 will continue to be made public the following year until 2013, when a federal reporting system will go online and take the place of the Massachusetts system for most reportable relationships.



From Capitol Hill

Imaging disclosure rules go into effect

The Centers for Medicare & Medicaid Services has finalized disclosure requirements for a provision of the Patient Protection and Affordable Care Act that affects in-office imaging services.

The provision requires physicians who perform MRI, CT and PET services in their offices – and rely on the in-office exception to the physician self-referral, or "Stark," law – to notify patients in writing at the time of referral that they have the right to receive those services elsewhere and to provide a list of alternative providers.

The rule also states that the list must include 10 alternative suppliers within 25 miles of the physician's office; that the requirement would be limited to MRI, CT and PET services; and that the physician must be able to provide documentation of compliance in the patient's medical record, though the patient's signature is not required.

Medicare physician pay cut delayed again

President Barack Obama has signed into law a measure to delay for one year a sharp cut in Medicare pay to doctors.

The action to prevent a scheduled 25-percent pay cut to doctors as of Jan. 1 will cost an estimated \$19 billion, to be paid for by shifting money from the federal health care reform law. The money will come mostly from tightening the rules on tax credits in the health care law intended to prevent waste. The credits will make premiums more affordable for millions of people.

A 409-2 House vote came the day after the Senate approved the measure by a voice vote. Obama had urged quick passage of the bill, which he said was "an important step forward to stabilize Medicare."

The physician pay cuts are the result of a 1990s budget-balancing law that tried, but failed, to keep Medicare spending in line through automatic reductions. Congress has repeatedly stepped in to waive the cuts. Lately, lawmakers have had to act every few months.

Congress was under tremendous pressure this time, with medical groups estimating that as many as two-thirds of doctors would stop taking new Medicare patients.

The one-year delay "was vital to preserve seniors' access to physician care in 2011," said Cecil B. Wilson, president of the American Medical Association. "Many physicians made clear that this year's roller coaster ride, caused by five delays of this year's cut, forced them to make difficult practice changes like limiting the number of Medicare patients they could treat."

Congress will use the 12-month reprieve to try to come up with a new way of paying doctors that rewards quality care instead of sheer numbers of tests and procedures.

OIG issues 'roadmap' on fraud, abuse laws

The Office of the Inspector General has issued a booklet designed to help medical students and residents understand how to comply with federal fraud and abuse laws.

The "Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse" is aimed at assisting physicians in identifying issues that could lead to potential liability in law enforcement and administrative actions.

OIG conducted a survey of medical school deans and designated institutional officials at institutions that sponsor residencies and fellowships to learn what types of instruction medical students, residents and fellows receive on Medicare and Medicaid fraud, waste and abuse. Nearly all respondents said they would like OIG to provide educational materials they can use.

The roadmap summarizes the five main federal fraud and abuse laws and provides tips on how physicians should comply with these laws in relationships with three frequently encountered entities: payers, vendors and fellow providers.

The roadmap is available at <http://oig.hhs.gov/fraud/PhysicianEducation> and may be printed or downloaded free of charge.

Bill exempts doctors from 'red flags' rule

Congress has passed a measure exempting physicians from the controversial "red flags" identity theft rules.

At press time, the bill was expected to be signed by President Barack Obama.

The rule requires businesses that accept deferred payments from clients to create written policies outlining how they will prevent, detect and address identity fraud. It was designed to apply to businesses in the financial services industry, but Federal Trade Commission officials said other businesses – including medical practices – would be covered as well.

The American Medical Association had sued the FTC, challenging the application of the rule to doctors.

In December, the Senate and House both approved S. 3987, The Red Flag Program Clarification Act of 2010, which would exempt lawyers, accountants, doctors, dentists and other health care and service providers from the rule. Those who "advance funds on behalf of a person for expenses incidental to a service provided by the creditor to that person" would no longer be covered under the rule.

Instead, under S. 3987, the rule would apply only to businesses that use consumer reports in connection with credit transactions, furnish information to consumer reporting agencies in connection with a credit transaction or advance funds.

— Correy E. Stephenson

GOP set to strike at health care overhaul

GOP lawmakers are considering using their new posts in powerful House committees to make changes to President Barack Obama's health care overhaul.

In the House, Republicans control three major committees with a mandate to affect health care, with the possibility of issuing subpoenas if necessary. And in the Senate, the GOP has added leverage on two key panels.

Republicans say they want to focus on what the new health care law will mean for Medicare and employer health plans. They will likely want to make changes to improve the law as they see it – even if they cannot achieve a full repeal.

A full repeal is unlikely to pass both chambers and would likely be vetoed by Obama. GOP lawmakers are apt, however, to call in Donald Berwick, the director of the Centers for

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Medicare and Medicaid Services, and Health and Human Services Secretary Kathleen Sebelius to give testimony on the health overhaul.

Congress passes Alzheimer's plan

The U.S. House of Representatives has voted unanimously to create a coordinated national plan to overcome the Alzheimer's disease crisis, according to the Alzheimer's Association.

The Senate previously passed the bill, also by unanimous vote. The National Alzheimer's Project Act is expected to be signed by President Barack Obama soon.

The measure will ensure the coordination and evaluation of all national efforts in Alzheimer's research, clinical care, institutional and home- and community-based programs and their outcomes.

The project would fall within the Department of Health and Human Services.

The bill was first introduced in 2007 in an effort to establish a national strategic plan to focus U.S. efforts. More than 10 other countries, including England, France and India, already have developed or are developing similar national strategies to fight the disease.

"Today, an estimated 5.3 million Americans are living with Alzheimer's disease, more than double the number in 1980," said Sen. Susan M. Collins, R-Maine, who along with Sen. Evan Bayh, D-Indiana, introduced and championed the legislation. "If nothing is done to change the current trajectory of the disease, 13.5 million Americans over the age of 65 will have Alzheimer's disease by 2050. Moreover, if nothing is done to slow or stop the disease, Alzheimer's will cost the United States \$20 trillion over the next 40 years."

Judge in Virginia declares Obama health care law unconstitutional

A federal judge has declared the Obama administration's health care law unconstitutional, siding with Virginia's attorney general in a dispute that both sides agree will ultimately be decided by the U.S. Supreme Court.

U.S. District Court Judge Henry E. Hudson is the first federal judge to strike down the law, which has been upheld by two other federal judges in Virginia and Michigan. Several other lawsuits have been dismissed and others are pending, including one filed by 20 other states in Florida.

The key issue in the case was Virginia Attorney General Kenneth Cuccinelli's claim that the federal law's requirement that citizens buy health insurance or pay a penalty is unconstitutional.

Hudson, a Republican appointed by President George W. Bush, sounded sympathetic to the state's case when he heard oral arguments in October, and the White House expected to lose this round.

Administration officials told reporters that a negative ruling would have virtually no impact on the law's implementation, noting that its two major provisions – the coverage mandate and the creation of new insurance markets – don't take effect until 2014.

The central issue in Virginia's lawsuit was whether the federal government has the power under the constitution to impose the insurance requirement. The Justice Department said the mandate is a proper exercise of the government's authority under the Commerce Clause.



AP Photo/Gerald Herbert

Cuccinelli argued that while the government can regulate economic activity that substantially affects interstate com-

merce, the decision not to buy insurance amounts to economic inactivity that is beyond the government's reach.



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Accountable Care Organizations 101: a primer



By Craig Schneider, Ph.D.

The Patient Protection and Affordable Care Act of 2010 includes provisions to create “accountable care organizations” (ACOs).

ACOs are health care providers that would be paid based on performance rather than purely on a fee-for-service basis. In Massachusetts, policy makers are looking to the ACO model as a way to reduce costs and improve quality. However, there is much that is unclear about what ACOs are and how they would work.

The Centers for Medicare & Medicaid Services (CMS) defines an ACO as “an organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”

Conceptually, ACOs have three essential aspects:

- 1) The ability to deliver services across the continuum of care,
- 2) Prospective budgets, which establish the ACO's total costs in advance, and
- 3) A sufficient number of patients to support the validity of performance measurement.

Elliot Fisher, MD, director of The Center for Health Policy Research at Dartmouth Medical School, who is credited with coining the term “accountable care organization,” has said that the three key attributes are organized care, performance measurement and payment reform. These attributes should be aligned to support physicians in improving the quality of care.

The theory behind ACOs is that, by taking on the risk of delivering care on a prospective payment basis, providers would have incentives to manage patient care across multiple settings. While this might sound like capitation revisited, the difference between the ACO (and other global payment models) and the managed care of the 1990s is the connection to quality measures. The incentives are based on delivering value, rather than on under-utilization (capitation) or over-utilization (fee-for-service) of health care services.

From the physician perspective, the orientation toward ACOs would require a major cultural shift, said Dr. Lawrence Casalino of Cornell Medical School to a *New England Journal of Medicine* roundtable. “Quality” will change from what the doctor does for an individual patient at the point of care to what the organization does for the population of patients throughout the year.

There are three different models of ACOs that are relevant to consider: a “virtual” organization that aligns physician practices, a hospital and perhaps other providers to receive value-based payments; an actual organization that integrates both the insurance and care delivery functions; and a legally



contracted organization that is paid on a fee-for-service basis but shares savings for efficient quality care – the model that is used under the new Medicare program.

• The virtual ACO

Under the virtual model, hospitals, physicians and other providers do not need to be legally organized, but might have a memorandum of understanding about how payments will be distributed.

For example, the PROMETHEUS payment model is designed to pay providers based on evidence-informed case rates for a specific condition, and allows either such “virtual” organizations or integrated delivery systems to participate. (See www.hci3.org for more information.)

• The integrated ACO

While ACOs may seem like a theoretical construct, there are several prominent organizations that are serving this function today, and deriving their incentives for efficient and quality care by integrating the insurance and delivery roles.

Examples include Geisinger in Pennsylvania, Kaiser Permanente in California and other states, Group Health Cooperative of Puget Sound in Washington and Dean Health System in Wisconsin.

• The Medicare ACO

The new Medicare program is scheduled

to begin in January 2012. It is important to note that it is not a pilot or demonstration, but rather a permanent part of Medicare.

Each Medicare ACO must have a formal legal structure to receive shared savings payments and distribute them among participating providers, and must meet quality and reporting standards.

In addition, an entity applying to become an ACO must have at least 5,000 Medicare beneficiaries to ensure the statistical validity of performance measures. The organization must also have a defined process to promote evidence-based medicine, report data for quality and cost measures and coordinate care.

The Medicare ACO requirements include automatic assignment of patients to the ACO, performance measurement, shared savings based on reducing costs relative to targets and no risk initially of provider costs exceeding budgeted amounts (although this could change over time).

Although patients are assigned to an ACO, Medicare beneficiaries served by the ACO would also be able to receive care outside of the ACO.

Medicare ACOs will have three-year contracts. Payment will be made on a fee-for-service basis, but the ACO will receive shared savings payments if spending is lower than the per-person spending growth for all Medicare beneficiaries in that ACO, with some complicated adjustments.

Further, bonus payments will be available for meeting quality metrics.

In addition to Medicare ACOs, the law allows states to establish ACOs for their Medicaid programs under a demonstration program beginning in 2012 that is designed for pediatric providers.

At the end of 2010, CMS sought comments on how small physician practices might participate (and suggestions for other payment models that might be appropriate for small practices), how to determine which beneficiaries are part of an ACO's patient pool at a given time, how to measure patients' care experience, quality metrics, measures of patient-centeredness and proposals for alternative payment methods.

Clearly, there are numerous details that still need to be determined.

In the interim, analysts are assessing the potential transformative impact of ACOs. Because the Medicare ACO program model does not involve risk and would pay providers based on fee-for-service rates, some have questioned how “accountable” these organizations have to be.

While some are dubious about the ability of ACOs to solve the problems with the health care system, there is widespread consensus that the fee-for-service system is broken, and Congress and CMS believe that the new Medicare program is a promising way to begin to transform it. **MMLR**

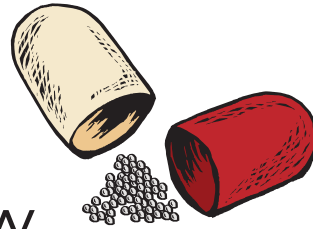
Craig Schneider is the Director of Health-care Policy at the Massachusetts Health Data Consortium in Waltham. The Consortium's website is www.mahealthdata.org.



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Good Medicine



What doctors are talking about now

Q: What are the major legal questions physicians should be asking about forming Accountable Care Organizations?

“Physicians who are considering forming or joining an ACO should be sure it meets the federal government’s criteria, which are intended to promote improved patient care and will allow the ACO to receive payments. An ACO must have a governance structure that allows physicians to control medical decision-making, even if the ACO has a hospital partner. In addition, the ACO’s procedures for care coordination, quality reporting and cost management must be ‘patient-centered.’ Also, revenue-sharing among ACO providers may create liability under the federal Stark and anti-kickback laws, and collaboration among physicians may create liability under antitrust laws. Physicians should obtain detailed information about the financial implications by reviewing any proposal with legal counsel and a financial consultant.”

— Sally K. Levy, health law attorney, Ankner & Levy, Boston

“ACO relationships may trigger a number of legal issues as lawyers help clients structure them against a regulatory backdrop not designed for these arrangements. Areas of potential concern include antitrust, the Stark Law, the anti-kickback statute and tax issues. Sharing substantial financial risk or clinical integration may provide protection but requires significant efforts to achieve. How to safely move toward integration is a challenge for which regulatory guidance is needed.”

— Daria Niewenhous, member of health law practice, Mintz, Levin, Cohn, Ferris, Glovsky & Popeo, Boston

“ACOs must comply with antitrust laws, especially price-fixing laws. They must involve collaboration among competitors to negotiate rates, must share sufficient financial risk and must exhibit ‘clinical integration’ to minimize antitrust exposure. An ACO’s internal allocation of shared savings payments among independent providers will need to satisfy the anti-kickback law. Absent a waiver by the Department of Health and Human Services, applicable payments must fit within a Stark law exception. The civil monetary payment law must be carefully navigated. ACOs must also comply with insurance laws that regulate the assumption of financial risk and with privacy, security and state security breach laws. They must avoid fee-splitting among providers and the corporate practice of medicine. HHS may waive some of these laws, but not antitrust laws or state-law protections.”

— Regina Rockefeller, partner in the health services group at Nixon Peabody, Boston

“Antitrust: How much market share will the ACO represent? Is there sufficient clinical and financial integration? Leadership/governance: How will the ACO engage physicians in quality and efficiency initiatives and discipline those who do not meet the standards? Capital/capacity: How will the ACO raise capital? Fraud and abuse: Unless a waiver is granted by HHS, how will the ACO’s financial arrangements be structured to fit within the requirements of the Stark Law, the anti-kickback statute, the civil monetary penalty statute and state fee-splitting laws? State law: Will the ACO be considered a health plan or managed care organization that is subject to state insurance, managed care laws or other laws requiring reserves?”

— Dan T. Roble, health care partner at Ropes & Gray, Boston



For doctors, ACOs present substantial legal issues

By Alice Coombs, M.D.

Accountable Care Organizations have taken center stage in the effort to control health care costs. ACOs – a cornerstone of federal health reform – are projected by the Congressional Budget Office to save Medicare nearly \$5 billion over the next seven years.

ACOs have been embraced at the state level as well, with a push toward a system of payment reform that includes global payments and other payment models. With global payments, providers would receive a fixed amount for the total care of a patient.

While undefined under the federal health reform law that provides for them, ACOs commonly include arrangements or partnerships of providers who have agreed to care for patients

with improved standards of quality and reduced costs. Payment structures vary, but most contain some combination of global

payments, risk sharing and coordination of care.

Advocates believe that ACOs and global payments are a panacea for the ills of soaring costs, but others are skeptical. Most patients have yet to be heard, although some patient advocacy groups are active in the discussions.

Of note, ACOs such as Geisinger Health System in Pennsylvania have achieved both improved quality and cost containment with traditional “fee for service” payment mechanisms in their health care delivery systems.

Putting aside the economic and clinical ques-

tions for a moment, it’s clear that physicians face substantial legal issues with any ACO design.

Physicians – particularly solo practitioners and those in small practices, who make up the majority of physicians in our state – should proceed with caution, and likely considerable legal help, when approaching ACOs.

Here are some of the key areas for physicians to consider:

• The corporate practice of medicine

Massachusetts and many other states have laws governing the corporate practice of medicine. Historically, the organization of medical practices in Massachusetts has been limited to physician offices, licensed clinics and hospitals. New legal entities such as limited liability partnerships have expanded these options further, but at the same time have raised concerns about the required licensing as a health care facility if the corporate structure does not fall under physician control. The creation of ACOs will result in different configurations, which are likely to raise similar concerns.

• Anti-trust and anti-kickback laws

The Attorney General’s 2010 report, Investigation of Health Care Cost Trends and Cost Drivers, put the issues of competition and market share squarely at the center of the cost control debate. As ACOs develop, federal agencies such as the Federal Trade

Commission and Department of Justice will scrutinize ACO commitments to ensure that such arrangements do not lead to price-fixing or competitive imbalances.

The good news is that the Justice Department has indicated that it will help doctors and hospitals avoid anti-trust violations. There must be coordination between the federal government and state law as well.

Anti-kickback laws – which prohibit knowing and willful payments to another person if those payments are intended to secure referrals for health services – also apply. The statutes on fraud and abuse are so complex that one law firm recommends engaging “sophisticated legal counsel” when creating an ACO.

• **Self-referral and the Stark Law**

The Stark Law prohibits a physician who has a financial relationship with an organization from referring a patient to that organization for health services paid for by Medicare. Yet concerns about self-referral often overlook the nature of an ACO as a facilitator of clinical integration.

If ACOs are responsible for the overall care of a patient, then it logically seems to follow that they must be allowed to contract and refer within the structure of their organization. This will allow for the best quality care and cost control – the very reasons for the creation of the ACO.

• **Risk-bearing issues**

This area raises multiple questions of financial and professional risk. Providers within an ACO accept responsibility for the overall care of a patient, agreeing to deliver all medically necessary services.

But who determines what is “medically necessary”? Will risk be adjusted for sicker patients, and who will make such adjustments? Will a set global payment influence what is “medically necessary” and thus present a significant risk of denial of medical ser-

vice (which may lead to liability issues)? Will ACOs be required to carry reserves, as insurance companies do?

• Professional liability

Legislative reforms are desperately needed to reduce and eliminate defensive medicine, a costly and widespread practice. This is integral to the entire payment reform and cost control debate. However, no such changes appear to be forthcoming.

In medical malpractice actions, how will the issue of joint and several liability apply to participants in an ACO? Will all members be responsible for the claims against one? In ACOs where hospitals are present, how will the charitable immunity statute apply?

Physicians entering ACOs must also address the multiple legal steps required in forming any new legal entity: governance, tax structures and considerations, capital development and contracts with third parties, such as vendors and claims and billing companies.

What makes all of this even more complex for physicians is the fact that laws at both the federal and state levels are applicable to most, if not all, of these considerations. The consequence of trying to serve two masters, in areas such as anti-trust, self-referral or fraud and abuse, for example, can be daunting.

All of this is not to suggest that physicians are averse to ACOs. Some have already been established and are proving successful. But the varied nature and structure of our current medical delivery system underscores the notion that one size doesn’t – and won’t – fit all as we move to new models of care. The legal issues may not be insurmountable, but are many and considerable.

If ACOs are not addressed deliberately and carefully, the unintended consequences could damage physician-patient relationships and put further stress on a workforce short on key specialties and already overburdened with administrative requirements and regulations.

Alice Coombs, M.D. is president of the Massachusetts Medical Society.



Doctor’s Rx

Verdicts & Settlements

Man loses ability to walk after ER stay

The patient, a 48-year-old male, presented to the emergency room complaining of right-side chest pain. He had a slightly elevated temperature and a white blood cell count of 16,000. His chest X-ray was normal.

The patient returned to the ER a few days later at around midnight and was examined by an ER physician, who noted that the patient was unable to void, was sweating profusely and complained of upper back pain. The patient had been able to void for the previous 12 hours, but only minimally.

The ER physician ordered a CT scan of the abdomen and pelvis, which were normal, and some lab studies which showed a white blood cell count of 12,000. Before admitting the patient to the hospital, the ER physician re-examined him and found that although he had a normal exam of his extremities on admission, he was unable to walk at 3:23 a.m. The ER physician ordered an orthopedic surgical consult at that time.

The orthopedic surgeon noted that he was told by the nurse that the patient had lower back pain, difficulty ambulating, leg pain and numbness in his legs. He ordered X-rays of the low back.

The orthopedic surgeon did not see patient until 6 p.m., when he was on a stretcher on his way to get an MRI. He briefly examined the patient at that time and diagnosed spinal cord compression.

Meanwhile, a nephrologist had seen the patient at 1 p.m. He considered spinal cord compression and ordered an MRI and a neurology consult. A consulting neurologist was notified at 6 p.m. to evaluate the patient for cord compression.

The neurologist determined that the patient needed urgent surgery and tried to locate a spine surgeon and neurosurgeon but was told that they were unavailable. He then prepared the patient for transfer to a Boston hospital for surgery.

The patient was transferred and a neurosurgeon performed an emergency operation for evacuation of an epidural abscess and decompression of the spinal cord. However, the patient remains a paraplegic.

The case settled for \$3.5 million against the ER physician and the nephrologist. The case is still pending against the orthopedic surgeon.

Action: Medical malpractice

Injuries alleged: Failure to diagnose spinal cord compression resulting in paraplegia

Date: July 2010

Submitted by: Barry D. Lang and Max Borten, Gorovitz & Borten, Waltham (for the patient)

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Patient dies after overnight stay in ER

The patient was an insulin-dependent diabetic and former smoker with a known history of coronary artery disease, mitral regurgitation and paroxysmal atrial fibrillation. He presented to the emergency room on Dec. 7, 2004, with substernal chest pain radiating to the back and left jaw.

The symptoms had begun at home at about 5 p.m. with nausea and shortness of breath. The patient had not had any chest pain in the prior three months.

The ER record began at 6:35 p.m. and indicated that the patient had continual high-intensity substernal pain, presumed to represent cardiac ischemia or inadequate blood supply to the heart.

A progress note taken at 9:50 p.m. indicated that he had no relief from his chest pain, despite receiving medication including nitroglycerine and intravenous morphine. An exam performed at that time reported evidence of heart failure.

The patient's rhythm monitor was reported to show atrial flutter with heart block and left bundle branch block, while his chest X-ray showed heart enlargement and pulmonary edema. A blood test confirmed the development of moderate heart failure. Subsequent EKG and echocardiogram testing revealed the unstable rhythm and severely reduced function.

By 11 a.m. the next day, the patient was exhibiting recurrent ventricular tachycardia, which was treated with repeated electric shocks. Blood gas readings taken at 11:40 a.m. showed the patient to be severely acidotic. He began seizing, at which point a code was actuated and he was transferred to another hospital, where catheterization revealed severe coronary disease including proximal occlusion of his "main and right coronary artery."



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An intra-aortic balloon pump was placed, but the patient experienced recurrent ventricular tachycardia; eventually, support was withdrawn and he died.

The case settled against the doctor for \$400,000 prior to trial. The trial against a co-defendant physician is pending.

Action: Medical malpractice

Injuries alleged: Wrongful death

Date: September 2010

Submitted by: Gregg J. Pasquale and Melissa A. White, Keches Law Group, Taunton (for the patient's family)

Patient's throat set on fire in laser surgery

A 66-year-old woman presented to a hospital with complaints of shortness of breath, coughing and blood-tinged sputum. It was discovered that a tumor was partially obstructing her right upper lobe bronchus and she was admitted for a laser bronchoscopy.

While firing the laser, the surgeon accidentally set the patient's throat on fire, extinguishing it by disconnecting the endotracheal tube and blowing down into it. The patient sustained extensive burn injuries to her airway and was transferred to the ICU, where she was put on a

ventilator. She died approximately six-and-a-half weeks later as a result of her injuries.

The surgeon was sued, both for negligently causing the fire and for exacerbating the damage by his actions once the fire occurred.

An interventional pulmonologist and pioneer in laser bronchoscopy was prepared to offer expert testimony that the fire was caused because the surgeon negligently placed the tip of the laser too close to the bronchoscope and endotracheal tube.

The expert pulmonologist would also have testified that use of a rigid metal bronchoscope instead of a flexible one would have eliminated any risk of fire. In addition, a forensic pathologist would have opined

that that when the surgeon blew down the endotracheal tube, he spread the fire damage and burns throughout both lungs, dramatically increasing the severity of the injuries.

The plaintiff also argued that because the surgeon was relatively inexperienced in performing the procedure, he should have referred the patient to one of the two recognized centers of excellence for this procedure in the same geographic area.

The surgeon theorized that the fire occurred when he hit an air pocket with a higher oxygen concentration as he lasered through the patient's tumor.

A resident anesthesiologist was added as

Verdict & Settlement Reports

Massachusetts Medical Law Report compiles the summaries of verdicts and settlements on this page from reports sent by attorneys to us or to Massachusetts Lawyers Weekly. The report information is generally provided by one of the lawyers in the case, although occasional reports may be based on court records and news reports. We edit the material for style, grammar, length and, where appropriate, content. We are interested in printing verdicts won by health care providers as well as plaintiffs, in addition to settlements.

If you have an item you would like to submit, please contact Matt Yas at matt.yas@lawyersweekly.com or 617-218-8152.

Woman blinded after receiving undiluted drug in eye

The patient, a 54-year-old woman, was virtually blinded in one eye after her doctor failed to dilute an antibiotic before injecting it intraocularly.

The patient began treatment with the physician in March 2006 for toxoplasmosis, which had recently been diagnosed and was causing floaters and other visual changes. The doctor prescribed a number of different oral antibiotics over the course of several weeks, but the various combinations caused migraines and gastrointestinal problems.

On April 7, the doctor advised the patient of the option to receive intraocular Clindamycin in lieu of the oral antibiotics. The patient agreed to that course of treatment and scheduled the injection for later in the day.

The physician testified that prior to administering the injection, he retrieved undiluted Clindamycin and was supposed to add saline to the medication pursuant to a written protocol, in order to make it appropriate for intraocular injection.

The procedure then required the doctor to take and withdraw 0.1 cc of the liquid into a syringe and inject the diluted solution intraocularly. However, the doctor did not dilute the antibiotic prior to performing the injection.

The patient complained of an inability to see with her left eye immediately after the injection. Based on her complaints, the physician took immediate steps to try to determine the cause of her vision loss, but was unable to correct the situation. Eight

hours later, the doctor performed an emergent pars plana vitrectomy of the patient's left eye due to the abrupt loss of vision.

On April 8, the patient returned to the doctor with complaints of mild pain in her left eye. During his examination, the physician noted that the patient was able to finger count only at two feet.

Four days later, the patient returned with complaints of blurry vision. The doctor documented that the patient was not able to count fingers at all and was only able to see hand motions.

The doctor confirmed that undiluted Clindamycin was the cause of the problem and informed the patient and her husband of all matters documented in that visit's note.

Since April 2006, the patient has undergone seven surgical procedures to the left eye in an attempt to restore her vision. To date, her vision in that eye remains unchanged, leaving her with only the ability to see hand motions.

During the course of discovery, the doctor acknowledged responsibility for his failure to dilute the medication prior to administering the injection, and the claim settled for \$1.85 million.

Action: Medical malpractice
Injuries alleged: Left-eye blindness
Date: March 2010
Submitted by: Andrew C. Meyer and Krysia J. Syska, Lubin & Meyer, Boston (for the patient)



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a defendant for failing to turn off the gas and remove the endotracheal tube immediately after the fire started.

The case settled for \$500,000.

Action: Medical malpractice
Injuries alleged: Tracheobronchial burn injuries, death
Date: Sept. 21, 2010
Submitted by: Jonathan A. Karon and John A. Dalimonte, Karon & Dalimonte, Boston (for the patient)

Patient requires hysterectomy after surgery

The patient gave birth to a full-term

daughter and was discharged several days after the delivery.

Two weeks later, she presented to the emergency room complaining of vaginal bleeding. She was diagnosed with retained products of conception, and the gynecologic surgeon performed a sharp uterine dilatation and curettage.

During the procedure, the surgeon created a two-centimeter uterine perforation through the use of a sharp curette. As a result, she performed corresponding diagnostic laparoscopy, followed by a laparotomy.

Following the surgery, the patient did not have a menstrual period and suffered from recurrent abdominal and pelvic pain that was diagnosed as Asherman's Syndrome, a medical condition that manifests itself by intrauterine adhesions through the presence

of scarring within the uterine cavity.

According to the patient's attorneys, the most common cause of Asherman's Syndrome is excessive force with a sharp instrument that also scrapes away or causes trauma to the layers of the endometrium. Injury to the underlying basal layer of the endometrium can lead to intrauterine scars and result in adhesions, which can obliterate the uterine cavity. Further complications include an absence of menses, extraordinary pain and infertility.

The patient underwent a hysterectomy 28 months after the uterine perforation in order to control the chronic pain.

The case settled for \$350,000.

Action: Medical malpractice
Injuries alleged: Onset of Asherman's Syndrome fol-

lowing gynecologic surgery, leading to eventual hysterectomy

Date: August 2010
Submitted by: Max Borten and Sidney Gorovitz, Gorovitz & Borten, Waltham (for the patient)

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Negotiating the best possible hospital employment offer

Continued from page 1

Assessing your leverage

In any negotiation, “information is power,” said Mandell.

You need to research the market for physicians in your area with similar qualifications and evaluate their worth to employers.

“Markets drive your leverage. In the country in general, there is an increasing shortage of doctors in virtually all specialties. Markets are driven by supply and demand. Your leverage increases as the supply of doctors diminishes, and as the demand for their services increases, particularly with health reform going national by 2014.”

If you’re a new doctor who graduated last in your class, your bargaining power is limited, adds Haron. That’s in contrast to the experienced doctor, with many positive relationships within the medical community and outside it, an impressive resume and recommendations.

Recruiters are often knowledgeable about the market, Mandell said, and they play the important role of bringing physicians and hospitals together. But remember that recruiters are often paid by the hospital.

A lawyer can give an unbiased opinion to help you assess your leverage. A lawyer should also know when to push for more – and when to stop – and a lawyer is best suited to make sure what’s negotiated is accurately reflected within the contract, Mandell said.

Negotiating the essential terms

• Duties

Expect an outline of your central job responsibilities in the contract. Items such as regular clinical hours, emergency room coverage and administrative duties, research time and on-call expectations might be addressed, Haron said.

Make sure the description of duties and schedule in the contract is not generic and is tailored to your type of practice. Hospital-based physicians, such as hospitalists and pulmonologists staffing ICUs, have very different schedules and duties from primary care physicians and other outpatient-based specialties, noted Mandell.

In addition, will you have access to the nursing staff? Currently many hospitals and their affiliated groups are hiring fewer nurses than in the past, requiring physicians potentially to do things that a nurse might have previously done, such as inserting a PIC line.

• Salary and benefits

With regard to pay, Mandell said to expect standard terms such as “base compensation” and “incentive-based compensation.” This will vary, depending on your specialty. Compensation may be driven by formulas based on productivity, patient satisfaction or other performance benchmarks.

There can be a lot of flexibility here. For one of Haron’s physician clients, receiving grant monies was a compensation factor. Or, compensation might be based on the number of referrals you receive from other physicians.

Occasionally compensation might be based on a percentage of collections, said Haron.

However, it’s important to make sure that whatever scenario is crafted doesn’t create Stark and/or anti-kickback law issues. These are laws that strictly regulate the way physicians are paid, and violations have serious consequences.

Sometimes signing bonuses are discussed, as well as reimbursement for relocation costs, added Mandell. As for benefits, there might not be much room for variation here, because group benefit plans are frequently in place.

• Expenses

With regard to costs, will you be reimbursed for technology, mobile telephones, association dues, continuing medical education and associated travel? Will you be reimbursed for marketing expenses incurred, such as entertaining other doctors in an effort to increase your patient volume?

A major concern here is the cost of malpractice insurance, said Haron.

If you’re leaving a private practice for hospital employment, did you have “occurrence” or “claims made” coverage? The latter is more

Are you hospital employee material?



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If your focus is primary care, cardiology or oncology, hospitals are definitely interested in your skill set, said Chad Stutelberg, a physician practice consultant at Integrated Healthcare Strategies in Minneapolis.

“Hospitals need physicians in just about every area,” he said. “What we don’t see a lot of need for is GI, orthopedics, radiology or ENT.”

Hospitals nationwide are recruiting physicians. The need is greatest in rural or urban “safety net” hospitals. Not too surprisingly, hospitals in Alaska are always looking to hire. Also, some hospitals in warmer climates often have vacancies.

Beyond clinical competence, hospitals are looking for candidates who interface well with patients and are constantly striving for better outcomes. Comfort with technology and the potential to be a “physician leader” are also desirable; some of the best-known medical practices such as the Mayo Clinic, Geisinger and Cleveland Clinic are all physician-led organizations versus hospital-affiliated groups.

Stutelberg said that a physician’s attorney is welcome at the negotiation table, as long as he or she understands health and employment law – not a friend or relative with completely unrelated skills.

Hospitals and larger medical groups tend to seek uniformity in their physician employment contracts. From a business standpoint, if the group or facility employs 1,000 doctors, it would be completely unmanageable if everyone had widely divergent agreements, especially when their qualifications are similar, Stutelberg explained.

Moreover, some hospitals’ desire for consistency is resolute. It just depends on the facility and a physi-

cian has to gauge that when considering his or her leverage and the entire package.

That’s not to say there isn’t room for negotiation. Generally, even if there’s not much hope of changing the boilerplate used by a large health care employer, there’s almost always room to negotiate the specifics of the relationship. But a physician must be prepared to justify his or her needs, because the hospital will likely want transparency with other staff: You’re getting x dollars, benefits, time off, etc., because of compelling reason y.

About 75 percent of the contracts Stutelberg sees lately call for termination by either side at will, allowing 90 to 180 days’ notice. When they do contain a term, typically compensation is annually adjusted. Rarely do terms exceed five years.

Finally, Stutelberg advised physicians to be optimistic about their future employment.

“Hospitals employed a lot of physicians in the early to mid-’90s, quite aggressively, in an attempt to get in front of ‘capitation,’ or managed care, and build large primary-care networks.”

It didn’t go very well, he recalls. “A lot of doctors left employment with a bad taste in their mouths.

“Today, hospitals are employing physicians once again, and I would argue they’re doing a better job of it, learning the lessons from the past. They’re looking for the right candidates. They’re not doing special deals on every contract. They’re being transparent. And they’re open to more physician involvement in setting compensation and managing their practices.”

— Jane Pribeik

common in professional liability policies, where the insurer only covers a physician for a claim made during the period the policy is in effect, even if the alleged malpractice occurred during that time but the claim is made after the policy is terminated.

If you had claims-made coverage, tail coverage is necessary, and you will want to determine who pays for that.

• Term and termination

Some employment contracts run for a defined time period, during which you can only be terminated for cause, said Haron. What happens when the term ends, and is a renewal process outlined?

With such provisions, it’s also wise to define what constitutes cause – malpractice, disobeying the rules, insubordination? In which instances will the state medical licensing authorities be notified? Sometimes, noted Haron, termination for cause mirrors the due process

safeguards afforded to non-employee, independent contractor physicians with privileges at hospitals.

More common is “at will” employment, where either party can terminate the relationship for any reason, with the requisite notice.

Understanding the boilerplate

A noncompete clause in an employment contract seeks to limit a physician’s ability to practice in competition with the hospital should the relationship end.

“The enforceability of those varies from state to state,” said Mandell. “Some states, like Massachusetts, do not allow the enforcement of standard noncompete [agreements] in most employment situations.”

Other restrictions might include a nonsolicitation clause, which prohibits a departing physician from soliciting patients related to the hospital, and a nondisclosure clause,

which says that all of the practice’s information, such as patient identities, contacts and other valuable relations, are exclusive to the hospital’s practice.

Mandell listed other potential concerns, such as:

- Indemnification clauses, where a physician will be required to reimburse the hospital’s attorney fees and costs should a claim arise against him or her.
- HIPAA violation clauses, spelling out whether a physician will be responsible if there’s a violation of federal law pertaining to medical information that the hospital stores.
- Compensation formulas that eventually put the employed physician at 100 percent risk of having his or her stated base salary reduced if his or her collections do not reach a certain level.

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Questions or comments can be directed to the editor at: reni.gertner@mamedicallaw.com

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Course Information

Intended Audience

This course is intended for physicians and allied health professionals.

Course Objectives

- Review current data on the frequency of malpractice actions and documentation strategies to reduce the risk of medical-malpractice lawsuits.
- Explore common medical record "red flags" identified by legal teams.
- Discuss language and actions to avoid when documenting a patient encounter.

Course Credit

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Avoiding failure-to-diagnose suits

By Eric T. Berkman

Failure to diagnose a patient's condition is a common ground for medical-malpractice lawsuits – and physicians need to take careful steps to avoid being sued.

Neurologist Luke Sato, chief medical officer at CRICO/RMF, the captive liability insurer for Harvard University's medical institutions, says 26 percent of all malpractice claims filed with his company in the past five years involved allegations of missed or delayed diagnoses, representing a staggering 42 percent of all med-mal dollar losses.

"It's a huge problem from the financial perspective" as well as the clinical perspective, said Sato.

Boston med-mal defense attorney David M. Gould cited a case where the physician didn't realize that a patient had undergone a nuclear imaging test until two days after the patient suffered sudden cardiac death. Unbeknownst to the doctor, the test had shown a grossly abnormal result. Neither the doctor nor his large group practice had a system to track whether tests were completed, received and reviewed.

"It doesn't happen all the time, thankfully, but there are enough occasions where something gets done and is not reported [to call it] a continuing problem," said Gould, who practices at Ficksman & Conley.

The missed or delayed diagnosis danger is growing in part because hospitals and health care networks are increasingly assigning critical care to ambulatory clinics and offices, often without spreading their institutional checks and balances to these peripheral settings.

Also, many patients expect nearly instantaneous diagnoses, increasing the risk of hazardous shortcuts by physicians.

And perhaps most significantly, the volume of patients that doctors are expected to see has exploded, increasing the risk that a test result, specialist's report or missed office visit could get lost in the shuffle.

While there's no fail-safe "silver bullet" solution, experts have identified the following "five commandments" for avoiding failure-to-diagnose litigation:

I. THOU SHALT FOLLOW UP ON THY PATIENT'S TESTS, REFERRALS AND SUBSEQUENT CARE.

Anne Huben-Kearney, a registered nurse and vice-president of clinical risk management at ProMutual Group in Boston, calls inadequate follow-up "the number one problem" behind failure-to-diagnose claims.

"Part of the problem is that physicians think it's the patient's responsibility to follow up, call back, make appointments and so on," she said. "But we say – and the courts say – that the physician is responsible."

It's paramount that medical practices have a paper or electronic system to track tests, referrals to specialists and orders for subsequent treatment.

"We actually have tracking forms that we give physicians that state the date a test [or referral] is ordered, the date it came in and some indication that the physician or des-

ignated person has looked at the results," said Huben-Kearney.

Ann Louise Puopolo, CRICO/RMF's director of loss prevention and patient safety, said that such a system need not distract a physician from clinical duties; it can be staff-driven.

"You don't need a clinical expert to manage the process because they're not actually in the role of interpretation," says Puopolo. "They're just managing results to completion."

Max Borten, who was a physician before becoming a med-mal plaintiffs' lawyer, said doctors often miss another vital aspect of follow-up: communication with the specialists to whom they've referred their patients.

For example, if an ultrasound report is confusing, "just pick up the phone and call the radiologist" to discuss it, advised Borten, a partner at Gorovitz & Borten in Waltham.

II. THOU SHALT NOT MAINTAIN SLOPPY OR INCOMPLETE FILES.

Martin C. Foster, a veteran med-mal defense lawyer at Foster & Eldridge in Cambridge, said that lack of documentation is another significant factor in failure-to-diagnose cases.

To avoid this, he said, the progress notes for any visit should start with the patient's chief complaint and incorporate his or her vital signs, carryover problems, an assessment and a plan.

"But frequently, if a physician knows a patient quite well, he may skip these basic elements of documentation, or with an [electronic health record], information from previous encounters may be simply carried over or omitted," he said.

Sato urges doctors to document not just their decisions and recommendations, but also their thinking behind them.

"Why did you order that lab or radiology study? That thought process is absolutely critical, not just to cover [yourself], but it's really critical from a continuity-of-care perspective," he said. "If another physician happens to be covering for you, they'll need to know what your thinking is."

Similarly, said Foster, if a doctor disagrees with a consulting physician's recommendation – or if a doctor discusses a case with another practitioner in an informal "curbside consultation" – that should be noted in the record, along with the rationale for the doctor's subsequent plan of action.

Such documentation may help show that despite a bad medical outcome, the physician followed the standard of care, which is the linchpin of any medical-malpractice case, Foster said.

III. THOU SHALT COMMUNICATE WITH THY PATIENT.

As Gould points out, patients don't sue their doctors because they're greedy. They do it because they're frustrated.

Accordingly, he urges practitioners to find ways to be accessible and to *listen* to the patient from the very beginning, not just after a negative incident occurs.

"The more people feel that their

providers are concerned, compassionate and interested, the less likely it is that in the event of an adverse outcome someone will end up in a lawyer's office," said Gould.

Foster cited a case where the physician assumed that the patient's chest pains were associated with gallstones. He ordered an ultrasound but not an EKG.

Within the next 12 hours, the patient died of a heart attack. A post-mortem exam indicated that the patient was having a myocardial infarction at the time of the visit. The case settled for a confidential but "large" figure, Foster said.

"The pain was from an area that could have been a gallbladder, but it could have also been referred pain from the myocardial infarction," said Foster. "The point is, the doctor didn't carefully listen to the patient and jumped to a conclusion that resulted in an erroneous diagnosis."

Huben-Kearney said that one of the biggest traps resulting in missed diagnoses is the failure to get a complete medical history.

As a result, ProMutual urges its insured physicians to ask patients to sign a statement indicating that they have provided a thorough medical history.

"I talk with physicians regularly who say patients aren't honest about what's going on," Huben-Kearney said.

For patients who refuse a referral or diagnostic test, ProMutual provides doctors with an "informed refusal" form acknowledging that they understand the consequences.

"Physicians who've presented the form say it's like a wake-up call for the patient," said Huben-Kearney. "They realize a physician isn't just saying something to say it, but that maybe they really *should* go through with that exam, procedure or referral."

IV. THOU SHALT DELEGATE TASKS WISELY.

Borten said that many practitioners risk missed diagnoses because they don't delegate responsibilities appropriately.

For example, he recently settled a case where his client had his prostate removed but was also billed for an appendectomy. When the patient called to inquire, the billing clerk mistakenly informed him that his doctor always performed an appendectomy as part of the prostate procedure.

Two years later, the patient suffered an acute case of appendicitis, but assumed that couldn't be the case because he thought his appendix had been removed. The resulting delay in seeking treatment necessitated major surgery.

"When a patient calls with a question like that, give it to the surgeon," advised Borten. "He knows whether the procedure was done. There happened to be a billing error and a patient got hurt as a result of the billing clerk making a medical decision."

Huben-Kearney said the issue of improper handling of phone calls is more common than one might think.

"We're finding that patients are calling and not being documented

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Avoiding failure-to-diagnose suits

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or triaged," she said.

To prevent this problem, each practice needs to create a "decision tree" indicating when to route calls to doctors and how quickly.

The plan should be developed with the clinical expertise of the physicians – not only by the office

manager – and all calls must be documented in the record, Huben-Kearney advised.

At the same time, said Puopolo, physicians must avoid the urge to do everything themselves. For example, things like age- and risk-stratified health screening orders should be handled by staff or outsourced.

"Nonphysicians can look at patient panels ... and make sure that age and risk appropriate [screenings are] ordered for appropriate health maintenance, like colonoscopies, cholesterol screenings and mammography," she said. "Of course, all test results must still go in front of the doctor or nurse practitioner."

V THOU SHALT SEEK THE EXPERTISE OF THY LIABILITY INSURER.

Many physicians do not realize how helpful a resource their liability insurer can be in terms of identifying and implementing systems to reduce the risk of delayed or missed diagnoses.

ProMutual's risk managers, for example, will appraise a practice as a condition of insurance and also perform office appraisals at a physician's request, Huben-Kearney said. **MMLR**

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The Physician's Corner

Avoiding failure-to-diagnose litigation

By Henry Tulgan, M.D. FACP

Medical-malpractice lawsuits claiming that a provider failed to diagnose a patient's condition are becoming increasingly common. The term "malpractice" typically refers to a scenario in which a treatable condition was never diagnosed, precluding treatment or resulting in death. Adding claims for a delay in diagnosis to this definition casts the malpractice net wider, and makes it more likely that a physician will be sued.

Boston-based medical liability insurer ProMutual Group, in a 2005 report entitled "Failure to Diagnose: Putting the Pieces Together," analyzed closed claims from 2002 to 2004 in seven specialties, and confirmed that overall the most common medical liability allegation is failure to diagnose. The report's breakdown of claims by specialty was as follows:

Specialty	Percent of cases claiming failure to diagnose
Radiology	74.8
Pediatrics	63.8
Family Medicine	54.3
Internal Medicine	51.5
General Surgery	20.0
Orthopedic Surgery	15.8
OB-GYN	15.0

Other insurers have reported similar findings, with failure-to-diagnose

as the most common cause of litigation in non-surgical areas of practice. The majority of failure-to-diagnose cases are cancer-related, with breast cancer the most common, followed by colo-rectal, lung and prostate. With the dramatic changes in the way that medicine is practiced in the 21st century as compared to earlier times – including the near replacement of solo practitioners by group practices, the proliferation of specialists and subspecialists and the advent of hospitalists and nocturnists, along with the growth in laboratory diagnosis and technology – it's no surprise that litigation has increased.

Too often, patients do not receive timely, understandable reports of their test results. This may result from poor definitions of who should be required to provide them or because record systems are inadequate. It may also be a result of reports by a radiologist or lab expert that require clarification or explanation.

Poor communication magnifies negative feelings toward health care providers and further prompts thoughts of litigation.

Clearly, maintenance of updated records, wide implementation of electronic health records, prompt response to patients about testing results and clear recording of these encounters in the medical record will obviate many legal actions and protect practitioners if litigation does en-

sue. In addition, the following risk management strategies present actionable steps that may help reduce the risk of suit.

Risk management strategies

- Develop and maintain a paper or electronic system to track tests, referrals to specialists and orders for subsequent treatment.
 - Begin progress notes for any visit with the patient's chief complaint and incorporate his or her vital signs, carryover problems, an assessment, a plan and the practitioner's decision thought process.
 - Ask patients to sign a statement indicating that they have provided a thorough medical history.
 - Find ways to be accessible and to listen to the patient from the very beginning, not just after a negative incident occurs.
 - For patients who refuse a referral or diagnostic test, have the patient sign an "informed refusal" form acknowledging that they understand the consequences.
 - Create a "decision tree" indicating circumstances in which a physician's office staff should send a patient's calls to a physician and how quickly.
 - Utilize your liability insurer as a resource to help identify and implement systems to reduce the risk of delayed or missed diagnoses.
- As demonstrated initially at the University of Michigan – where

malpractice actions have been reduced by 40 percent – apology combined with an explanation may reduce litigation substantially.

Will our profession ever achieve 100 percent accuracy and consistently complete communication of findings with our patients? Six sigma advocates would hope so, but it isn't likely. Therefore, providers faced with failure-to-diagnose suits should notify and involve their liability carrier and attorney.

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- The danger of missed or delayed diagnosis is decreasing in part because of hospitals and health care networks.
 - a. True
 - b. False
- Medical practices should have a paper or electronic system to track tests, referrals to specialists and orders for subsequent treatment.
 - a. True
 - b. False
- Practices should create a "decision tree" to help staff determine when a patient's call should be sent to a physician.
 - a. True
 - b. False
- Lung cancer is the most common malignant condition for which litigation is pursued.
 - a. True
 - b. False
- Apology is one way to reduce malpractice actions.
 - a. True
 - b. False

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Loss-of-chance lawsuits aren't on the rise, legal experts report

Continued from page 1

ory "a profound revision" of state law that would likely expand the number of cases filed against physicians and medical care providers by patients who were dissatisfied with the outcome of their care rather than physically harmed through negligence.

But Cambridge, Mass., defense attorney Martin C. Foster, a partner at Foster & Eldridge, said that a number of "attempted applications" of loss of chance have already failed, making it less likely that more of these claims will be brought against physicians.

"I don't think it's made much of a difference at all," agreed plaintiffs' attorney Ralph F. Sbrogna of Sbrogna & Brunelle in Worcester, Mass.

Sbrogna said he's had only one case (involving failure to diagnose prostate cancer) where loss of chance has come up, but it settled before trial so the loss of chance doctrine was never applied.

Few cases have gone to trial

Waltham, Mass., attorney and physician Max Borten, who co-represented the plaintiff

in the *Matsuyama* case, said that because there have been so few loss-of-chance cases tried since the decision, with most settling be-

seems to be confusion over what the ruling means and when it can be used appropriately, Borten said.



"A number of 'attempted applications' of loss of chance have already failed."

— Martin C. Foster

fore trial, it is difficult to definitively measure how the ruling has influenced jury awards. One lingering problem is that there still

Borten receives calls weekly from attorneys both in Massachusetts and outside the state who want to know if they have a valid

loss-of-chance case. Most times, he said, they do not.

Salem, Mass., attorney Annette Gonthier-Kiely, who represented the plaintiff in *Renzi*, said she got a nearly \$4.7 million jury award in Essex Superior Court last May using the loss of chance argument for the first time.

In that case, Gonthier-Kiely argued that a nurse practitioner failed to diagnose her 31-year-old patient's colon cancer for six months. By the time of his May 2002 diagnosis, the cancer had reached Stage IV and there was a zero chance of survival. The man died in December 2004.

The plaintiff's oncologist testified that the man would have had a 45 percent chance of survival had the cancer been detected when he first sought medical attention.

Despite this successful use of the argument, Foster said that in Massachusetts, where the plaintiffs' bar is small and "cautious," there's little reason to conclude that the ability to seek loss of chance will give juries further opportunity to unfairly ratchet up awards against health care providers.

"I'm not worried about it," he said. **MMLR**

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Managing the risks of practicing telemedicine

Continued from page 1

Patients need to be assured that whatever personal medical information they're transmitting is going to the right person, she said.

"I think people are concerned that their information is going to be hacked," said Huben-Kearney.

An important place to start is by ensuring that the patient and physician each have a unique, secure password to link up.

"Otherwise, you don't know who you're actually talking to," she said. "It could be anyone using a patient's name going onto the site saying, 'I have these questions and concerns.' So we like to see passwords that aren't shared with anyone."

If your group practice implements an Internet-based telehealth platform, the vendor should set it up so that doctors have to be on a list of approved providers within the group to sign up, said Schoenberg.

He said there also needs to be a security infrastructure that ensures all live communication is completely encrypted.

"The storage of any information generated must be accessible only to the actual patient and physician," not even to the vendor or system operator, Schoenberg added. "It must be encrypted at the database level."

It's also critical to remember that patient confidentiality regulations like HIPAA apply regardless of whether the communication takes place in person or via technology, said David Harlow, a health care lawyer and consultant in Newton, Mass. and author of HeathBlawg, a health law and policy blog.

In fact, Harlow pointed out that amendments to HIPAA under the HITECH Act impose additional requirements on business associates of health care providers, including telemedicine vendors.

"It's no longer sufficient to get a vendor to say, 'I understand the requirements and will keep information private,'" said Harlow. "There's an affirmative obligation on the health care provider to be responsible for the privacy

and security operations of the vendor."

In addition, any practice using telemedicine tools needs to update its HIPAA privacy notice to address how it protects privacy when engaging in telemedicine, Harlow advised.

- **Informed consent**

Huben-Kearney said that any Internet-based telemedicine site should be up front with the patient about the limitations of the technology – particularly its security – and have the patient sign off on that.

"Patients need to be informed. They're making a decision to participate, but they need to be made aware of the potential risks," she said.

Any informed consent form should include the patient's responsibility to use the technology appropriately (for example, don't use the Internet to report a medical emergency); should inform the patient that any messaging platform might only be checked on, say, a daily basis; and that there is no sharing of passwords.

- **Maintaining continuity of care**

Pho said he hasn't used telemedicine technology such as videoconferencing or communication over customized Internet platforms. But he is a heavy user of social media tools and says many of the risks are the same – particularly when it comes to continuity of care.

"The biggest risks occur when encounters aren't documented," he said. "With a Skype call, a videochat or even a phone call, everything must be appropriately recorded in the chart."

Harlow agreed. "You want to ensure continuity of care by ensuring all records of patient encounters end up in the same place easily," he said. "[Remote consultations] can end up in the same place, but that can often mean double or triple the work for the physician."

Huben-Kearney added that ProMutual likes to see proof of informed consent scanned into the record.

- **Staying in state**

Some Internet-based telehealth involves

patients logging onto a secure website and, after providing the relevant information, being connected online with a doctor whom the patient does not know, but who practices in the necessary specialty.

If you're the doctor who has volunteered to consult with individuals at one of these sites, said Harlow, you need to make sure you're only providing services to patients in the state where you're licensed.

"It goes by where the patient is, not by where the doctor is," he said. "A company like American Well would presumably only connect a Massachusetts patient with a Massachusetts doctor, and some states have limited licensure for telemedicine – sort of a separate category of licensure – but most states do not."

Any doctor who is not careful about this issue risks an action by the Board of Registration in Medicine for the unlicensed practice of medicine, Harlow added.

- **Ensuring the reliability of the technology**

Harlow said that the technology itself can be a liability concern.

For example, what if the connection cuts out at a key moment in the conversation where a doctor is telling a patient to be sure not to take the prescribed medicine with food? Now a technical glitch has resulted in a transmission of inaccurate medical advice.

"If that results in an injury to the patient and there's a lawsuit, who's liable?" asked Harlow. "The standard contract from the technology vendor would say they disclaim all liability. This is something to be aware of."

Of course, depending on the bargaining strength of a physician group versus the tech company, everything is negotiable.

"So this kind of issue would militate in favor of a physician signing up with a larger group. ... By being part of an organization you get better leverage in the negotiation with the vendor," said Harlow.

It's best to try to avoid technical glitches altogether, said Huben-Kearney, which

means selecting a competent vendor. Since most physicians and small group practices lack the level of technical expertise to do this effectively on their own, she suggested they contact their liability insurer for advice.

- **Choosing the appropriate clinical context**

Telemedicine is effective in two major areas of health care delivery, according to Schoenberg.

The first context is acute primary care – emergent issues where patients need timely care, such as bronchitis, urinary tract infections and gastrointestinal infections.

"Usually they're sick and going to see a doctor is difficult," he said. "Or their child is sick at 11 at night and they don't know if they need to go to the emergency room. A telehealth system allows them to bring up a live doctor to make that decision with them."

The other scenario is patients with a chronic condition where the doctor is not establishing a diagnosis, but the condition requires complex daily management.

"Either they can't wait to get to a doctor or it's very difficult for them to show up in the office with the frequency their condition requires," Schoenberg said. "[Telemedicine] allows doctors to be more balanced with how they're treating complex conditions. Diabetes, asthma and heart patients use these systems extensively."

But anything that has to do with trauma or requires a physician to give surgical rather than medical advice is completely inappropriate, he said. Additionally, escalating medical conditions such as chest pains and very high fevers should be dealt with in person.

"In all these cases, even if patients are presenting on our system with these kinds of conditions, the physician will instantly tell them to go the emergency room to be seen physically by a physician," said Schoenberg. **MMLR**

Questions or comments can be directed to the editor at: reni.gertner@mamedicallaw.com

Telemedicine as usual: advice for old-fashioned telephone use

Anne Huben-Kearney, vice president of risk management at ProMutual Group in Boston, said that 100 percent of the physicians insured by her group practice telemedicine.

That doesn't mean they're all consulting with patients via videolink or over a secure, customized web portal – talking on the phone counts, too. And there are some common sense dos and don'ts of phone consultations that many doctors forget.

First, said Huben-Kearney, doctors' offices need to maintain a good triaging system.

"We prefer that the best practitioner in the office be the triage person," she said. "It absolutely should not be the secretary or receptionist. If there's a clinical concern, it should go immediately to a higher level, preferably a registered nurse."

Additionally, she said, every telephone communication with clinical relevance needs to be documented, just like a consultation in the office. And if there are two calls for the same problem within a finite period of time, the patient should be seen.

"When I mention documenting phone calls," she added, "I'm talking about afternoon and weekend calls as well."

The volume of calls in some practices, such as pediatricians after hours, is so high that they can miss how important it is to document everything, even when it's telling a patient to go the ER.

The right systems help with documentation, and the best systems are frequently the lowest tech.

"We recommend having a piece of paper by your bed in case you're called in the middle of the night," said Huben-Kearney. "Something readily accessible so wherever you're taking the call, you can write down the time, the name of the patient, the nature of the call and the advice you gave."

Another suggestion is having a back number for the office that has an answering machine.

"That way [the provider] can literally finish the call, call the back number and record it all onto the answering machine to be transcribed by the staff in the morning," Huben-Kearney advised.

–Eric T. Berkman



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