

## \$40M malpractice verdict just an 'aberration'



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Lawyers who represent doctors say that when a Lowell jury awarded a medical-malpractice plaintiff \$40 million on Aug. 17, it was a "scary" moment for physicians, but also an aberration.

Attorneys also note that a "high-low" agreement in the case meant that the doctor involved was, in fact, only required to pay an amount in the vicinity of \$1 million—and that the judgment was entirely covered by her insurance.

In the case, the patient's lawyer was able to convince a jury that a doctor's inexperience led to the severe brain damage suffered by the plaintiffs' son at birth. The jury

awarded the family a \$23.4 million award; \$40 million with interest.

But during the course of the trial, the lawyers in the case agreed that no matter what the jury awarded, there would be both a minimum and maximum limit on recovery. The maximum limit was identical to the doctor's insurance coverage.

But even though the doctor will turn over none of her personal finances in the case, a \$40 million verdict is still one that has the legal—and the medical—community talking.

"I don't comprehend what went through the minds of the jurors," said attorney Charles P. Reidy III of Boston. "It's as if they think it's 'funny money.'"

Reidy added: "This is scary for doctors, and it might add to the

tort-reform debate, but aberrations don't make the rule."

Attorney Charles J. Dunn Jr. of Boston said he was "shocked" when he heard of the decision.

"Somebody must have made that jury angry," said Dunn. "The doctor told the jury that [when it came to being a doctor], she had

a 'gift.' That will piss them off."

Curtis R. Diedrich, a Boston lawyer, stated that this was a shocking but unusual decision.

"I look at this as an aberration as opposed to a trend," he noted. "Massachusetts has been pretty conservative with the frequency

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## Health care proxies: preventive measure or potential minefield?

By **Lisa K. Bruno**  
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From the time she was admitted to Massachusetts General Hospital in 1999, suffering from the progressive debilitation inflicted by Lou Gehrig's Disease, Barbara Howe breathed with the help of a ventilator.

Five years later, her condition deteriorating, her doctors sought to withdraw the 78-year-old from life support in the belief that it was prolonging her suffering. The rare move pitted the hospital against Howe's daughter, her health care agent, who asserted her mother's wish was to be kept alive.

The ensuing two-year legal battle captured the spotlight as a case that could influence how hospitals, doctors and families handle complicated end-of-life medical care when the patient can't speak for herself.

There were no answers, however, as the parties ultimately reached an agreement under which the life-sustaining treatment was to be extended by some three months—long enough, it turned out, for Howe to die naturally.

While the highly publicized Terry Schiavo case in Florida vividly illustrated the turmoil that can result when a patient hasn't left an advance directive for health care and end-of-life decisions, the Howe case demonstrates that there are no easy guidelines even when a written health care proxy is in place.

Yet, attorneys who have grappled with these issues agree that health care proxies are helpful for both care providers and families in navigating otherwise emotionally-laden situations.

"It's great when wishes can be known as specifically as possible," stated Robert R. Hamel Jr., counsel to MGH in the Howe case. "But as we go forward, the areas that will continue to evolve are those when an agent is at odds with a medical provider's ethical responsibility to his patient."

### Gray areas

Under the state statute that governs health care proxies—Chap-



AP Photo/Family photo via The Boston Globe

Barbara Howe, who was at the center of a two-year legal battle

ter 201D of the Massachusetts General Laws—the health care agent can make any decision that the patient could have made if competent, unless the proxy specifically limits the authority of the agent or a court order overrides the proxy.

What is included in the grant of authority to a health care agent has not been tested, remarked Gary S. Zalkin, who represented Howe's daughter.

But physicians are generally directed simply to follow the instructions of the document presented to them, explained Lisa M. Cukier of Boston, who specializes in probate and family law litigation.

They are not, however, required to honor the agent's decision in all instances, she reminded.

"The provider can determine that the decision being made by the agent goes against moral or religious views of the doctor or of the hospital," Cukier says. "Then that doctor or hospital would have the obligation to transfer the patient to a health care provider

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## Taking the stand: tips for providing expert testimony

By **David E. Frank**  
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It can often represent the most important part of a trial.

An expert witness takes the stand, faces the jury and attempts to answer questions that address a critical aspect of a case.

So why is it that jurors sometimes do not seem to get it?

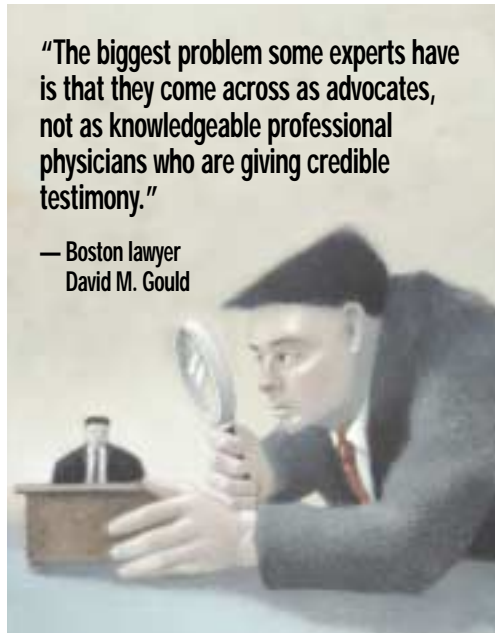
"The biggest problem some experts have is that they come across as advocates, not as knowledgeable professional physicians who are giving credible testimony," said Boston health care lawyer David M. Gould, a faculty member and course director at Harvard Medical School who frequently speaks to doctors about presenting expert testimony.

Gould, along with medical personnel who regularly provide expert testimony, stressed the importance of preparation and noted that such testimony fails to resonate with jurors when doctors make use of intricate medical terminology that most people simply do not understand.

### Preparation

In order to persuade a group of jurors listening to what is often highly technical and complex medical testimony, lawyers and doctors agree that mapping out a game plan is key.

"Medical cases are won or lost before lawyers ever step foot in the courtroom," Gould remarked. "Discovery these days means you know exactly what the other side is going to say, so when somebody sits down with their expert they have to understand that the issues are there in black and white."



Getty Images

"The biggest problem some experts have is that they come across as advocates, not as knowledgeable professional physicians who are giving credible testimony."

— Boston lawyer  
David M. Gould

Once the issues are identified, he noted, lawyers and doctors need to develop a mutual understanding of how they will anticipate and respond to opposing counsel's line of inquiry.

During pre-trial preparation, Gould advises doctors that "when they get cornered by a question, they can't come off as an advocate and they really need to respond in a way that will reflect an honest, credible position."

When Clyde D. Bergstresser of Boston meets with an expert, he makes sure to address all aspects of his case, including its weaknesses.

"A mistake I often see made by lawyers is to pretend the problem doesn't exist," he said. "The lawyer has the responsibility of not only spending the time with the witness discussing it, but also identifying a way to address it on direct examination rather than waiting

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# Sharing what hospitals know: a challenge to the medical staff review process

By J. Mark Waxman and Lawrence M. Kraus

The medical staff peer review process is a challenging one. The public is entitled to be protected from physicians whose skills do not meet adequate clinical standards. To accomplish this, Massachusetts hospitals create and implement a Patient Care Assessment Program, including a peer review process. G.L.c. 111, §203:205; 243 CMR 3.00.

Physicians are entitled, however, to a fair hearing (and may litigate) when their practice privileges are threatened. See *Ayash v. Dana-Farber Cancer Institute*, 443 Mass. 367 (2005). A careful balance is required.

What are the rules when an event occurs at one hospital that raises questions regarding the physician's ability to practice at another? Massachusetts regulations not only envision, but may require, exchanging such information.

## The applicable law

No federal statute or regulation requires hospitals to share information concerning pending (but not completed) reviews of a physician's competence.

The federal Health Care Quality Improvement Act (HCQIA) and its regulations require reporting to the National Practitioner Data Bank (NPDB) upon a final action to restrict clinical privileges for longer than 30 days, or a surrender of privileges while the physician is under threat of investigation. 42 U.S.C.

§11133(a).

Similarly, Massachusetts has extensive statutory and regulatory requirements regarding reporting "disciplinary action" to the Board of Registration in Medicine (BRM). G.L.c. 111, §53B; 243 CMR 2.07(17).

To allow full and frank evaluation of clinical activities, "the proceedings, reports and records of a [hospital's] medical peer review committee shall be confidential," and participants in good faith peer review activities are generally immune from liability for their participation. G.L.c. 111, §204, 203(c); 243 CMR 3.04.

"The statute, thus, protects a physician who, in good faith, provides information or an opinion ... in the professional context of peer review proceedings from thereafter being held liable in tort ..." *Ayash*, 443 Mass. at 394; *Carr v. Howard*, 426 Mass. 514 (1998) (discussing privilege); *Miller v. Milton Hospital & Medical Center*, 54 Mass. App. Ct. 495 (2002) (administrative letter not privileged, and may be used against hospital).

Federal law also provides limited immunity for good faith participation in certain peer review activities. 42 U.S.C. §§11111-11113. Peer review activities are generally maintained as confidential within a hospital.

Hospitals are, however, authorized to exchange information about pending disciplinary actions as part of "credentialing" — i.e., evaluating a physician seeking patient care privileges at a hospital. See 243 CMR 3.05 (credentialing regulations). Massachusetts regulations mandate that hospitals cannot hire, credential or re-credential unless the physician:

- identifies any hospital where he has had employment or privileges, and the reasons for any discontinuance thereof;
- authorizes the release of any information that is "relevant either directly or indirectly, to the licensee's competence to practice medicine";
- authorizes the hospital to "exchange information" with those other hospitals "regarding any pending or final disciplinary action" ... including any voluntary or in-

voluntary course of counseling, treatment or testing for drug or alcohol abuse." 243 CMR 3.05(f)–(h) (emphasis added).

A credentialing hospital is also required to make "reasonable inquiry" to every hospital that has credentialled a physician concerning "an assessment of clinical skills" and "information regarding any pending or final

Center (KMC) requested pre-employment information from the hospital that had previously credentialled him, including "a candid evaluation of [the physician's] training, continuing clinical performance, skill, and judgment, interpersonal skills and ability to perform ..." The Hospital responded with only the physician's dates of employment.

The physician subsequently attended a surgery at KMC in which the patient suffered "extensive brain damage," allegedly as a result of the physician's "gross negligence."

The family sued the physician and KMC for malpractice. Following a \$7.5 million settlement, KMC (and its insurer) sued the group and the hospital (as well as individual doctors providing references), claiming that KMC would not have credentialled the physician had it been provided with complete information.

Relying on Louisiana law, the federal court refused to dismiss KMC's claims based on the "alleged omission of material facts in a letter representing [the physician's] term of service at the [hospital]."

Although not Massachusetts precedent, *Kadlec* highlights the risks of insufficient responses, and counsels that another hospital's proper information request regarding an applicant must be carefully considered.

Risks also exist in releasing information about pending (or even completed) disciplinary proceedings.

Physicians experiencing adverse credentialing, employment, peer review or licensure results may sue a hospital and physicians who have furnished information, alleging claims including defamation, intentional interference with contractual relations or infliction of emotional distress.

In *Miller v. Tope*, a physician seeking to be licensed and credentialled in Massachusetts sued two of her residency supervisors, alleging that their responses regarding her competence defamed her. 2003 WL 22794487 (D. Mass. Nov. 24, 2003).

Notably, on summary judgment the court upheld one of the physician's claims that his communications were permissible, and rejected the other's — again illustrating the risks.

## Guidelines for exchanging information

Although the proper approach for exchanging information when permitted will depend on the specific circumstances, some general guidelines are:

1. Avoid informal communication. Outside of the specific contexts discussed above (or unless protected by a signed release), sharing disciplinary information risks liability. Informal communications, especially with regard

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## Remember that the career of the physician, as well as the health of patients, may be affected by the information provided.

disciplinary action, malpractice litigation, and any other information relevant, either directly or indirectly, to the [physician's] character or competence to practice medicine." 243 CMR 3.05(i) (emphasis added).

Several elements within this regulatory scheme may be troublesome to hospitals.

First, the regulations focus on a "pending or final disciplinary action." Although Massachusetts regulations provide a detailed definition of "disciplinary action," 243 CMR 3.02, when an "action" is "pending" is not always clear — e.g., when an investigation of a serious complaint has commenced, but there is no actual "pending disciplinary action."

Second, there is no clear guidance as to what information, in what form and by whom, can be exchanged. This becomes more challenging when a physician is under review in a patient care or quality review committee or hospital department, but no formal "disciplinary action" is pending.

If not conducted properly, hospital credentialing and peer review activities can result in large damages. See e.g. *Poliner v. Texas Health Systems*, 2003 WL 22255677 (N.D. Tex. Sept. 30, 2003) (\$266 million verdict entered against hospital and doctors who summarily suspended surgeon without proper process).

## The pitfalls of sharing too much or too little

*Kadlec Medical Center v. Lakeview Anesthesia Associates* illustrates the serious risks from providing insufficient information. 2005 U.S. Dist. LEXIS 10328 (C.D. La 2005).

There, an anesthesia group terminated a physician who failed to answer pages for 24 hours; was found asleep, apparently sedated; and was suspected of diverting Demerol. The physician moved, and Kadlec Medical



Waxman



Kraus

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# 'Children's Hospital Corp. v. Kindercare Learning Centers': last tango with ERISA

By John D. Hanify

Consider the following case, *Children's Hospital Corp. v. Kindercare Learning Centers, Inc., et al.*:

A newborn was transported from Connecticut to Children's Hospital in Boston with a life-threatening heart condition. The mother of the ill baby was a member of an out-of-state Blue Cross/Blue Shield licensee, and her employer, Kindercare, is a company with child care facilities in various states.

Regence Blue Cross of Oregon, where Kindercare is headquartered, managed her employer's plan and, as such, she was entitled to treatment for herself and her dependents through the national Blue Cross association. The association's BlueCard program joins the Blue Cross affiliates throughout the United States in a network that supports a member's health care in whatever state that member is located. During five months of hospitalization, the staff at Children's Hospital periodically spoke with Regence Blue Cross Oregon to secure authorizations for treatment.

The contractual touchstone of the relationship between Children's and Blue Cross/Blue Shield of Massachusetts is called a Health Services Agreement (HSA). In that contract, Children's agrees to provide Blue Cross members with medical services at various rates negotiated periodically and to provide up-to-date eligibility data. This contract is also the basis upon which Regence Blue Cross in Oregon could expect Children's in Boston to be providing services to one of its members.

After five months of hospitalization and repeated confirmations of authority for treatment, Kindercare discovered that this particular mother had not been paying her premiums. Almost immediately after Kindercare learned of these circumstances, it dispatched a 10-day cancellation notice to the mother and thereafter confirmed the termination of the policy. The hospital was advised that, notwithstanding the string of authorizations, the mother had an unpaid premium problem and was not actually insured.

Children's Hospital brought an action against the insurer and Kindercare for breach of contract and misrepresentation. After Children's filed its lawsuit in Superior Court, the defendants "removed," or attempted to transfer, the case to federal court, contending that ERISA completely preempted the hospital's claims. The defendants contended that the case required a federal forum and that the hospital, in fact, had no remedy under state law.

ERISA, the Employment Retirement In-



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come Security Act of 1974, was intended to protect the integrity of health and benefit plans between employers and employees. As drafted, ERISA sweeps under its aegis any claim that "relates to" an employee benefit plan. It provides that its terms "supersede any and all State laws" that "relate to" an ERISA benefit plan.

The defendants contended that any recovery against the employer or its insurer

on the efficacy of this defense in circumstances where contracts or other common law duties affect the rights of insurers and providers.

Not long after Judge Saris' decision in the Children's Hospital case, her colleague U.S. District Court Chief Judge William G. Young issued a lengthy decision on June 16, 2005 that comprehensively evaluates the state of the law with respect to ERISA preemption.

## Not long after Judge Saris' decision in the Children's Hospital case, U.S. District Court Chief Judge William G. Young issued a lengthy decision on June 16, 2005 that comprehensively evaluates the state of the law with respect to ERISA preemption.

would necessarily have the effect of imposing additional costs on the underlying "plan," or that in the process of determining the hospital's claim, the language of the plan would be implicated.

In response, Children's Hospital contended that its claims had only to do with either the hospital's contract with the insurer to provide hospital services or the direct representations made by the defendants to the hospital, and not the underlying ERISA benefit plan. Indeed, the hospital had never seen the underlying benefit plan and maintained that its terms were irrelevant to the controversy.

### 'Avalanche of litigation'

Variants of this ERISA preemption defense have resulted in "an avalanche of litigation in the lower [federal] courts" (DeBuonov NYSA, 520 US 806, 809 n.1) reflecting, in one federal judge's view, "an overzealous readiness in the federal courts to bar all state-law claims which even smell of ERISA under the broad umbrella of preemption ..." (Jones dissenting, Cromwell 944 F2 1279)

These cases have heretofore turned on an evolving interpretation of what "relates to" an ERISA plan. The broader the application of the term "relates to," the more evident it has become that almost any incidental relationship to an ERISA plan can frustrate a worthy state law claim.

In the Children's Hospital case, U.S. District Court Judge Patti B. Saris in Boston dealt directly with this question. She found that ERISA preemption was operative only when a party could have brought any of its state law claims under section 502 of ERISA and where no other independent legal duty supported any such claim.

Section 502 speaks to claims by individuals arising from denials of coverage under an ERISA-regulated employee benefit plan. The hospital's claim was not brought in the name of an individual, but was based upon a duty owed to it directly by defendants for intentionally or negligently misrepresenting the existence of coverage. Judge Saris found that the hospital's claims could not have been brought under section 502 of ERISA and that the case should be sent back to state court.

That decision appears to represent the evolved consensus now among federal courts

dorsed Saris' analysis of the scope of the term "relate to" and concluded that none of the plaintiff's state law claims "related sufficiently" to any ERISA plan so as to warrant preemption.

Young also recognized that when cases in this posture are sent back to state court, there is effectively no appeal from the order of remand. Having catalogued the decisional law supporting his and Saris' analysis, he nevertheless determined to certify the question to the 1st U.S. Circuit Court of Appeals for a conclusive determination of the issue.

### Heyday is over

The great problem with this species of ERISA defense is that its unbridled application would, and sometimes did, leave health care providers without any remedy for the damages caused by insurers or employers in failing to pay claims.

When dealing with a state law regulating how much hospitals could charge for services, one court observed that the argument that "because this regulation affects pension plans in their dealings with hospitals by increasing their costs of doing business, it must be found preempted, proves altogether too much ..."

The heyday of ERISA defenses is clearly over. This evolved and more conservative view of ERISA preemption may also hasten the further state regulation of insurance practices that promote the more efficient payment of claims since such regulation is not likely to be treated as preempted by ERISA.

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# A note from the publisher

**G**reetings and welcome to the inaugural issue of Massachusetts Medical Law Report.



Lawyers Weekly has been delivering news to the legal community since 1972. But for the first time, we have created a product that is about the law — but written specifically for the medical community.

We want to cover anything about the law that is

of interest to doctors and health-care professionals. Naturally, this will include topics such as insurance, standards of malpractice, health-care proxies, tort reform and many others.

This is a heady time for law and medicine. While national leaders call for reform of our health-care system, the law seems on the precipice of great change.

And in many ways, Massachusetts is at the apex of any debate concerning health care and the law. With the innumerable fine physicians and hospitals in this state, we feel this is a natural place to delve into the host of issues that exist where medicine and law converge.

With all the debate over health care and the intricacies of medical-malpractice law, you need the facts on your side. That's where

we come in.

In the quarterly Medical Law Report, you will receive reports on important legal decisions that you won't find elsewhere. You'll read articles written for you by leading attorneys who understand these issues. You'll read the latest on verdicts and settlements in cases that otherwise might have flown under your radar screen.

But that's just a start. We want to hear what you want to know about the convergence of law and medicine. So talk to us. E-mail me directly at david.yas@lawyersweekly.com and let me know what direction you'd like Medical Law Report to take.

Thanks for reading. Please enjoy — and make use of — this new publication.

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Join Solomon McCown & Company and Massachusetts Lawyers Weekly as we examine the current place for the public apology with:

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## Good Business

Means Sometimes Having to Say I'm Sorry

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# Fraud and abuse: the Final Stark II Phase II regulations

By Dean P. Nicastro and William M. Mandell

**F**ifteen years after Congress passed the first Stark Law generally barring physicians from referring patients or specimens for Medicare-covered tests to clinical labs with which they had a financial relationship, the Center for Medicare and Medicaid Services (CMS) has issued a set of final regulations intended to clarify the rules on physician self-referral across a wide range of delivered health care services.

These regulations, known as the Final Stark II Phase II regulations, can be found on the CMS website at <http://www.cms.hhs.gov/medlearn/refphys.asp>. They became effective July 24, 2004.

## General Stark overview

Congressional legislation in the early '90s expanded the scope of Stark to include nine other categories of health care services, so that regulatory scheme now limits physician self-referrals in the following 10 categories, collectively known as "designated health services" (DHS): clinical laboratory services physical therapy, occupational therapy and speech language pathology services radiology and imaging services radiation therapy services and supplies durable medical equipment and supplies parenteral and enteral nutrients, equipment and supplies prosthetics, orthotics and prosthetic devices and supplies home health services outpatient prescription drugs inpatient and outpatient hospital services

As this list suggests, the regulations cover the "waterfront" of health care services for which physician referrals are the gateway. The addition of referrals of hospital services as a DHS makes virtually every hospital-physician financial relationship subject



Nicastro



Mandell

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to Stark.

Furthermore, any medical practice — even solo practices — that bills Medicare or Medicaid for one or more categories of DHS are subject to Stark.

The Stark law and regulations prohibit physicians from making referrals of DHS covered by Medicare or Medicaid to entities with which they (or their immediate family members) have a "financial relationship," unless the arrangement falls within a stated exception.

"Financial relationship" is defined to mean an ownership or investment interest or a compensation arrangement. These interests or arrangements can be either direct or indirect. The entity that furnishes the DHS is also barred from billing for payment for such services.

The Stark rules constitute a separate, but interconnected part of the federal government's regulatory arsenal for dealing with fraud and abuse in the health care system.

They are a companion to other enforcement tools such as the Anti-Kickback Law, the False Claims Act and the Qui Tam ("whistle-blower") provisions. Each state also has its own set of fraud and abuse laws that often include anti-kickback and physician self-referral or anti-fee-splitting provisions.

Violations of Stark can result in denial and recoupment of claims for payment to the billing practice, facility or other DHS provider, or civil money penalties (CMPs) up to \$30,000 per claim that can be imposed upon the referring physician or the DHS entity.

Flagrant violators of Stark, including physicians, can also be subject to CMPs of up to \$100,000 per violation and/or exclusion from the Medicare and Medicaid programs.

## Exceptions to the physician self-referral prohibition

Any known financial relationship between

a referring physician and a DHS entity that is subject to Stark must come within one of the exceptions provided in the Final Stark II regulations in order to avoid a violation of the law.



within any of the other Stark exceptions, is that the compensation arrangement must either meet an anti-kickback safe harbor, or be specifically approved by the OIG in a favorable anti-kickback advisory opinion, or otherwise does not violate the federal anti-kickback law.

Knowing whether a payment to a physician is "fair market value" is prone to differing opinions under the anti-kickback law. Because most parties do not want to go to the expense and delay of seeking an advisory opinion, this leaves huge uncertainty in terms of Stark compliance for any such physician-financial relationship.

Among exceptions worthy of note are those in the general exception category for "in-office ancillary services" and for academic medical centers.

The in-office ancillary services exception will apply to almost all DHS rendered by a solo or group practice, provided the service is furnished personally by the referring physician, another physician in the group, or an individual (e.g., a physical therapist) supervised by the referring physician (or supervised by another physician in the group) under the level of supervision required under Medicare's payment and coverage rules.

The DHS must also be furnished in the "same building," defined to require alternative various particulars for the physician's professional presence on the premises on either a full-time or part-time basis; in the case of group practices, the DHS can be furnished in a "centralized building" used by the group to provide some or all of the group's DHS.

The in-office ancillary services exception contains certain specifications for billing as well. Any group of physicians providing in-office ancillary services covered by Stark must also meet the Stark requirements to be a group practice. These are very detailed and serve to require a truly integrated group operating out of one legal entity for most situations.

The Stark rules lay out three categories of exceptions to the self-referral ban: general exceptions applying to both ownership/investment interests, exceptions applying to ownership/investment interests only, and exceptions applying to compensation arrangements only.

The exceptions were drafted by CMS with the intention of creating clear "bright line" tests. However, the application of several of the exceptions in the Final Stark II regulations to particular common fact situations is open to some degree of uncertainty.

A number of the exceptions are predicated upon compliance with the federal anti-kickback laws and other state and federal billing and claims submission statutes and regulations.

To the extent compliance with these cross-referenced laws and rules is not certain, confirmation of Stark compliance is left uncertain.

For example, one of the conditions to meet the Stark fair market value compensation exception, which can protect physician compensation arrangements that do not come

*Continued on page 14*

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# News Briefs

## Bill limiting damages in med-mal cases OK'd

Before its summer recess, the U.S. House of Representatives approved a bill that would cap noneconomic damages in medical malpractice cases to \$250,000 for plaintiffs, according to the Washington Times.

The medical tort reform bill, which was approved 226-201, is the third version to pass the House in the past three years. The previous two measures died in the Senate.

Republican sponsors of the bill said they hope their party's majority in the Senate will get the legislation to President Bush, who has supported medical tort reform initiatives.

"We are losing too many good doctors from the skyrocketing cost of medical liability insurance premiums and the rise in frivolous lawsuits," said Rep. Phil Gingrey, Georgia Republican and sponsor of the bill.

But Democratic lawmakers and trial lawyers said the bill would limit accountability in the health care industry and reduce the number of legitimate malpractice cases being brought to court.

But Gingrey argued that his bill does not stop injured patients from bringing malpractice cases against doctors, hospitals or medical product manufacturers, which include pharmaceutical companies.

The bill only limits noneconomic damages, the so-called pain and suffering, Gingrey said, and does not cap economic damages such as lost wages and medical bills.

The bill also reduces punitive damages to no greater than twice what the patient receives for economic damages.

## Electronic medical records are hard sell

Electronic medical records could improve patient care and possibly save billions of dollars, yet many doctors aren't investing in the technology because they may not reap the savings — insurers and the government will, researchers report.

It's one of several pitfalls blamed for slowing adoption of computerized medicine in a collection of provocative, sometimes conflicting studies published Sept. 14, 2005 in the journal *Health Affairs*.

No more than a quarter of U.S. hospitals and 20 percent of physician offices have

## Justice Department limits prosecution under HIPAA

The Department of Justice has issued a memorandum limiting the parties who can be prosecuted directly under the Health Insurance Portability & Accountability Act.

Under HIPAA, "a covered entity may not use or disclose protected health information, except as otherwise permitted or required."

Covered entities include health care providers, health plans — including insurance companies and HMOs — and health care clearinghouses, such as billing services for physicians.

The guidance limits those who can be prosecuted under HIPAA to including covered entities and, "in limited circumstances," managers of those entities.

Under the memo, other individuals — such as employees — may not be prosecuted under the criminal penalties of the HIPAA privacy rule.

However, the memo clarifies that "conduct that may not be prosecuted under [the criminal enforcement provision of HIPAA] directly may be prosecuted according to principles either of aiding and abetting liability or of conspiracy liability."

The law is Public Law No. 104-191, the "Health Insurance Portability and Accountability Act of 1996."

You can read or print the full text of the memorandum and the law in the "Important Documents" section of Lawyers Weekly USA's website: <http://www.lawyerweeklyusa.com/subscriber/treas.cfm>

adopted electronic medical records, the RAND Corp. found. Usually, they're hospital or doctor-specific, not easily transferred and read by other health care providers.

RAND researchers set up a statistical model to predict the possible savings from such health care improvements and from improved business efficiency, such as eliminating redundant care and shortening hospital stays, if 90 percent of hospitals and doctors ultimately adopted such a network.

A conservative estimate came to \$81 billion a year, \$77 billion from improved efficiency and \$4 billion from reduced medication errors and side effects, RAND lead researcher Richard Hillestad said.

Replacing paper records with such a connected electronic network would take about 15 years and cost hospitals about \$98 billion and physicians about \$17 billion, Hillestad estimated.

But another study from the University of California, San Francisco, found the technology not as expensive. Among 14 single or small-group physician practices, the average spent about \$44,000 per full-time provider to establish an electronic medical records system and about \$8,500 a year to maintain it, money recouped within 2 1/2 years.

Most of the hoped-for improvements from

electronic medical records are still hypothetical, cautioned David Himmelstein and Steffie Woolhandler of Harvard Medical School.

Moreover, nobody yet knows what computer features doctors should buy. A third study from Brigham and Women's Hospital, said that in addition to record storage, systems should include electronic viewing of test results, paperless prescriptions, electronic claims submissions and secure patient e-mail.

But such systems will be useless unless the records can be shared between doctors and hospitals.

To help establish standards, Health and Human Services Secretary Michael O. Leavitt named a 16-member commission of representatives from hospital, doctor, insurance, government and patient-advocacy groups.

## Seniors urged to sign up for drug benefits

With the federal government's new prescription drug benefit program slated to begin Jan. 1, state and federal leaders acknowledged that despite an extensive outreach program, there may be some seniors who do not sign up and receive the benefits to which they are entitled.

U.S. Secretary of Health and Human Services Michael Leavitt and Gov. Mitt Romney said they are doing everything they can to inform seniors about the new program prior to Nov. 15, when a six-month enrollment period begins.

Romney, who believes 1 million state residents will sign up for the new prescription drug benefit under Medicare, said a "team" of administration officials has been working to get information to seniors and others eligible.

Massachusetts state government currently administers its own prescription drug insurance program called Prescription Advantage, with roughly 100,000 residents enrolled, Romney said. With the institution of the federal program, Romney said Prescription Advantage will act as a "wraparound" to ensure recipients don't lose any benefits under the Medicare program.

Supporters of Prescription Advantage and Democratic critics question whether the new federal program will be able to meet the needs of seniors, and have pushed to have more generous benefits included in the package.

Financially, Romney said, he believes the state will break even in rolling out the new program this year, but eventually save money by not having to pay for the more generous Prescription Advantage program.

## Changes made to 'free care' program

Gov. Mitt Romney's administration, which recently launched an initiative to help all residents get health insurance, is changing the rules for a "free care" program that advocates say will make it harder for the uninsured to get health care.

The administration has proposed that effective Oct. 1, hundreds of thousands of uninsured residents would have to pay \$3 to \$5 co-payments toward their medical care, a move some say will scare off poor residents, according to *The Boston Globe*.

Also, some patients who get services through the state's free care program, but have other options for coverage, would be excluded, and prescription drug coverage for all uninsured would be restricted.

Administration officials said the moves are designed to ensure that the free-care program is not more attractive than MassHealth, the state's Medicaid insurance program for low-income patients. They want to encourage more people to enroll in MassHealth because costs are shared by the state and federal governments, *The Boston Globe* reported.

Financing of the free-care program comes from taxpayers, hospitals and health insurers. The cost this year is \$502 million.

## Study: malpractice rates rise, payouts flat

Rates for medical malpractice insurance rose dramatically over the past five years, but the amount insurers paid out in claims did not, according to a study from a consumer advocacy group.

The study, released July 7 by the Center for Justice & Democracy, found that malpractice rates increased by 120 percent from 2000 through 2004, while the amount of money paid in claims went up by 5.7 percent.

"This is wacky," said Jay Angoff, a former insurance commissioner in Missouri during the 1990s and the primary author of the study. "Now what's the insurance companies' defense to this?"

Researchers looked at annual statements filed with state insurance departments by the nation's 15 largest medical malpractice insurers.

The report also found that the leading insurers increased their surpluses — money accumulated beyond what they anticipate needing to pay future claims — by a third.

"The extra cherry on top for the industry, and the extra knife in the gut for doctors, is not only did claim payments go down ... the companies also added to their surpluses" Angoff said.

Consumer advocates and public officials said the study has the potential to recast the often bitter debate about who is responsible for rising malpractice rates: doctors, trial lawyers or the industry.

Insurers were critical of the study's methodology, saying that it failed to take into account other costs insurance companies face, such as underwriting. Larry Smarr, president of the Maryland-based Physician Insurers Association of America, said if those costs had been included, it would have shown a much different picture of the companies' finances.

Because it takes time for claims to materialize and be paid, companies must collect premiums based on future cost expectations, he said.

"We know it takes on average 4½ years from when an accident happens until a claim is paid," Smarr said. "Comparing the premiums collected today with the claims that were incurred as long as 10 years ago is a totally inappropriate comparison."

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# Fraud allegation won't save 'late' med-mal suit

## Complications at birth led to disabilities for plaintiff

By Lisa K. Bruno  
lisa.bruno@lawyersweekly.com

A minor and his mother could not sue a physician and a nurse for injuries the minor allegedly sustained during birth more than eight years after the date of delivery, even though the plaintiffs claimed the defendants had fraudulently concealed the cause of action, a Superior Court judge has held.

The plaintiffs contended that the defendant medical providers had suspended the applicable statute of repose — which limited the duration of liability to seven years — by falsifying medical records, which effectively prevented the filing of the suit until after the statute's expiration.

Although he acknowledged the "harsh result" produced by the statute of repose, Judge Kenneth J. Fishman disagreed and dismissed the negligence claims.

"This Court concludes that the decision reached in this case is compelled by Massachusetts precedent and the intent of the Legislature of this Commonwealth," he stated. "Our courts have clearly stated that a statute of repose cannot be tolled for any reason, and our Legislature is willing to tolerate a certain degree of inequity in order to realize the goals behind a statute of repose."

### Ripe for review

Doyle C. Valley of Boston, who represented the defendant physician, observed that whether or not the statute of repose applicable to medical malpractice claims could be suspended (or "tolled") was an issue that the commonwealth's appellate courts had not yet addressed.

While an earlier Superior Court ruling had concluded that a claim of fraudulent concealment tolled the statute applicable to architects and contractors, he explained, the present case differed from that precedent because of the Legislature's intent to provide a "bright-line" limitation to the liability of medical providers.

The statute of repose was enacted in response to the adoption in medical malpractice suits of the discovery rule, which provides that a cause of action does not accrue until a patient learns, or should have learned, of a harm caused by the negligence of a medical provider.

"By allowing the plaintiffs to recast their argument as a fraud action would be contrary to the scheme the Legislature developed," Valley said.

He called the ruling a "good step" towards providing medical providers with some comfort, but cautioned that until an appellate



court rules on the issue, medical practitioners cannot "breathe a complete sigh of relief."

Observing that statutes of repose have not been the subject of much litigation, Douglas

N. Perlo of Boston, counsel to the defendant nurse, said he was pleased to see the ruling give the statutes their intended meaning, as well as "some bite."

With respect to the statute relating to claims brought by adults, he remarked that he had never before seen its applicability to nurses questioned, and described the decision as one of "huge" significance.

"It was very important that Judge Fishman ruled that it would be an inharmonious result to have a statute of repose applicable to the minor plaintiff suing the nurse, but not to the mother," he commented.

Elizabeth N. Mulvey of Boston, who with Philip J. Crowe Jr. represented the plaintiffs, noted that an open question remained as to whether or not the statutes were tolled by the allegations of fraud.

"If this stands up, what you're saying to doctors is, the better job you do of falsifying records, the more likely you are to get away with it," she said. "That doesn't seem like a very good public policy and it doesn't sound very fair to the victim of the malpractice."

The plaintiffs intend to appeal the decision, reported Mulvey, who agreed that the issue was ripe for appellate review.

"Having read and lived through the history of the statute of repose, I believe what it was intended to do was to impose an outer limit on the discovery rule," she stated. "I really don't believe that it was meant to address a situation involving fraud."

### Incomplete records

Sharon Judkins, the plaintiff, gave birth to Andrew Chace, the minor plaintiff, on Sept. 22, 1995, at Holy Family Hospital in Lawrence.

During the course of his birth, there were signs of a prolapsed cord, which presented a danger to the unborn child. As a result, a Caesarean section was performed.

Upon delivery, Andrew was attended to by the defendant nurse, Ann Taylor, the defendant physician, Arlene Curran, and nurse Shelagh Galvin. The three undertook resuscitative efforts on Andrew, and the plaintiffs alleged that during this treatment the defendants were negligent and caused Andrew injuries, resulting in multiple severe physical and mental disabilities.

In March 2001, the plaintiffs filed a complaint against the obstetrician who delivered Andrew. During discovery in that suit, Galvin allegedly revealed that the medical records prepared by the defendants immediately after the birth were inaccurate and incomplete in material ways.

Specifically, she testified that an endotracheal tube was not recognized, and as a result, Andrew did not receive oxygen for several minutes after his birth.

Following this revelation, the plaintiffs filed the present suit. The defendants moved

*Continued on page 16*

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# Medicare's new drug and health plan program: your privacy or your life?

By James M. Jacobson

For the vast new Medicare drug and health plan program to succeed when fully rolled out in four short months, seniors and the disabled need to understand their options well enough to sign up for the drug benefit and elect health plans that can coordinate their care, provide preventive services, and offer all of the other cost and quality improvements over traditional fee-for-service Medicare.

Yet, the Center for Medicare and Medicaid Services (CMS), by its own repeated admission, lacks the resources and ability to educate and counsel Medicare enrollees on their

**The Center for Medicare and Medicaid Services should move immediately to rewrite its thousands of pages of guidances, FAQs, Q&As and guidelines to ensure that it does not continue to exalt health privacy over health care.**

options, and even its hundreds of millions in television ads won't change that a whit.

By all accounts, the only effective means of conducting outreach and enrollment is through the private sector sources with the strongest community relationships with patients and their families, and the best track record of coordinating their care: providers and health plans.

Yet these are precisely the entities that are most HIPAA-hamstrung. After churning out thousands of pages of HIPAA privacy "protections," the Bush health care agencies have



James M. Jacobson is a partner in the national health law group at Holland & Knight in Boston. He co-chairs the firm's national health law team and chairs H&K's managed care team.

recently pumped out tens of thousands of Medicare Part C (Medicare Advantage health plans) and Part D (Prescription Drug Plan) regulations, guidances and FAQs.

But they have yet to reconcile the two behemoths, despite two years of preparation time, and even though up to \$700 billion and the health of America's elderly depend upon it.

For example, even after CMS's publication of yet another 154 pages of guidance on Aug. 15, 2005, this time specifically devoted to marketing, outreach, education and enrollment, it is still arguably illegal — in fact, criminal — for physicians and other providers to disclose identifying information about their fee-for-service patients to Medicare Part C and Part D plans so they can conduct outreach and education efforts.

Yes, under the new marketing guidelines, physicians and plans are permitted to describe these new programs to their current patients, but that is next to useless. Physicians have no time or resources, and the guidelines permit them no financial incentive, to research the best new plans, master the details of their benefits and convey them to their patients.

Health and drug plans, on the other hand, have plenty of incentive, expertise and resources, but no relationship with the Medicare fee-for-service beneficiaries who could benefit the most, and thus no contact data.

Therefore, a Medicare fee-for-service patient with, for example, congestive heart failure (the most expensive of all Medicare Diagnosis Related Groups) is unlikely ever to know that there is a special needs PPO right in her back yard that specializes in meeting all of her specific care coordination needs: a 24/7 nurse call line; specialty centers of excellence devoted to congestive heart failure care; free remote monitoring devices to track water weight gain and other indicators of decompensation; and a personal health record that combines all of her primary care, specialty, hospital, drug, lab, imaging and pharmacy info in one place so that medical errors from fragmented care won't kill her in an emergency.

Interestingly, these are the very tools, offered only by the new plans and not by Medicare fee-for-service, that the Institute of Medicine in its seminal book, "Crossing the Quality Chasm," considers the most critical both to improving seniors' health and to maintaining fiscal control. And these tools depend entirely upon the free flow of health information between providers and plans.

Understandably, no senior wants to hear from a health plan trying to sell a policy at



dinnertime, let alone a drug company. But seeing it from the trenches, with the best educational and outreach data my clients can provide, I am convinced that contacting seniors by telephone is the only successful route to informing them fully.

Health and drug plans can only do so if CMS expressly permits providers to divulge phone numbers and plans to use them. Medicare enrollees, especially the frail or institutionalized elderly, simply will not read mailers, call hotlines or otherwise proactively opt into contact lists and volunteer their information to plans.

Of course, we would all agree that plans should only be able to call at certain times,

use certain scripts, obey do-not-call registries, permit people to opt out, and avoid any hard-sell tactics or kickbacks.

But do we really need hundreds of pages of new guidelines that focus more on how CMS's name and logo should look on plan mailings than on how to ensure patients get the best care?

CMS should move immediately to rewrite its thousands of pages of guidances, FAQs, Q&As and guidelines to ensure that it does not continue to exalt health privacy over health care.

That is a laudable goal on which, I trust, liberal Bush Republicans and conservative Clinton Democrats can all agree. MMLR



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# Responding to the Board of Medicine: Don't go it alone

By Paul R. Cirel

"Who are those guys, anyway?"

Those of us old enough to remember "Butch Cassidy and the Sundance Kid" (yes, I mean the movie), will recall a frustrated Butch posing that question to the Kid, as they tried in vain to shake the pursuit of a posse that seemed capable of tracking them anywhere.

These days, as the Board of Registration in Medicine increases its investigations and disciplinary actions against physicians, I find many of my clients asking the same question. Here is a brief and perhaps sobering primer — with a few observations thrown in along the way — about who "those guys" are, what they do, and how they go about it.

Massachusetts has had a Board of Registration in Medicine for over 100 years. The board has seven gubernatorially appointed members: five physicians and two representatives of the general public — usually, lawyers.

As part of its oversight authority, the board establishes standards for licensure and risk management; serves as the main repository of data for incident reports and malpractice cases; and maintains and publishes physician profiles.

But its primary focus is revealed in the opening lines of the law that describes its duties and responsibilities and makes clear that the board is first and foremost a policing agency, one that also happens to have an awful lot of data about all of its usual suspects.

## Complaints and statutory reports

Complaints get to the enforcement division from two main sources: unsolicited communications, usually from patients or their relatives; or, more commonly, from mandated reports initially filed with the board's data repository unit, but then passed on to the enforcement division for investigation.

In the lexicon of the board, only the former are called "complaints"; the latter are termed "statutory reports." While the board investigates both complaints and statutory reports through what it calls its complaint process, the distinction between "complaints" and "statutory reports" is not without a difference.

By law, all investigations remain confidential during their pendency. However, once an investigation is completed — even if the matter is dismissed and the case is closed — complaints become a matter of public record. Statutory reports on the other hand, are always confidential.

The practical effect of that can be seen during the annual routine of recredentialing, which inevitably includes the question: "Has a complaint been filed against you?" A yes answer is a red flag that demands at the very least more disclosure and explanation. Unfortunately, many physicians answer "yes" incorrectly, because they are not advised that what they thought was a complaint was, in reality, a statutory report.

Ironically, complaints tend to be less meritorious than statutory reports. Many are without medical foundation, others are about bedside manner, while still others are, frankly, from chronic complainers.

Statutory reports present a far different story. They come to the board from mandated reporters in specifically identified circumstances. Accordingly, a physician should almost never be surprised that a report has been filed with the board.



Paul R. Cirel is a partner at Dwyer & Collora in Boston and focuses his practice on the representation of health care professionals including individual practitioners, corporate providers and group practices.

## Reporting process

The variety of statutory reports that could trigger the complaint process begins with the physicians themselves, who are required to renew their licenses every two years using board prescribed forms.

Those forms require disclosure of, among other things, pending or settled malpractice claims or actions, criminal charges and disciplinary actions, restrictions or limitations regarding the ability to possess or prescribe controlled substances and any non-malpractice lawsuits relating to the practice of medicine. Each of these events is potential fodder for an enforcement division investigation.

Disciplinary action reports from hospitals, other licensed health care facilities, HMOs and professional societies are another prime source for board inquiries. Physicians should be aware that reports of current or ongoing discipline (for example, a period of supervision, or a restriction on the exercise of certain clinical privileges), generally draw the prompt attention of the board.

As a result, special consideration should also be given to documenting and reporting remediation, which will likely have a substantial effect on the board's assessment of whether its intervention is necessary.

Reports of malpractice cases come to the board in ways other than license applications and renewals. The clerk of courts is required to give the board notice of any finding by a malpractice tribunal, along with a copy of the civil complaint. When that case is concluded, whether by judgment, settlement or dismissal, the clerk must notify the board again.

Regardless of the outcome, liability insurers are also required to notify the board upon the final disposition of "any claim or action" that alleged malpractice. The reference to both claims and actions means that insurers are required to report settlements even when no lawsuit was formally filed.

In addition to malpractice actions the clerks of court must also report information on criminal cases to the board. Specifically, the criminal clerks must notify the board any time a physician pleads or is adjudged guilty of any crime. That reporting obligation is independent of whether the crime in question is related to the practice of medicine.

In addition to convictions, the board is also notified of all pleas of nolo contendere or even when a physician accepts a continuance without a finding. In that regard, physicians — and especially their counsel — should expect that the board's prosecuting attorneys will seek to obtain a transcript of the proceedings from the court.

Physicians should also be aware of their own obligation to report the conduct of colleagues which they reasonably believe violates the board's rules or regulations.

That obligation does, however, provide exceptions for privileged information, such as matters learned in the course of psychotherapy or peer review proceedings. Physicians are also relieved of their obligation to report colleagues who they believe to be impaired by alcohol or substance abuse, if the impaired physician is actively receiving treatment.

All board investigations are conducted with an eye toward determining whether the physician's conduct violates one of the board's myriad disciplinary standards. The board regulations currently identify 18 separate grounds for discipline, with the added caveat that the list is not intended to be exhaustive.

On the non-clinical side, the list includes the fraudulent procurement of a license, conviction of a crime, misconduct, drug or alcohol dependency, practicing medicine fraudulently or with the intent to deceive and failure to respond to the board's request for information. Massachusetts courts have also sustained the board's imposition of discipline for lack of good moral character and conduct that undermines public confidence in the medical profession.

The board's most commonly invoked basis for discipline on the clinical side is conduct

which places into question the physician's competence to practice medicine.

## Investigatory process

Whether initiated by a complaint or by a statutory report, the board generally commences its investigation with a letter to the physician asking for a written response to the conduct or circumstances in question. Responses to such requests are not optional. In fact, as previously noted, failure to reply to the request is itself a sanctionable offense.

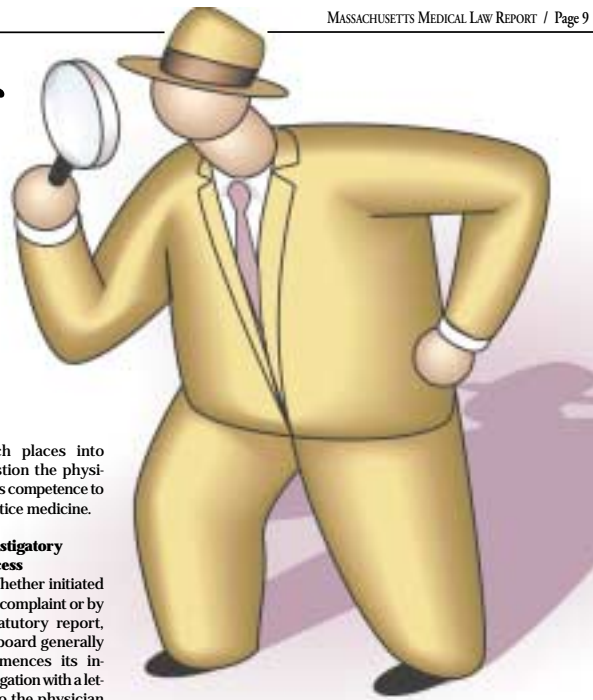
The board's investigative methods are hardly limited to seeking responses from licensees. Staff can conduct witness interviews, both at the board's offices and in the field.

More significantly, the board has investigatory subpoena authority and can therefore summons recalcitrant witnesses to the board,

and require the production of documents. Medical records produced to the board are examined in-house by nurse/investigators and are often sent out for expert review.

As should be evident, the design and execution of the complaint investigation process is adversarial, and no response should be attempted without the advice and assistance of experienced counsel. Indeed, should the physician later be invited to appear before

*Continued on page 13*



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# Verdicts & Settlements

## Patient loses leg after knee surgery

\$1 million settlement

On Jan. 12, 1999, the plaintiff was admitted to Baystate Medical Center as a patient of the defendant doctor for a right knee arthrodesis.

In his operative report, the defendant detailed the surgical procedure which included isolation of the patella, application of a plate with screws fixed to the femur and tibia, additional fixation with cannulated screws, release of the surgical tourniquet for ten minutes. There was a notation of a "significant amount of blood" and "lots of clots," loss of several hundred ccs of blood, administration of a unit of the plaintiff's blood and "oozing of blood" for "still another 30 minutes or so while closure was being accomplished and cauterization was being done."

The note also reflected that the plaintiff awoke, "looked somewhat pale" and that there "was a moderate to marked loss of blood after the tourniquet was let down" with blood loss possibly up to one liter.

After the surgery, over the course of the next few hours, the plaintiff was noted not to have any sensation in her toes or on the top of her right foot. After a vascular consult, when no dopler pulses were present below the plaintiff's right knee, an emergency arteriogram was ordered. The diagnostic impression was that a transection of the popliteal artery had occurred. As a result, the plaintiff was taken back to the operating room for emergency surgical repair by a vascular team.

The emergency surgery revealed a transected popliteal artery and vein with subsequent compartment syndrome. At the conclusion of the surgical repair, the wound on the ankle as well as the wound on the right calf were left open for drainage due to the severe swelling and fear of further compression. These fasciotomies required substantial wound and surgical care, and the plaintiff underwent weeks of physical and hydrotherapy treatment followed by further home nursing and hygiene care for eight to 10 months thereafter.

Throughout this period of recovery and continued care, the plaintiff had no active movement and very little sensation of her right foot. Following a long, painful treatment and non-recovery process, and with the input of multiple physician opinions, including the plaintiff's new orthopedic surgeon, the plaintiff was advised to undergo amputation of her right foot with a plan for prosthetic replacement due to the persistent presence of necrotic tissue.

The plaintiff experienced wound healing problems with her amputated stump which became ischemic due to necrotic tissue over the stump, and as a result she was forced to undergo another surgery for further amputation just below the right knee.

The plaintiff began using a right lower leg prosthesis while ambulating with the aid of two crutches. However, she then began to experience high fevers, increased pain and infection drainage about her right lower leg stump, which required additional hospitalization and high doses of pain medication.

Due to continuing infection, including the question of infectious involvement with the previously surgically placed right knee plate, the plaintiff underwent surgery to remove the orthopedic right knee hardware. The plaintiff was taken back to surgery for tissue debridement but was ultimately required to undergo a further above the knee right leg amputation.

The plaintiff presented the report of Gregory Brick, M.D., an orthopedic surgeon, who noted that the operative note prepared by the defendant indicated that the amount of bleeding documented was excessive and should have alerted the defendant to an arterial or venous injury at the time that the surgery was being performed.

In Dr. Brick's opinion, the defendant's failure to investigate the excessive bleeding at the time of the operation, which indicated

## Woman addicted to anti-anxiety meds commits suicide

\$600,000 settlement

The decedent was a married woman with two young children who had a past psychiatric history notable for depression and anxiety. Her prior psychiatrists noted difficulties managing the amount of psychiatric medications she took.

The decedent's psychiatric problems contributed to problems in her marriage, so she and her husband tried marriage counseling. The counseling did not help, in large part because the marriage counselor became engaged in a personal and physical relationship with the decedent. When the affair ended in 1993, the decedent became extremely depressed, and there were concerns that she might be suicidal.

The decedent's psychiatrist at the time recommended hospitalization. When the decedent was discharged from that admission, she began treating with the defendant psychiatrist who continued to treat her over the next several years. The defendant prescribed medications for the decedent's anxiety and depression.

In the summer of 1996, the decedent and her husband separated. The decedent attempted suicide and was again hospitalized. At the time, the decedent became addicted to her medications, particularly the Ativan that the defendant prescribed.

In 1997, the defendant continued to see the decedent, including six or seven visits through October 1997. By this time, the decedent had been divorced and continued to have a number of psychiatric issues. She also continued to be dependent on her Ativan.

In addition to the in-person therapy visits in 1997, there were numerous records of telephone calls regarding the prescription of medications. The decedent would frequently call the defendant requesting more medication, and the defendant would frequently call the pharmacy to authorize a further prescription. The telephone encounters included calls regarding Ativan.

The decedent's last in-person visit with the defendant took place in October 1997. The plaintiff offered evidence that, by this time, the defendant had become extremely frustrated with the decedent's lack of progress. However, the defendant continued to prescribe Ativan, among other medications, over the telephone, but did not see the decedent that November or December.

an arterial laceration, and his failure to treat the arterial laceration in a timely fashion caused irreversible damage to the muscles and soft tissue of the plaintiff's right leg. As a result, the plaintiff required multiple major surgical procedures, including an amputation of the plaintiff's right foot, an amputation below the right knee and, ultimately, an amputation above the right knee.

Injuries alleged: Amputation right above the knee

Name of case: Fairbanks, et al. v. Grant Court/case #: Hampden Superior Court, No. HDCV2002-0026

Tried before judge or jury: N/A (settled)

Special damages: \$590,051

Amount of settlement: \$1 million

Date: June 2005

The defendant denied any such frustration and noted that every prescription was preceded by a detailed telephone conversation. He pointed to historical periods of time reflected in the records in which phone consultations took place without any problem, often the result of missed or canceled appointments by the decedent after the defendant had tried to make appointments. The defendant and a defense expert also testified regarding numerous recommendations for further therapy and treatment that the decedent declined to follow.

On Jan. 6, 1998, the decedent called the defendant without success. Despite having received a prescription for Ativan the day before, the decedent was seeking still more of the medication. After several attempts to reach the defendant, the decedent attempted to obtain her medication from the pharmacy directly, by impersonating the defendant. The pharmacy did not fill the false prescription and called the defendant.

The defendant finally received the decedent's telephone messages, as well as those from the pharmacy, and called her back around 7 p.m. The decedent was at home, with her reverend, who she had called in an agitated state. The defendant spoke with both the decedent and the reverend over the telephone. The reverend told the defendant that the decedent had been agitated when he first found her and that he would take her wherever the defendant instructed him to go, including an emergency room or inpatient psychiatric treatment facility.

The defendant told the reverend that she would have medication delivered if he would agree to pay for it, give it to the decedent and see her to bed.

The reverend agreed and gave the decedent the medication when it arrived. The decedent went off to bed and the reverend left. Later, however, the reverend received a call from the police department reporting a break-in at the church. When he arrived at the church, he found that it was the decedent who had been seen trying to gain access to the church. The reverend assured the police that it wasn't a criminal matter, and the police agreed to follow the decedent home.

According to telephone records, after getting home the decedent placed a final call to the defendant. The phone records indicate that the lines were connected for approximately five minutes, but the defendant testified that she did not get this

call and did not know about it until she got her messages the next day. The defendant's records regarding the call indicated that the decedent had said that she had gone to see the reverend at the church, had tried to climb through the window to get in and that the police had come to the scene.

The next day, however, the decedent was found dead in her home with one end of a leather strap around her neck and the other at the top of a ladder leading up to a loft space. The cause of her death was hanging.

A jury trial lasted six days. The plaintiff claimed that the decedent's psychiatric condition had deteriorated as of Jan. 6, 1998, as evidenced by her numerous telephone calls and her attempt to call in her own prescription.

The defendant maintained that the frequency of calls was not unusual for the decedent and that neither her messages nor her demeanor over the telephone raised any concern about suicide. The defense offered evidence that there are thousands of suicides annually that do not show any warning signs to families or health care practitioners.

The defendant further argued that neither the reverend nor the police felt the decedent was at risk to harm herself, based on their observations. However, plaintiff's counsel obtained concessions from every medical witness that her attempt to get into the church was a new, risky behavior that warranted in-person psychiatric evaluation. Plaintiff's counsel argued that the defendant's lack of action confirmed the plaintiff's evidence that the defendant had become frustrated with the decedent and had, in fact, given up on her.

Prior to trial, there had been no settlement offers and the case was designated a "no pay" case. After the jury had deliberated for approximately three hours, the defense made its first settlement offer. Negotiations ensued and the case settled before the jury returned a verdict.

Injuries alleged: Wrongful death, suicide

Name of case: Wittheld

Court/case #: Wittheld

Tried before judge or jury: Jury (case settled during jury deliberations)

Amount of settlement: \$600,000

Date: June 2005

Attorneys: Adam R. Satin and Ursula Knight, Lubin & Meyer, Boston (for the plaintiff)

Demand: \$1 million  
Highest offer: \$1 million  
Most helpful expert: Gregory W. Brick, M.D., Boston  
Attorney: Nancy Frankel Pelletier, Robinson Donovan, Springfield (for the plaintiff)

## Man dies of sepsis

\$250,000 settlement

The plaintiff's decedent, a 76-year-old, had a G-tube insertion for dysphagia following encephalitis. Two days after transfer to a rehabilitation facility, the G-tube, which had become dislodged, was reinserted by the defendant nurse contrary to physician's orders. An X-ray was obtained with contrast,

which was read by the defendant radiologist as showing proper placement of the tube in the stomach.

The plaintiff's decedent became extremely ill over the next few days, was re-admitted to the hospital and died of sepsis two weeks later. After his death, the X-rays were re-read by the defendant radiologist's associate who reported the G-tube as intraperitoneal, not in the stomach.

The defendants were expected to argue that chronic medical history, including asbestosis, interstitial pulmonary fibrosis, coronary artery disease and myocardial infarction would have severely limited the plaintiff's decedent's life expectancy, even if he recovered completely from encephalitis and accompanying pneumonia.

The case settled prior to depositions taking place.

# Verdicts & Settlements

**Injuries alleged:** Death  
**Name of case:** Withheld  
**Court/case #:** Withheld  
**Tried before judge or jury:** N/A (settled)  
**Amount of settlement:** \$250,000  
**Date:** June 23, 2005  
**Attorneys:** Barry D. Lang and Zachary B. Lang, Barry D. Lang, M.D. & Associates, Boston (for the plaintiff)

## Plate misaligned in arm during surgery \$165,000 settlement

The plaintiff, a 50-year-old resident of Pennsylvania, was camping in Massachusetts when a large dog from the adjacent campsite charged her, causing her to fall and fracture the ulna in her left arm.

A local doctor performed surgery to reset the broken arm with the insertion of hardware.

The plaintiff traveled home to Pennsylvania and saw an orthopedic surgeon one week later regarding her ongoing pain. The doctor opined that the position of the bone fragments was unacceptable, the screws had not been turned completely to the plate, which was undersized, and another screw had penetrated the joint.

The doctor performed surgery one week later and found that the plate was misaligned and "flopping around" due to the initial failure to tighten the screws.

The plaintiff's expert contended that while there was no question the plaintiff would have had some reduction in range of motion of her elbow, her significant loss of pronation and supination was due to the negligent act of the doctor in Massachusetts.

**Injuries alleged:** Loss of pronation and supination  
**Name of case:** Withheld  
**Court/case #:** Withheld  
**Tried before judge or jury:** N/A (settled one month after tribunal)  
**Amount of settlement:** \$165,000  
**Date:** June 2005  
**Highest offer:** \$165,000  
**Attorney:** Patrick W. Morgan, Rifkin Law Offices, Salem (for the plaintiff)

## Man suffers stroke en route to doctor \$2.9 million settlement

The 58-year-old African-American plaintiff had a past medical history that included obesity, smoking, hypertension, hypercholesterolemia and atherosclerotic vascular disease. His family history was also significant in that his mother had suffered a stroke and myocardial infarction. In addition, it was noted that 10 out of 11 maternal aunts and uncles had suffered strokes or myocardial infarctions while in their 50s.

On March 11, 1999, the plaintiff presented to the defendant's office with complaints of lightheadedness and nausea. Without any testing, the defendant diagnosed the plaintiff with an otitis media and prescribed an antibiotic and an antihistamine. The defendant recommended that the plaintiff return to the office for a follow-up visit in two weeks.

The plaintiff returned to the defendant's office on March 29, 1999, after having completed the prescribed course of antibiotic therapy. The plaintiff informed the defendant that he continued to experience lightheadedness and nausea and was also experiencing double vision. The defendant did not order testing, but rather sent the plaintiff to see an ENT physician.

The plaintiff was evaluated two weeks later by the ENT, who was unable to come to a definitive cause for the plaintiff's dizziness

and double vision. The medical records and findings of the ENT were made available to the defendant. Despite being aware that there was still no cause for the plaintiff's symptoms, the defendant did not perform any diagnostic testing on the plaintiff.

Over the next several weeks, the plaintiff continued to suffer from double vision and dizziness. On the morning of June 2, 1999, the plaintiff phoned the defendant's office to report severe lightheadedness and double vision. Instead of sending the plaintiff to an emergency room, the defendant scheduled an appointment for the plaintiff for 1 p.m. The plaintiff left his home later that morning and headed to the defendant's office, but he never arrived.

At 5 p.m. the plaintiff was found unresponsive in his car at the side of the road. Upon arrival to Beth Israel Deaconess Medical Center's emergency department, the plaintiff was noted to be unresponsive to all but painful stimuli. An emergent CT scan was performed and showed a small, old, right perifrontal lacunar infarct. An MRI/MRA performed the following day revealed that there was no blood flow through the plaintiff's right vertebral and basilar arteries.

The plaintiff now resides in a nursing home; he is a quadriplegic and is only able to communicate by blinking his eyes in response to questions. Despite his severe brain injury, the plaintiff is completely aware of his surroundings and condition.

The plaintiff expected to present expert medical testimony that the defendant was negligent in his care and treatment when he failed to rule out an evolving stroke as the cause for the plaintiff's double vision and lightheadedness. The plaintiff further expected to present evidence that the massive stroke would have been avoided had the defendant placed him on proper medication.

It was anticipated that the defendant would present expert medical testimony stating that he acted appropriately when he sent the plaintiff to a specialist to determine the cause of his problems. The defendant was further expected to present evidence that the blood vessels affected in the plaintiff's brain, which caused the stroke, were small vessels that would not have been treatable even if the defendant had made the diagnosis earlier.

Prior to the trial, the parties entered into a mediation process that resulted in a settlement of \$2.9 million.

**Injuries alleged:** Severe neurologic injuries  
**Name of case:** Withheld  
**Court/case #:** Suffolk Superior Court (no. withheld)  
**Tried before judge or jury:** N/A (settled)  
**Amount of settlement:** \$2.9 million  
**Date:** June 25, 2005  
**Attorneys:** Andrew C. Meyer Jr. and Robert M. Higgins, Lubin & Meyer, Boston (for the plaintiff)

## Plaintiff: MD did not warn of priapism

\$300,000 settlement

This case involved a 52-year-old man who sustained permanent damage to his penis as a result of a failure of his treating psychiatrist to warn him to seek immediate medical attention when he developed priapism.

The plaintiff had his first appointment with the defendant on Dec. 14, 2000. The plaintiff was experiencing acute anxiety and panic attacks with difficulty sleeping, which he felt was due to pressure at work, fear of losing his job and resulting financial difficulties. The defendant prescribed Xanax 0.25 mg along with Trazadone 50 mg and advised the plaintiff to take one or two tablets of the Trazadone at bedtime as a sleep aid.

According to the plaintiff, he was not told that he was at risk for the development of priapism from taking the Trazadone. He was

also not advised of the dangers associated with priapism or that he needed to seek immediate medical attention if the condition was to develop.

Two weeks later, on Dec. 28, 2000, the plaintiff was again seen by the defendant. The plaintiff reported that he was doing better on the medication and the defendant increased the dosage of Xanax to 0.5 mg and advised that it be taken three times per day. The Trazadone was also continued. Again, the plaintiff was not advised of the risk of priapism, and was not warned of the need to seek immediate attention should the condition develop.

The following morning, Dec. 29, 2000, the plaintiff reported that he awoke with a painless partial erection. He had experienced this in the past and was not concerned with this development. The partial erection persisted throughout the day and was still occurring when the plaintiff awoke on Dec. 30, 2000. Again, the plaintiff had no idea of the potential significance of this and continued about his daily activities.

By the morning of Dec. 31, 2000, the erection had become quite painful, so the plaintiff presented to the emergency room for evaluation. He was seen by a urologist who diagnosed the plaintiff's condition as priapism. The urologist was immediately concerned, as the condition had persisted for more than 48 hours and the blood inside the penis could have congealed to the extent that it could not drain properly. Initially, the urologist inserted a needle into the plaintiff's penis to try and extract the blood, without success. The urologist then performed surgery to extract the clotted blood from the penis and to insert shunts to facilitate blood flow to the penis.

At the conclusion of the surgery, the plaintiff was advised that he should be transferred to a major hospital for additional specialized care. The transfer was carried out immediately.

At the subsequent hospital, the plaintiff came under the care of another physician who advised him for the first time that priapism is a known side effect of taking Trazadone. According to a letter from a physician at the subsequent hospital, the plaintiff had not been informed of the side effects of Trazadone and did not understand the condition of priapism.

The plaintiff was placed on Casodex, an antiandrogen hormone, to diminish the erection, along with Percocet for pain. On Jan. 3, 2001 the plaintiff reported increased pain in

the glans penis which was noted to be swollen and dark with blisters forming.

On Jan. 10, 2001, a black eschar was noted to be forming on the entire aspect of the glans. The plaintiff was seen again on Jan. 16, 2001, and the black eschar was noted to have completely covered the entire glans including the meatus. The area was debrided under local anesthesia. The meatus was noted to be closed by necrotic tissue. The suprapubic tube was left in place and the plaintiff was treated with anticholinergics for bladder spasms. The erection was noted to be gone but firm fibrotic tissue was palpable on the penis shaft.

Additional necrotic tissue was removed on Jan. 19, 2001. The plaintiff was noted to have continued pain in the glans of the penis and in the penile shaft. On Jan. 24, 2001, the plaintiff was noted to have continued necrotic tissue returning and eschar formation on the glans penis primarily in the region of the corona and meatus. The suprapubic tube remained in place and the bladder spasms continued. The notes indicated that on Jan. 29, 2001, there was new blister formation and the plaintiff was still struggling with progressive necrosis. Concerns were raised that he may need treatment with hyperbaric oxygen to halt the progressive necrosis.

In April 2001, the plaintiff was noted to have residual stricture of his urethra but the suprapubic tube was clamped to allow a trial of voiding through the urethra. According to the plaintiff, he was left with permanent scarring and disfigurement of his penis, he is not able to achieve an erection or have intercourse with his wife.

The defendant maintained that, although he had no specific memory of having informed the plaintiff of the risks of priapism, it would have been his custom and practice to do so, as well as advising him of the need for immediate medical attention if the condition was to develop.

The defense also stressed that the length of time between the plaintiff noticing the condition until the time that he sought medical care was long enough to raise an issue of comparative negligence.

Ten days prior to mediation, a case based on similar theories of negligence and causation and based on the same drug was tried in Superior Court. The jury could not reach a decision after three days of deliberation

*Continued on page 12*

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# Verdicts & Settlements

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and a mistrial was declared.

The case settled at mediation for \$300,000.

**Injuries alleged:** Scarring and disfigurement of penis

**Name of case:** Withheld

**Court/case #:** Withheld

**Tried before judge or jury:** N/A (settled)

**Amount of settlement:** \$300,000

**Date:** July 2005

**Attorneys:** Gregg J. Pasquale and Melissa A. White, Keches & Mallen, Taunton (for the plaintiff)

## Treatment blamed for deformed wrist

\$300,000 settlement

The 53-year-old plaintiff fell at home and injured his left minor wrist. He was diagnosed at the emergency room as having suffered a Colles fracture of the left distal radius and ulna styloid with approximately 30 degrees of dorsal angulation of the distal radius. The defendant orthopedic surgeon reviewed the emergency room X-rays and performed a closed reduction. He discharged the plaintiff in a short arm cast without having taken any post reduction X-rays.

The defendant physician saw the plaintiff again a week later when X-rays showed a dorsal tilt to the fracture and questionable angulation. At that time the defendant physician discussed the possibility of a surgical reduction of the fracture with the plaintiff, but discouraged the plaintiff from considering surgery.

The defendant physician and the plaintiff met again a third time one week later when the plaintiff expressed increasing concern about the developing angulation of his wrist and his unremitting pain. He again inquired about the option of surgery. The defendant physician assured the plaintiff that his wrist was healing adequately and continued to discourage the plaintiff from considering a surgical reduction.

The defendant physician and the plaintiff met for a fourth time 10 days later, at which time the plaintiff expressed great concern about the continuing development of an awkward angulation in his wrist, as well as apparent shortening of the length of his arm. He continued to have pain. Again, the defendant physician told the plaintiff that his wrist was healing as well as could be expected and encouraged the plaintiff to stay the course rather than consider surgery.

The defendant physician and the plaintiff met a fifth and last time two weeks later during which the physician noted that the plaintiff's wrist was shortening more than had been expected. The defendant physician continued to recommend a non-surgical approach to the care of the injured wrist despite the plaintiff's expressions of concern that his wrist seemed to be deteriorating.

The plaintiff then sought alternative care several weeks later and a CT scan revealed nonunited fractures and fracture deformities of his left distal radius and ulnar styloid. His subsequent physician informed him that the prognosis for a good recovery was poor and that the wrist joint could not be restored. A distal radius osteotomy was recommended by the new physician and was performed under general anesthesia three and one half months after the original injury.

The procedure included bone grafting with material harvested from his hip. The plaintiff's wrist was cut and lengthened with the bone material from his hip. He underwent a second surgical procedure two months later to remove fixator hardware from his wrist and to undergo further bone grafting.

Almost a year later, the plaintiff was examined and the physician at that time described the injury as a "major deformity."

Fourteen months after the original injury,

under general anesthesia, the plaintiff underwent a "realignment and reduction of severe deformity with lengthening of the radius and relocation of the distal radial ulnar joint and autogenous iliac crest bone graft and two plates along with lengthening of the flexor carpi radialis and brachial radialis." Significant disuse osteoporosis was noted during surgery. Part of the surgery was to remove the plate from the prior surgery, as the plate had broken in the interim. This was the second procedure in which bone material was harvested from the iliac crest of the plaintiff's hip.

The end result for the plaintiff has been a deformed wrist with severe angulation, significant weakness and instability, scarring and loss of fine and gross motor abilities. Pain remains intermittent.

No claim was asserted for lost wages or lost earning capacity, as the plaintiff managed to work as a lawyer and land surveyor throughout his ordeal.

The plaintiff's orthopedic surgeon expert was prepared to testify that with the type of injury originally suffered by the plaintiff, the standard of care called for surgical open reduction and internal fixation and that the defendant physician had a window of three weeks within which to adhere to the standard of care and surgically reduce the fracture, but failed on multiple occasions to avail himself of the opportunity to do so. The result was the deformity, scarring, multiple surgeries, pain, suffering and loss of function experienced by the plaintiff.

The case settled for \$300,000 in mediation.

**Injuries alleged:** Malunion with deformity of fracture of distal radius of left minor wrist

**Name of case:** Gay v. Jaslow

**Court/case #:** Bristol Superior Court, No. 2001-00671

**Tried before judge or jury:** N/A (mediated)

**Name of mediator:** John Fitzgerald, Cogavin & Wayslack, Boston

**Amount of settlement:** \$300,000

**Date:** July 7, 2005

**Attorney:** Traver Clinton Smith Jr., Donovan Hatem, Boston (for the plaintiff)

## Testing questioned in cancer case

\$525,000 settlement

The plaintiff's decedent was a 66-year-old who began treating with the defendant primary care physician in 1998. Although the defendant recorded in the medical record that she "would discuss sigmoidoscopy on the next visit," no discussion was ever recorded for 10 visits spanning three years.

Although the defendant's records reflect hemoccult tests given to the plaintiff's decedent on three occasions, no record of results of those tests appeared in the medical chart.

The defendant testified in deposition that she had discussions concerning colon cancer screening and that hemoccult results were either negative, since she would have recorded a positive test and would have pursued the cause of bleeding, or the plaintiff's decedent didn't perform and return the tests as instructed.

In 2001, the plaintiff's decedent was diagnosed with metastatic colon cancer and died 18 months later.

**Injuries alleged:** Death

**Name of case:** Withheld

**Court/case #:** Withheld

**Tried before judge or jury:** N/A (mediated)

**Name of mediator:** John Ryan

**Amount of settlement:** \$525,000

**Date:** July 29, 2005

**Attorneys:** Barry D. Lang and Zachary B. Lang, Barry D. Lang, M.D. & Associates, Boston (for the plaintiff)

## Stomach lesion turns into cancer

\$700,000 settlement

The 58-year-old plaintiff had an endoscopy performed by the defendant doctor on Dec. 1, 1999.

The study showed an ulcerated lesion in the upper stomach. Biopsies were positive for H. Pylori, a known risk factor for the development of gastric adenocarcinoma.

Despite this finding, the defendant did not perform any repeat endoscopies or order any other follow-up testing.

Almost two years later, the plaintiff was diagnosed with stomach cancer.

Almost four years after the diagnosis of stomach cancer, the plaintiff is cancer-free and doing well.

The case was settled for a lump sum payment of \$700,000 before any depositions were taken.

**Injuries alleged:** Failure to timely diagnose stomach cancer

**Name of case:** Withheld

**Court/case #:** Withheld

**Tried before judge or jury:** N/A (settled prior to discovery depositions)

**Amount of settlement:** \$700,000

**Date:** August 2005

**Attorneys:** Philip J. Crowe Jr. and David W. Suchecki, Crowe & Mulvey, Boston (for the plaintiff)

## Girl loses ovary despite ER visits

\$300,000 settlement

The plaintiff, a 10-year-old child, suffered a sudden onset of acute abdominal pain and vomiting on a Saturday morning at home. A few hours later, she was taken by her mother to a teaching hospital's emergency department where her differential diagnosis included possible appendicitis or renal colic. After blood work, a urinalysis and an abdominal X-ray, the emergency department resident and the attending physician (the attending physician being the first of two defendants) both examined the child and diagnosed her as suffering from acute, non-surgical abdominal pain. The attending physician prescribed a light diet for that night and instructed the child, through her mother, to call her pediatrician if the pain or vomiting returned.

Approximately one hour later, the child was brought back to the emergency department via ambulance for worsening abdominal pain and vomiting. The same attending physician, defendant #1, examined the child during this second visit, but no new testing was ordered. Despite her worsening symptoms and without additional testing being performed, defendant #1 diagnosed the child as suffering from "vomiting." She was prescribed one liter of intravenous fluids, over one hour, for resuscitation. At 10:15 p.m. an emergency department nurse found the little girl "crying, knees to chest, screaming in pain." The nurse reported the aforementioned observations to defendant #1, who discharged the child two hours later, shortly after midnight, with instructions that she may "continue to vomit some with some abdominal pain, but watch for her to be getting worse, in which case she might need to come back for excessive vomiting with dehydration."

Later that Sunday, at approximately 7:45 p.m., the young girl returned to the emergency department for the third time in approximately 24 hours. On that occasion, she was examined by a different attending physician (defendant #2) for complaints of continued abdominal pain and vomiting despite two emergency department visits the day before. A resident noted that the child's pain had

started the day before, had spread throughout her lower abdomen, varied in intensity, and that the pain was crampy and sharp. The resident also noted the studies that had been done the day before during the first emergency department visit and also noted that no further studies had been ordered during the second visit. Later, defendant #2, an attending physician, examined the child during this third visit and also noted that she had been evaluated on two separate occasions the day before, and that she suffered diffuse, shifting and crampy abdominal pain. Without ordering any diagnostic studies, and despite a negative rectal examination, defendant #2 diagnosed the child as suffering from "constipation" and "abdominal pain" and, for the third time in 24 hours, discharged the girl to her home with a prescription for enemas for constipation and instructions through the child's mother to drink as much fluids as she could, to eat vegetables, fruits and fiber, to consume two-three tablespoons of mineral oil daily until her stools were soft and to call her primary care physician and let her know how she was doing.

The next day, the child's mother contacted their pediatrician as she had been instructed to do and was given an appointment for the child on the following Thursday, five days after the onset of the child's signs and symptoms. At that scheduled Thursday visit, the child had a fever and suffered from continued abdominal pain, and her pediatrician immediately referred her right back to the same hospital emergency department.

That same day, the child was examined in the emergency department for the fourth time in less than one week. Upon examination it was noted that she suffered from lower abdominal pain and slight involuntary guarding and complained of diarrhea and vomiting. The ER attending at that time (not one of the defendants) reviewed her prior ER admissions, obtained her family's medical history, the child's past medical history, and performed a physical examination. Additionally, the attending ordered both a CT scan and an abdominal ultrasound to rule out ovarian torsion. The CT of the abdomen and pelvis revealed "a large complex heterogeneous mass-like abnormality in the pelvis in the expected region of the uterus and ovaries. ..." The pelvic ultrasound revealed a complex mass within the cul-de-sac that most likely represented a torsed ovary, with no arterial blood flow.

A pediatric surgical consultation was requested and performed, and the pediatric surgeon was informed of the pelvic ultrasound findings. The child was admitted to the hospital and on that Thursday, five days after the onset of acute abdominal pain, underwent emergency surgery for a torsed right ovary. The surgery included video laparoscopy, open laparotomy and right salpingo-oophorectomy. Her right ovary was discovered to be "black and obviously infarcted."

After an unsuccessful attempt to excise the ovary laparoscopically, the surgeons performed a lower abdominal transverse incision and removed the right ovary and right fallopian tube. The 10 year old girl remained inpatient for four days and was confined to bed at home for an additional week.

The plaintiff's expert emergency department physician was prepared to testify that defendant #1 was negligent in failing to order diagnostic testing, either by means of a CT scan or ultrasound, of the child's abdomen on her second visit to the emergency department that Saturday, because the child's presenting symptoms, history and return visit warranted such diagnostic testing. He was prepared to say that a CT scan and/or an ultrasound of the pelvis would have revealed the ovarian problem, later diagnosed as ovarian torsion. And he was prepared to say that as a direct result of the attending physician's failure to order such diagnostic testing, as required by the standard

# Verdicts & Settlements

of care, the torsion of the ovary went undetected for an additional five days, eventually completely cutting off the flow of blood from the right ovary, causing the ovary to infarct and become necrotic. He was also prepared to testify that if a timely diagnosis of ovarian torsion had been made, the ovary would have been saved, and the surgical procedure to save it would have been less invasive and less complex.

The plaintiff's expert was also prepared to testify that defendant #2, who examined the child in her third visit to the emergency department in less than 24 hours, was also negligent in essentially the same fashion as defendant #1 from the day before, and that as of the second day of the child's signs and symptoms, appropriate action still would have enabled physicians to save the child's ovary with less invasive and less complex surgery than she had to undergo when her ovary had to be removed.

The plaintiff is left with a single ovary and fallopian tube and while she ultimately wants to have children, she has not tried to do so yet.

**Injuries alleged:** Loss of ovary in 10-year-old

**Name of case:** Paz de Jimenez v. Warton et al. Court/case #: Suffolk Superior Court, No. 2001-01014

**Tried before judge or jury:** N/A (settled)

**Amount of settlement:** \$300,000

**Date:** Aug. 12, 2005

**Attorneys:** Traver Clinton Smith Jr. and Alan D. Hoch, Donovan Hale, Boston (for the plaintiff)

## Newborn suffers brain damage

\$23.4 million verdict

On Nov. 5, 1996, in her 38th week of pregnancy, the minor plaintiff's mother went to the hospital for a scheduled non-stress test (NST) to check the baby's heart rate. It was determined that the heart rate was not reassuring, so a biophysical profile (BPP) was performed. The BPP came back normal with a score of 8/8, and she was sent home with instructions to return in one week.

On Nov. 7, 1996, the plaintiff noted decreased fetal movement after dinner and called her obstetrical practice. She spoke with the defendant obstetrician who was the on-call attending and who had been practicing for three months. She was told to go to the hospital for evaluation.

On arrival at 9 p.m., the minor plaintiff's mother was placed on a fetal heart monitor, and it was non-reassuring. Consequently, the defendant physician ordered a BPP to follow-up on the failed NST. Unlike two days earlier, the test failed. It was noted that the baby had little or no tone and there was no movement for a total of 45 minutes.

At trial, the plaintiffs' expert witnesses testified that the minor child was in trouble at this point and required an emergency Caesarean section for delivery. However, instead of delivering the baby emergently, and in spite of the fact that the plaintiff was not in labor, the defendant obstetrician decided to attempt a vaginal delivery.

At 2:30 a.m., induction of labor was initiated but was stopped at 4 a.m., when the fetal monitor showed repetitive late decelerations, indicating that the baby was in distress. It was at this point that the defendant decided that a C-section delivery was necessary. The defendant then waited another three hours before delivering the baby. The defendant testified that she waited for additional staffing to arrive and that in the interim she went to rest.

At 7:05 a.m., when the baby was delivered, he was blue, floppy and required oxygen, suction and stimulation, and his cord pH was 7.02, indicating acidosis. Within about 20 minutes, the baby began to experience seizures.

The minor plaintiff wears bilateral hinged ankle-foot orthotics and has developmental delays in all areas. At his present age of 8, his cognitive abilities are that of a 3 or 4-year-old, and he requires constant care and supervision.

The defendant claimed that the C-section, although necessary, was not emergent. Further, experts for the defense testified that the

intracranial hemorrhage occurred two to three days prior to delivery as evidenced by its appearance on the ultrasound on the day of delivery, and that the hemorrhage was more likely than not a consequence of a blood platelet aggregation problem suffered by the baby.

Additionally, the defense claimed that because the bleed occurred days prior, it was unlikely that an earlier delivery of the baby would have changed the baby's outcome.

**Injuries alleged:** Severe brain damage

**Name of case:** Antonelli, et al. v. Halladay Court/case #: Middlesex Superior Court, No. 99-4391

**Tried before judge or jury:** Jury

**Name of judge:** Christine M. McEvoy

**Amount of verdict:** \$23.4 million (\$40.2 million with interest)

**Date:** Aug. 17, 2005

**Demand:** Policy limits

**Highest offer:** \$0

**Attorneys:** Robert M. Higgins and Ursula Knight, Lubin & Meyer, Boston (for the plaintiff)

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## Responding to the Board of Medicine: Don't go it alone

*Continued from page 9*

the board, that invitation includes the advice that it might be wise to bring a lawyer.

By then, however, the physician will have missed the opportunity to shape the initial response with an eye towards the legal nuances of the board's disciplinary standards and procedures. Sadly, many physicians submit their initial responses without legal advice, unaware that most malpractice policies include coverage for the board related legal fees of counsel of the physician's own choosing.

After the board's staff completes its investigation, one of its prosecuting attorneys, known as complaint counsel, presents the matter to a subcommittee of at least two members of the board called the complaint committee.

The physician has a right to attend that session, to be represented by counsel and to respond to complaint counsel's presentation. Physicians attending such sessions should also expect to be questioned by complaint committee members.

Prior to the meeting, complaint committee members will have been sent a package that includes the original complaint/statutory report, the physician's response, and complaint counsel's investigative summary and recommendation.

Physician's counsel should give serious consideration to requesting the opportunity to provide a supplementary response to be included in the package that is sent to committee members. That is especially so if counsel was not involved in drafting the initial response.

If the complaint committee determines that disciplinary action is not warranted or that the evidence is and will remain insufficient to justify further proceedings, it has authority under the board's regulations to close the investigation without further review by the board.

However, even when closing a complaint, the committee's notice of dismissal often includes a letter of warning, concern or advice. Although such letters are not disciplinary in nature (and generally need not be disclosed in the course of future credentialing activities), they are in the public record. Also, because they are not disciplinary, they cannot be contested.

If the committee determines that discipline is warranted, it can recommend to the full board that it issue a statement of allegations, which formally charges the physician

## Massachusetts has adopted an adversarial process, the balance and temper of which comes not from within but from the licensee's ability to recognize the need for the assistance of experienced counsel.

with misconduct. Such recommendations are rarely rejected.

Before referring a recommendation for discipline to the full board, the complaint committee often suggests that the complaint counsel and the physician's attorney try to resolve the matter by an agreed-upon disposition called a consent order.

In such circumstances the complaint committee identifies the parameters of a settlement that it would find acceptable, and give the lawyers a two or three-week deadline to reach

agreement. Like any other plea bargain, the benefits (if any) to the physician lie in the opportunity to limit the nature and scope of the charges that are ultimately brought and admitted and the extent of the discipline imposed.

If an agreement is reached, the proposed consent order is presented to the full board for its review and approval. In the unlikely event the board rejects the proposal, neither the consent order nor the willingness to enter into it is admissible in any subsequent hearing. If accepted, the consent order immediately becomes a public document, and dissemination of its terms through a press release and mandated notices is a certainty.

The board's press policy provides that it will issue a press release for virtually every final disciplinary action. The only — and very rare — exception to that policy is for cases involving alcohol/chemical dependency or mental impairment that do not also involve the violation of any laws or any patient harm, and where the sanction does not include a time out of practice.

Although the press release is not certain to garner press attention, the likelihood is that it will. Regardless, the physician will also be required to provide the board with proof that the consent order was distributed to, among others, every health care facility, medical employer and other licensing authority with which the physician is affiliated.

If a physician is not willing to enter into a consent order, the case will proceed to an adjudicatory hearing. By special act of the Massachusetts Legislature, the board no longer hears its own cases. Instead, its cases are referred to the Division of Administrative Law Appeals (DALA) and assigned to an independent administrative magistrate who presides over the hearing.

Although not as formal as a trial, the hearing process is governed by a specific set of

procedural rules that allow for the ordered presentation of evidence and the examination and cross-examination of witnesses. Like a civil trial, the board has the burden of proving its case by a preponderance of the evidence.

At the conclusion of the hearing, the DALA magistrate issues a "recommended decision" to the board. While the board technically has the right to reject that decision, as a legal matter it is difficult to do so and, at least as to the Magistrate's findings of fact, it is rarely done.

If a decision is rendered adverse to the physician, the board must then decide the appropriate sanction. Any sanction the board imposes must also be consistent with its own mandate — which is not to punish the physician, but only to protect the public — and must be based only on the evidence presented at the hearing.

For both of those reasons, it is critically important that evidence of the physician's current ability to practice — as well as any evidence of mitigation — be presented at the hearing. If not, those crucial factors cannot be considered at disposition.

### Balance

The foregoing is not intended to suggest that the board is abusing its authority. Indeed, nobody wants to live where physicians are not subject to vigilant oversight.

Rather, the point here is to describe how the Massachusetts board employs both its authority and its skilled and experienced prosecutors to take an aggressive approach to the investigation and adjudication of complaints. Specifically, Massachusetts has adopted an adversarial process, the balance and temper of which comes not from within but from the licensee's ability to recognize the need for the assistance of experienced counsel.

Or, like Butch and Sundance, you can head for Bolivia. MMLR

# Sharing what hospitals know: a challenge to the medical staff review process

Continued from page 2

to pending corrective actions, increases the risk of spreading inaccurate information, and could jeopardize the peer review privilege.

2. Confirm the authorization to provide information. Credentialing applications generally include an applicant's written authorization to release information. A responding hospital should confirm that authorization, including that it encompasses the requested information. (Hospitals should also review their own applications to ensure that authorization is adequately expansive.) Any disclosure must always be made in good faith, without malice, and should be as limited as possible, while still being complete

(i.e., it should not be "malicious" or "unnecessary, unreasonable or excessive"). *Miller*, 2003 WL 22794487 at \*9 (citation omitted).

3. Respond in writing. Written responses provide a record of the request and its context. Oral communications can be misheard, and—if litigation arises—will be difficult to remember exactly (and will likely be remembered differently by the participants). E-mail should be avoided, as it is often not carefully considered, can be circulated broadly and is discoverable.

4. Stick to the questions and the facts. Any information exchanged should be based solely on the facts. Information regarding a completed disciplinary action should mirror the mandatory disclosure made to the NPDB or

BRM. If an appropriate request is made regarding pending claims, the disclosure should include only the nature of the claims, whether the physician is challenging them through the hospital's corrective action procedures, and should include only those specific claims (and not additional suspicions, lingering frustrations or past annoyances). A request for information is not an invitation for an information "dump." A complete credentialing file or peer review materials should not be forwarded.

5. Carefully choose your words; plan ahead. Remember that the career of the physician, as well as the health of patients, may be affected by the information provided. If the conclusion is to disclose negative information, consider

seeking legal advice as to what information is required and how it should be presented.

## Conclusion

Increased emphasis on quality and patient safety will give rise to an increasing number of physician reviews and peer review actions, which will, in turn, give rise to an enhanced desire to deliberate and act with complete information.

Inquiries to other hospitals where a physician practices will need to be addressed objectively, with consideration of patient protection and fairness to the physician, and the need to protect the disciplinary process.

MMLR

## Fraud and abuse: the Final Stark II Phase II regulations

Continued from page 5

ations, as well as restrict the level of outside activity of the group's physicians.

The group must set its compensation formula in advance, and while bonuses and profit distributions are permissible, they must be designed very carefully to avoid a correlation between the amounts paid and the volume or value of the physicians' DHS referrals.

DHS provided by an academic medical center (AMC) are excepted if the referring physician is a bona fide full-time or substantial part-time employee of one of the AMC's components, has a state license and a bona fide faculty appointment, and provides either substantial academic services or substantial clinical teaching services (or a combination of both; calculated using a "reasonable and consistent" method).

The referring physician's total compensation must be set in advance, and not exceed fair market value for services provided, and not vary based on volume or value of referrals or other business generated.

In addition, this exception sets out particulars for the AMC's internal money transfers and inter-component relationship. The referring physician's compensation arrangement with the AMC must not violate the federal anti-kickback statute or federal and state billing or claims-submission laws or regulations.

Other notable exceptions to the self-referral prohibition include those in the compensation arrangement category for bona fide employment, personal services, physician recruitment, fair market value, medical staff incidental benefits and non-monetary compensation not exceeding \$330 per year.

The bona fide employment relationship exception requires that the employment be for identifiable services, and that the amount of compensation be consistent with fair market value and not vary based on the volume or value of referrals, and that the agreement for remuneration be commercially reasonable. Productivity bonuses for services personally performed by the physician are permitted.

To satisfy the exception for personal services, the arrangement must be set out in writing, cover all the referring physician's services to the entity furnishing the DHS, and be for at least one year.

The aggregate services must not exceed what is reasonable and necessary for the legitimate business purposes of the arrangement, and the compensation is set in advance, does not exceed fair market value, and, except in the case of a physician incentive plan, does not vary with the volume or value of referrals or other business generated.

Under the physician recruitment exception, hospitals are permitted to pay recruited physicians as well as existing medical practices a subsidy to relocate their med-

ical practices to the hospital's geographic service area, if the remuneration arrangement is set out in writing, signed and not conditioned on the referral of patients to the hospital.

The hospital may not determine remuneration based on the volume or value of referrals or other business generated. Also, as a general rule, the physician must be allowed to establish privileges at other hospitals and refer to other entities. Permissible recruitment arrangements with existing practices are limited to those in which the hospital support is earmarked for incremental costs of adding the new physician and not for any shared existing overhead.

An arrangement between a physician and an entity providing DHS will qualify for the fair market value exception if contained in a signed, written agreement that specifies the timeframe for the arrangement and covers only identifiable items or services, all of which must be specified.

Compensation must be set in advance and not be determined based on the volume or value of referrals or other business generated.

The arrangement must be commercially reasonable and further the legitimate business purposes of the parties, and not violate the federal anti-kickback statute or federal and state billing or claims-submission laws or regulations.

Stark also covers and provides an exception for certain isolated transactions, such as the purchase and sale of a medical practice.

Finally, under the medical staff incidental benefits exception, hospitals and other facilities are permitted to compensate members of medical staffs with items or services, valued at \$25 or less per occurrence (adjusted annually for inflation), to be used on campus.

Again, such compensation must not vary with the volume or value of referrals or other business generated, and the arrangement must comply with the federal anti-kickback statute and other federal and state laws and regulations governing billing and claims-submission.

In addition, hospitals and other entities that furnish DHS may provide compensation, in the form of items and services up to \$300 (adjusted for inflation) in value per year, provided the compensation is not physician-solicited, there is similar legal compliance as with the medical staff incidental benefits, and the amount is not determined based on the volume or value of referrals or other business generated.



As Stark is designed as a "zero tolerance law," even inadvertent technical violations could result in a government prosecution, or a private whistleblower lawsuit.

Because of the limitations on these amounts, the American Medical Association has petitioned CMS for a Stark exception covering quality patient care-focused continuing medical education programs, without financial limit.

Physicians must also be aware that CMS has acknowledged that the category of outpatient prescription drugs under Stark will include prescription drugs covered by Medicare under the new Medicare Part D prescription drug benefit that goes into effect on Jan. 1, 2006.

CMS has announced its intention to further revise the Stark regulations to address the application of Stark to the Part D benefit. Physicians should assume that the Stark rules will be applicable to their (and immediate family members') financial relationships with any entities that render and bill Part D covered prescription medications, including their own medical practices, starting in 2006.

## General comments

In their complexity, the new federal Stark rules may introduce almost as much uncertainty in their implementation as they were intended to clarify.

For example, the cross-reference to Medicare supervision requirements cited in the in-office ancillary services exception opens up a measure of ambiguity, depending upon how those

requirements are to be squared with the Stark regulations themselves.

CMS does issue Stark advisory opinions, however, and some of these uncertainties may be resolved over time through additional changes to the regulations and court decisions.

This article (including the summary descriptions of the Stark exceptions highlighted above) is not meant to be exhaustive on all Stark details, so physician practices and other health care entities, as part of an overall fraud and abuse review, are best advised to seek expert legal advice on Stark when structuring professional and business arrangements that involve referrals.

Otherwise, they may risk violations, for which the penalties can include payment denials and refunds, substantial civil money penalties, and exclusion from Medicare and Medicaid.

As Stark is designed as a "zero tolerance law," even inadvertent technical violations could result in a government prosecution, or a private whistleblower lawsuit.

While compliance with Stark is often achievable, all physicians and medical practices must now be ever vigilant in entering into and negotiating their financial relationships with medical practices, hospitals and any other parties that provide services or items covered under this law.

MMLR

# Taking the stand: tips for providing expert testimony

*Continued from page 1*

for it to be exposed on cross-examination.”

Gould added: “Sometimes a witness will be completely clueless as to what’s really going on, and it’s the lawyer’s job during this critical preparation stage to educate the expert as to exactly what the issues are and figure out how to deal with them.”

Dr. Eli H. Newberger, a pediatrician at Harvard Medical School who has testified as an expert in countless civil and criminal cases, stated that prior to sitting down with a lawyer, he makes a point to review carefully whatever written data is available and to discuss in

depth his anticipated role with counsel.

“This should never be done in a casual way,” he said. “It’s possible to avoid embarrassment and actually have a solid basis for one’s opinion by working with the lawyer to prepare prior to sitting down in the witness chair.”

## Mind your language

When the preparation is complete and the time comes to present medical testimony to the jury, experts need to be cognizant of their word choice, remarked David M. Benjamin, Ph.D., a clinical pharmacologist and toxicologist.

“Being prepared doesn’t amount to much if

you can’t communicate in a way that people understand. Your job is to help the jury do their job, and a lot of that gets missed if you simply use your testimony as an opportunity to try to impress them with your vocabulary,” he said.

Benjamin noted that because physicians of ten use language at work that is different from what most jurors would understand, the persuasiveness of their testimony will be greatly diminished if such words are left undefined.

“The bottom line is, when you use a technical word, you’ve got to define it,” he said. “It’s a simple concept, but if you say that a patient has hypertension, tell the jurors that

it means he has high blood pressure.”

Newberger added: “It’s important for a doctor to face the jury, look at their expressions and make an earnest effort to avoid jargon or at least explain technical terms with great care if they have to be used.”

Gould tells his expert witnesses to speak to the jury as though they were speaking to a patient sitting in their office.

“We’re all capable of conveying information to people, but doctors, in particular, need to make sure that what they are saying can be understood by those who didn’t go to medical school,” he said. MMLR

# Health care proxies: preventive measure or potential minefield?

*Continued from page 1*

able to carry out the decision — or seek court relief.”

Moreover, when the patient’s wishes aren’t known or can’t be known, the statute returns the focus to the best interest of that patient.

“Then it becomes an evaluation by everybody involved about what the best interests of the patient are when you’re weighing personal values against quality of life,” said Hamel.

Given the personal nature of such issues and the continuing evolution of medical care, each situation calls for case-by-case analysis, he noted.

As a result, when a health care provider is at odds with a health care agent, there are few clear standards, and the little legal precedent that does exist cuts both ways.

In the event of such a dispute, Zalkin recommended first exploring what can be achieved through discussions with the agent. In the Howe case, in which the agreement was reached in a closed-door, three-and-a-half hour meeting, the judge gave much of his time to working out a solution rather than attack the authority of the document, he said.

Care givers may also be caught in a dilemma, Zalkin observed, when a patient incapacitated due to mental illness subsequently claims to have regained capacity. In those instances, he advised, should a specialist determine that the patient remains incapacitated, the health care provider should resort to the Probate Court and request that it affirm the health care proxy.

Gray areas can also be found in the wording of the health care proxy. Cukier explained that while Chapter 201D effectively supercedes living wills — documents in which individuals describe the medical treatment they would or would not agree to — as a practical matter, living will language is sometimes included in a health care proxy.

In that event, she reported, the language used in the proxy could end up being the subject of court proceedings.

“The proxy might say, for example, ‘I want all life support withdrawn under certain circumstances,’ and people might dispute whether those circumstances have, in fact, occurred,” Cukier suggested.

Such proxy documents may also not be responsive to medically unforeseeable circumstances, added Hamel. That said, he remarked that it is helpful to have wishes be known as specifically as possible.

If a patient has an idiosyncratic wish, Zalkin agreed, it is advisable to document it, as well as the reason behind it, for the sake of clarity.

“It wouldn’t be binding; it’s still the agent’s call,” he cautioned. “But if it’s in writing, it helps prevent conflict.”

Problems may also arise when medical providers are presented with an older health care proxy without knowing whether another proxy or durable power of attorney was executed subsequent to the document in their hands, Cukier pointed out.

This is all the more likely in recent times, she said, given an aging population that is susceptible to signing whatever document is put before them.

“They’re just too tired to fight or to in-

would be served well by having somebody make decisions for them,” he remarked.

The requirement that there be two witnesses to the document offers health care providers some degree of “backup,” Zalkin said.

He further noted that medical providers are also given some protection by Chapter 201D, which provides that every adult shall be presumed to be competent and that every health care proxy shall be presumed to be properly executed.

“I wouldn’t say that they were completely safe,” he states. “But it does appear to give them a safe harbor.”

## Can we talk?

Health care providers encourage the use of health care proxies, confirmed Hamel.

**“If doctors take a more active role, then the law will gradually become more flexible around patients’ needs and less beholden to what lawyers and family members feel should happen.”**

— Boston attorney Lisa M. Cukier

quire,” Cukier commented.

But even without knowing whether a subsequent proxy exists, health care providers need only follow the direction of the document they are handed, she said. Medical providers are not under any legal obligation to look into the background of the health care proxy or any other advance directive, Cukier explained, as the health care statute allows third parties to rely on the document that is presented to them.

“But the provider does have an obligation to determine whether their patient has sufficient mental capacity to give consent on their own,” she continued.

From the medical point of view, Zalkin said, the question is whether or not the level of competence required to execute the proxy is the same as the capacity needed to make competent medical decisions.

“One could argue that there could be a person who is not able to understand the pros and cons, the risks and benefits of a decision, but is able to understand that they

“These directives are important,” he stated. “They provide care givers with a central person in the family to deal with and provide a spokesperson for the patient.”

On this point he is joined by Zalkin, who represented Howe’s daughter.

“I think everybody wins,” he said, noting that proxies can provide clarity to medical providers with respect to an individual’s wishes.

Ideally, Zalkin noted, the patient will have spoken to the agent about those wishes.

In fact, communication is key to the effectiveness of a health care proxy, Hamel stressed, not only at the end of the patient’s life, but even as the directive is being filled out.

“To the extent that the health care provider can engage in communication with the patient and the proposed proxy, that’s an ideal situation,” he suggested. “Unfortunately, ideal situations don’t always arise. But the more communication, the less room there is for misunderstanding.”

Medical providers should also be involved

because they are in a position to assist the patient evaluate the likely contingencies, Zalkin pointed out.

“A lot of people don’t know what CPR is and for whom it’s contraindicated,” he offered by way of example. “They assume they should get CPR, like on television, then get up and dance home.”

Some tangential issues have yet to be settled, Zalkin said. He recalled the husband of an Alzheimer patient who requested that his meetings with his wife’s health care providers be also attended by a friend, a nurse, with whom he could then consult. The medical providers were concerned over confidentiality issues in the absence of the patient’s consent, reported Zalkin.

If the “third party” is helping the agent make decisions, she should be included, he opined. But he also suggested that facilities have agents sign a statement clarifying that they continue to be the decision-maker, but that they grant permission on the principal’s behalf for the third party to attend in the capacity of a consultant.

The need for communication, as well as caselaw and the health care statute, have culminated in the processes that are in place today, involving social workers, spiritual advisors and ethics committees, Hamel observed. As a result, most treatment issues are resolved prior to any sort of litigation, he said.

But Hamel acknowledged that agreement is not possible in every instance.

“That is why the statute is in place, the caselaw is out there and the courts will have some involvement,” he said. “But in a way, that’s no different from any other situation in which two parties have different responses to a given situation. The only problem is that there’s a greater emotional and ethical overlay here that needs to continue to be evaluated.”

Cukier stressed that an important lesson to be drawn by care givers is not to step back and withdraw from looming disputes and controversy. Written directly into Chapter 201D is a statutory right for health care providers — not just guardians and family members — to ask the courts to override an agent’s decision or determine the validity of the appointment itself, she noted.

“If doctors take a more active role, then the law will gradually become more flexible around patients’ needs and less beholden to what lawyers and family members feel should happen,” Cukier said. MMLR

# \$40M malpractice verdict just an 'aberration'

Continued from page 1

and size of these verdicts. And the average juror likes doctors. They live in an area where some of the best doctors work; they give them the benefit of the doubt. This verdict doesn't change that."

## The delivery

It was Nov. 7, 1996, when the plaintiff in the case, Lisa Antonelli, then 38-weeks pregnant, went to Saints Memorial Medical Center in Lowell after noticing that the baby she was carrying wasn't moving as much as it had been.

The defendant in the case, Dr. Jacqueline Halladay, was the on-call attending obstetrician and gynecologist who had just completed her residency that summer. She placed the expectant mother on a fetal heart monitor around 9 p.m., and followed up with a biophysical profile, which registered a six out of 10.

Dr. Halladay testified that she had to consult a textbook on how to handle the results of the test, and she decided to induce labor an hour after receiving the BPP results instead of delivering the child through a Caesarean section.

But at 4 a.m., after one-and-a-half hours of unsuccessful attempts at delivering the baby vaginally, the fetal monitor began showing that the baby was in distress.

At that point Halladay decided that a C-section was in order. The 12-minute procedure was performed three hours later. The child, Philip Antonelli, was delivered lacking in oxygen.

After 20 minutes, he began seizing and was transferred to New England Medical Center in Boston for evaluation and treatment. Tests determined that the baby had hemorrhaged from the brain.

The boy is required to wear foot braces now and he functions cognitively on a 3- or 4-year-old level.

## The verdict

The jury, after nearly seven hours of de-

liberation, found for the plaintiff and attributed \$2,413,867 of the verdict to the cost of the boy's future care. The rest of the verdict broke down as follows:

- lost earning capacity: \$2,080,002;
- pain and suffering and lost quality of life for child: \$7,500,000;
- loss of consortium for mother: \$6,900,000; and
- loss of consortium for father: \$4,600,000

Lawyers feared that the doctor may have made the mistake of appearing cavalier on the witness stand.

In general, said attorney Dunn, doctors who testify should be careful "not to talk down to the jury. Look at them. Be humble. Don't be condescending. And don't fight with the lawyer. Let the lawyers fight among themselves."

"Jurors don't like any witness who appears arrogant," said attorney Diedrich. "But I don't find that problem with doctors more than any other type of witness. They are hard-working, dedicated people."

## The high-low

The attorney for the plaintiff in the case, Boston's Robert M. Higgins, said that after the defendant's counsel approached him mid-trial with the high-low offer, he carefully evaluated his options: risk getting nothing for his clients or minimize the gamble by ensuring some recovery no matter the trial's outcome.

As the "high" in the agreement, the insurance company offered to pay the policy limits if the plaintiffs were successful, in exchange for the plaintiffs' agreement not to pursue the defendant's personal assets.

Higgins chose the sure thing and accepted the agreement proposal, which the jury never heard about. The "low" part of the high-low also called for some kind of payment, even if the jury didn't find for the plaintiff.

"It made sense for these clients," said Hig-

gins, who pointed out how difficult and time-consuming it can be to collect a judgment above an insurance policy limit.

Boston attorney Patrick T. Jones, president of the Massachusetts Academy of Trial Attorneys, said that high-low agreements, while not routine, are becoming more popular than they used to be and "make a lot of sense" in med-mal cases.

Lawyers who represent doctors seem to agree.

"I've used them," said Dunn. "I did one where the low was \$400,000 and the high was \$1.6 million — and won it, but still had to pay

**"The average juror likes doctors. They live in an area where some of the best doctors work; they give them the benefit of the doubt."**

— Boston lawyer  
**Curtis R. Diedrich**

the \$400,000. I did another where the low was \$250,000 and the high was \$1 million — and jury came back with \$4 million. So they can be lifesavers. In [the Lowell case], I think the lawyers were smart to make the deal."

Reidy said that "in a situation where the damages are serious and the liability is questionable so the client has significant exposure, it allows the lawyer to protect the client to an amount within insurance coverage and to allow some money to be paid so that the patient's family has some money. Everybody cuts their risk."

But Reidy warned of one potential pitfall of a high-low agreement.

"Even if the doctor wins the case, he still may be required to report the case to the national databank," he explained.

## The evidence

What was it that persuaded the jury to award a record amount?

Higgins, the plaintiffs' lawyer, stressed the fact that the doctor had to consult with a textbook as proof that the "green" doctor wasn't qualified to handle the case.

"I don't think jurors like to think that doctors have to run to a textbook to determine what numbers mean. If you are an airline pilot, even if it's your first flight, you expect they know how to land without looking at a manual," argued Higgins.

The attorney said he also believes the jury didn't like the fact that the doctor, in the interim period between deciding to perform a C-section and actually delivering the baby, took a break.

The doctor explained that the reason she took the time was so that she would be rested to perform the arduous procedure.

But Higgins questioned whether the real reason the defendant took the time was so that she would be fresh for other, more personal reasons.

"At 7 a.m., the child was born," Higgins recounted. "At 8 a.m., she left for New York for a job interview."

The attorney said he asked a lot of "why didn't you" questions, to which the defendant answered, "I can't tell you. This is what I do. It's just my gift. It's hard to explain."

Higgins said he believed it became clear that the doctor "probably didn't do a great job for this child" about mid-way through the two week trial.

It was then, Higgins said, that defense counsel approached him with the high-low offer.

Kenneth D. Weiss, the attorney for the defendant in the case, did not return phone calls from Lawyers Weekly. MMLR

# Fraud allegation won't save 'late' med-mal suit

Continued from page 7

to dismiss the claims as untimely under the applicable statute of repose.

## Statutory application

While the parties disputed which statute of repose governed the case, Fishman ruled that both G.L.c. 231, §60D and G.L.c. 260, §4 were applicable: as a minor, the claims asserted on Andrew's behalf were governed by Chapter 231, §60D, whereas the claims brought by the mother on her own behalf were controlled by Chapter 260, §4.

The judge rejected the plaintiffs' contention that nurses escaped the effects of the statute of repose because the word "nurse" was omitted from the section of Chapter 260, §4 that enumerated the medical professionals to whom the statute applied.

"It is difficult to perceive any reason that the Legislature intended actions against nurses to be governed by the medical malpractice statute of repose only when the claims are brought by minors as opposed to

adults," he remarked.

In the context of two analogous statutes enacted in the same legislative session, Fishman said, courts were permitted to look to the history and purpose of a statute to de-

**Lawyer Doyle C. Valley called the ruling a "good step" towards providing medical providers with some comfort, but cautioned that until an appellate court rules on the issue, medical practitioners cannot "breathe a complete sigh of relief."**

termine its proper construction, even if it was apparently unambiguous.

"To allow nurses to escape the version of the statute of repose applicable to actions brought by adults would foil the Legislature's efforts to provide a cut off for malpractice

litigation so as to reduce the cost of health care," he observed.

## Absolute bar

Fishman also dismissed the argument that

fraudulent concealment to apply to statutes of repose, it is reasonable to conclude that they would have articulated the exception in the statutory language."

Just as the discovery rule did not toll statutes of repose, Fishman concluded, the statute that enabled tolling for fraudulent concealment did not operate to toll the statute of repose.

He acknowledged that statutes of repose could work a hardship, because they barred all claims that exceeded the specified time limit, whether meritorious or frivolous and without regard to whether or not the failure to bring the action in time was through no fault of the plaintiff.

"While this result may be harsh or even unfair, the Legislature tolerates these inequities to serve the greater purpose underlying these statutes," Fishman continued.

The plaintiffs' direct claims of fraud and misrepresentation were dismissed without prejudice as not having been pled with particularity. The judge, however, granted the plaintiffs leave to amend their complaint on these counts. MMLR

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