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Nomination deadline extended to June 1 — See page 16

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Governor's apology bill would protect physicians, hospitals

By David E. Frank

Gov. Deval L Patrick has filed a controversial bill that would strongly encourage physicians to apologize to patients by keeping their statements out of court

Under the measure, a health care provider's "statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern" relating to an unanticipated medical outcome would be inadmissible at trial.

Jeffrey N. Catalano of Boston's Todd & Weld, who represents plaintiffs in medical-malpractice cases, said that state law already bars general statements expressing "sympathy" or "benevolence" from being introduced at a civil trial and that the governor's legislation goes too far.

"Patrick's proposal contradicts decades of laws of evidence holding that admissions of a party opponent are fair game for a jury to consider," Catalano said.

But med-mal defense lawyer Brent A. Tingle of Morrison Mahoney in Boston said that the proposal is part of a bigger trend.

"The trend locally and nationally in medicine is toward prompt disclosure of adverse events to patients or their family," Tingle said. "This amendment is consistent with that trend."

In an e-mail to Lawyers Weekly, the governor's Health and Human Services secretary, Dr. Judy Ann Bigby, said 35 states have laws offering some kind of legal protection for physicians who express regret or empathy to patients in the aftermath of an adverse event.

Bigby, who declined to be interviewed, said similar measures in other states have cut litigation costs in half and have created a

Continued on page 12

Managing risk when prescribing narcotic painkillers for patients

By Eric T. Berkman

More patients visit their doctors for pain than for any other reason. This means every physician needs to confront the option of prescribing narcotics to treat pain.

However, while opioids are frequently the most appropriate course of treatment for pain, managing such treatment creates a host of legal hazards for physicians. Mismanagement of opioids is increasingly resulting in legal consequences ranging from medical malpractice claims to disciplinary actions by the Board of Registration in Medicine.

"I was speaking with [our claims department] the other day, and they said we're seeing more and more allegations of physicians creating addictions in patients or overdoses from their failure to monitor patients appropriately," confirms Anne Huben-Kearney, vice president of risk management for ProMutual, the commonwealth's largest medmal insurer.

And general practitioners have more to worry about than certified pain specialists when it comes to risk over pain treatment.

"That's because they're the ones who deal the most with patients, treat the highest number of patients and have the widest variety of patients," said Edison Wong, a Fitchburg physiatrist and pain specialist who conducts frequent workshops on the subject. "They're the ones who also have the most limited time [to spend with a patient] on a per-episode basis."

While some physicians might try to avoid such risks by refusing to treat pain altogether, that course of action creates just as much risk.

"We've heard nationally of physicians being sued for malpractice because they didn't address the pain appropriately," says Wong. "They got scared and didn't prescribe strong enough medication and their patients complained. So it's kind of a double-edged sword. Sometimes it's too easy to throw up your hands and say, 'You've got to live with it.' That's not going to be acceptable most of the time."

Here are some tips for physicians in treating their patients for pain while minimizing the chance of falling into liability or disciplinary traps:

- **Maintain systems to identify and monitor patients for potential drug abuse.**

The failure to identify and monitor patients for potential abuse, misuse or diversion of opioids is the leading cause of negligence actions, according to anesthesiologist Edward Michna, director of the Pain Trials Center at Brigham and Women's Hospital in Boston and a licensed attorney who

Continued on page 8

Are your coding and billing practices safe from audit?

By Sylvia Hsieh

The ratcheting up of audits of medical billing practices is forcing doctors to bulletproof their coding and billing methods against an audit, investigation or, in the worst case, fraud allegations.

Recovery Audit Contractor audits, known as RAC audits, were piloted in several states and have been rolled out nationwide. Auditors are tasked with finding any improper payments to Medicare, but they are paid according to the percentage of overpayments they recover, thereby incentivizing discovery of overpayments.

"The auditing landscape has just increased with RAC auditors," said Andrew Wachler of Wachler & Associates, a health care law firm in Royal Oak, Mich.

In addition, there's an alphabet soup of other auditors including MICs (Medicaid Integrity Contractors), MACs (Medicare Administrative Contractors) and ZPICs (Zone Program Integrity Contractors).

Under the new federal health care reform law, RACs are authorized to audit Medicare Part C, Medicare Advantage and Medicare Part D, which applies to prescription drugs, for billing errors, Wachler said.

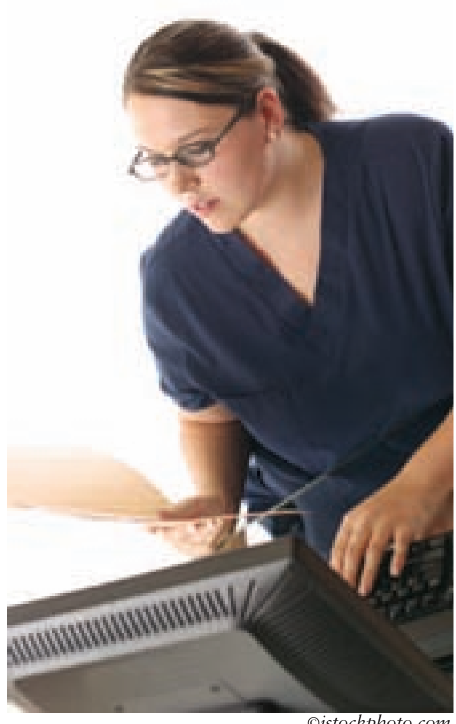
Besides the government, third party payors such as insurance companies and HMOs are also conducting their own audits.

Many physicians' practices delegate their coding and billing and never bother with it again.

But this is a mistake.

"The physician has a legal responsibility and the ultimate liability for any service that

Continued on page 12



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Communicating with patients is key every step of the way

Editor's Note

Dr. Ronald Sroka "has real conversations with you, and he remembers what's going on in your personal life. I really like that," said one patient in a recent New York Times article profiling Sroka, who has been a Maryland family physician for 32 years.

The patient continued: "At some medical offices, you feel like you should pull a number like at the deli. But Dr. Sroka's office is small-town medicine, and I like that. I'm dreading the day when he retires. I know it's coming."

As the article explores, that day may not be coming as fast as this patient thinks. In its profile, the Times reports that Dr. Sroka has not only been unable to sell his practice, but also unable to give it away. Young physicians generally do not want to take over solo practices, where the work falls largely on their shoulders alone.

The article goes on to extol the value, even for patients, of larger practices: "more preventive services, better cardiac advice and fewer unnecessary tests" in bigger practices mean better care, despite substantially less intimacy between doctor and patient.

But doesn't the foundation built by strong doctor-patient relationships, and the free-flowing conversation that characterizes them, improve the quality of care, and also reduce the risk of errors and subsequent lawsuits? Isn't this one-on-one, focused communication still critical in improving outcomes over the long-term, whether in a solo office or a multi-specialty group practice?

It seems clear that mistakes can be avoided – and patient satisfaction increased – if our health care system encourages physicians in practices of all sizes to take enough time to communicate with patients all the way through the process.

On page 9 of this issue, Dr. Alan Woodward makes a compelling case for more open communication at another crossroads in a patient's journey through the health care system.

Woodward, the Massachusetts Medical Society and others are advocating a new approach to responding to medical errors that includes full disclosure to a patient and his or her family of what happened and why; and for avoidable events, an apology and a fair and timely offer of compensation.

As Woodward notes, a similar approach has been successful at the University of Michigan Health System, where court cases were reduced by more than 90 percent within six years. When patients are comfortable with the way their caregivers respond in the face of a medical mistake, the moral of the story is they don't feel the need to take legal action.

It seems clear that what patients want most of all is communication with their health care providers. And no matter how streamlined, efficient and effective we make our health care services, we lose sight of this important fact at our own peril.

— Reni Gertner, MPH

Table of contents

3 Accountable Care Organizations
CMS issues long-awaited Medicare ACO regulations

4 Listening In
The news beat of the medical profession

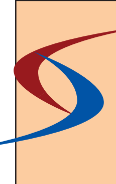
6 Bills, Rules & Regs

7 Verdicts & Settlements
Patient's family wins $9.5 million in bedsore case

9 Good Medicine
Q&A: Can a new model to transform medical liability, based on the concepts of disclosure, apology and offer, work in Massachusetts?

9 Doctor's Rx
Medical liability: It's time for a new approach

10 More Verdicts & Settlements



13 Earn CME Credits
Topic: The importance of discussing end-of-life care with patients

Board of Medicine comments on article about resignation 'mouse trap'

Letter to the Editor

Dear Editor:

I read with interest the recent article by Attorney Andrew Hyams entitled "The Board of Medicine's hospital resignation 'mouse trap.'" (Massachusetts Medical Law Report, March 2011). I appreciate the opportunity to respond to this article as it does not accurately represent the Board's compliance with its regulations and the law.

The reporting that Attorney Hyams takes issue with is that mandated by Mass. Gen. Laws Chapter 111, Section 53. This statute requires health care facilities to report several occurrences, including the acceptance of the resignation of any physician related to competence or any complaint/allegation regarding any violation of law, regulation or by-laws.

As with any statute, the Board, the agency charged with enforcement of the statute, promulgated regulations to assist in the interpretation of this statute. The correct citation of the regulation at issue is 243 CMR 3.02 et seq. In that section, the Board clearly defines "disciplinary action" for the purposes of reporting and includes several actions, including resignations, within that definition, whether voluntary or involuntary.

Although Attorney Hyams suggests that the Board has set a "trap" for unsuspecting physicians, it is the facilities themselves that determine whether a particular action is disciplinary and reportable pursuant to statute and the Board's regulations. The Board, in collecting disciplinary reports from health care facilities, is abiding by its statutory mandate. The Board is required to collect such data and is not empowered to look behind the report itself. The onus is on the health care facility to make a determination as to whether a report is required.

Any time a substantive change is made to a physician's Profile, a copy of that Profile is sent to the physician. The physician then has 14 days to review his changed Profile, during which time it will not be available to the public. The physician can then dispute the factual accuracy of the changes.

If a physician disputes a facility's report, we instruct that individual or his counsel that he needs to address his dispute with the facility, whether through the facility's own appeal process or the courts. If the Board receives notification that steps are underway for a facility to review a disciplinary report, the Board immediately puts an administrative hold on that physician's Profile, rendering it unavailable to the public until the dispute is resolved.

This brings us to another misimpression left by Attorney Hyams' article. When the reporting process was established in the 1980's, there were no Physician Profiles. The Physician Profiles were established by an amendment to Mass. General Laws, Chapter 112, Section 5 in 1996, wherein the legislation mandated that information contained in formerly confidential disciplinary reports be made public in Physician Profiles. In fact, the 1996 amendment specifically requires that a resignation appear on Physician Profiles.

The Board, in posting a physician resignation from a facility, is doing so pursuant to statutory and regulatory authority. No "trap" has been set by the Board; the Board is complying with the law.

Thank you for providing the Board the opportunity to clarify this issue.

Sincerely,

Stancel M. Riley, MD, MPA, MPH
Executive Director
Massachusetts Board of Registration in Medicine

The author responds:

The statute requires a report of a resignation related to competence, but if the physician never knew that his/her competence was being investigated, then the resignation could not have been related to competence. Far from just passively enforcing a statute, the Board has expanded the hospital reporting requirement to include a resignation during an investigation of which the physician is unaware. Thus, it is not the "facilities themselves that determine whether" a resignation is reportable to the Board; the facilities are complying with the Board's overreaching interpretation.

— Andrew Hyams, Esq.
Kerstein, Coren & Lichtenstein, Esq.
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CMS issues long-awaited Medicare ACO regulations

By Craig Schneider, Ph.D.

One of the most eagerly anticipated provisions of the Affordable Care Act is the Medicare accountable care organization (ACO) program, Section 3022 of the Act, which is now known as the Medicare Shared Savings Program.

The Centers for Medicare & Medicaid Services (CMS) released long-awaited proposed rules surrounding ACOs on March 31. The proposed rules were published in the *Federal Register* on April 7, and CMS is accepting comments on them until June 6. The program will be effective on January 1, 2012.

The principle of an ACO is to integrate providers across the continuum of care and reward them for delivering high-quality and more efficient care, which the fee-for-service payment system does not. According to CMS Administrator Donald Berwick, the current system's payment and delivery systems are fragmented, and "[f]ragmentation leads to waste and duplication – and unnecessarily high costs."

Medicare beneficiaries will not be required to receive care from a particular ACO. While this preserves patient freedom of choice, it will create challenges for attribution of services and the ACO's ability to manage the care for patients who seek services beyond the ACO's network.

ACOs participating in the Shared Savings Program must meet quality standards in the categories of patient experience of care, care coordination, patient safety, preventive health and care for at-risk patients and the elderly. There are currently 65 different quality metrics an ACO must meet across these five categories to qualify for the program, and eventually to receive the maximum shared savings.

CMS believes that the proposed rule offers 'considerable flexibility' to providers that are interested in forming an ACO.

CMS believes that the proposed rule offers "considerable flexibility" to providers that are interested in forming an ACO. Under the rules, ACOs may be organized by physician group practices, networks of individual practices, hospitals or partnerships of these various provider organizations. The governance of these Medicare ACOs must include community representation, including consumers.

Medicare proposes two levels to the program. For organizations that are trying to become an ACO for the first time, there is a "one-sided risk model" in which there would be shared savings between Medicare and the ACO during the first two years and only a risk of loss in the third year. The other track involves a two-sided risk model, in which providers and CMS share both savings and losses for all three years, and there is a greater opportunity for upside gains.

CMS expects that the ACO program will save Medicare almost $1 billion over the next three years.

The new Center for Medicare and Medicaid Innovation (created by another Affordable Care Act provision) will be testing other models for ACOs that offer greater flexibility than Section 3022 of the statute permits. The Innovation Center will also develop a technical support platform for ACOs.

One of the reasons that the regulation was delayed is ACOs are thought to have implications for antitrust law. The CMS rule was accompanied by an Antitrust Policy Statement from the Federal Trade Commission, a guidance statement from the Internal Revenue Service, and a recommendation for laws to be waived by the HHS Inspector General.

Some observers say that the ACO program will be a boon to legal experts and consultants. Ian Morrison of Strategic Health Perspectives told *The Washington Post* that ACOs will create opportunities for consultants and the legal community.

"There are legal, information technology and cultural changes needed to make it work," and this should result in revenue for lawyers, IT experts, and management consultants, Morrison said.

Former CMS Administrator Dr. Mark McClellan and Dr. Elliott Fisher of The Dartmouth Institute (who is widely considered to have coined the term "ACO") have identified the key questions regarding the Medicare Shared Savings Program.

Those questions include:

- Whether there will be limitations on access to care and stinting on care;
- Whether savings for payers will result;

Continued on page 8

Will your medical liability provider be there if you have a claim years, months or even weeks from now?

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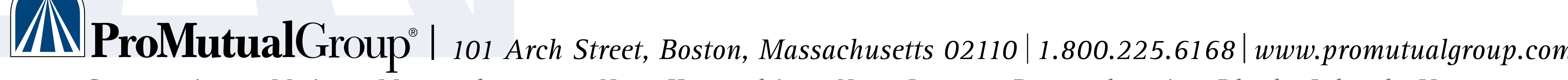

HIMSS, MGMA offer privacy toolkit for physicians

In a joint effort to help small clinics and physician practices safeguard their patients' health information, the Healthcare Information and Management Systems Society has partnered with the Medical Group Management Association to produce a specialized set of readily accessible informational tools.

The HIMSS Privacy & Security Toolkit for Small Provider Organizations contains chapters covering the Centers for Medicare & Medicaid Services; new privacy and security requirements regarding the American Recovery and Reinvestment Act/HITECH Act; HIPAA; guidance and resources; research and data; and useful information for executives and key decision-makers.

Toolkit users can contribute to the interactive resource on the HIMSS website by sharing privacy and security tools, ideas for new content or feedback. A P&S Toolkit Content Review Task Force will review all submissions before posting.

The concept for the toolkit emerged almost 10 years ago. With the passage of the American Recovery and Reinvestment Act of 2009 and its subsequent provision on becoming a meaningful user of health IT, HIMSS and MGMA worked to develop the toolkit specifically targeting clinicians, practice managers and others who are part of small provider organizations.

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Abuse uncovered in free health care pool

A program that pays for medical care for uninsured Massachusetts residents is spending millions of dollars on bogus claims such as foot X-rays for headaches and gynecological bills for men, according to the state's inspector general.

Inspector General Gregory Sullivan said the state's Uncompensated Care Pool spent $414 million on emergency health care for nearly 1 million claims in 2009.

That included $7 million for ineligible patients, such as nonresidents; $18 million for "medically unlikely" or "medically unnecessary" claims, such the X-rays and gynecological exams; and $6 million in duplicate claims. The state Health and Human Services Department says it is reviewing the report and working to eliminate waste.

The pool was established in 2006 under the state health care reform law.

Survey: CommCare largely successful

More than eight in 10 members of Commonwealth Care, a taxpayer-subsidized insurance program for low-income Massachusetts residents, say they're satisfied with their insurance coverage, according to an independent survey commissioned by the state Connector Authority. The survey conducted by research firm Market Decisions found that 84 percent of subscribers are satisfied with coverage and just 4 percent say they're dissatisfied.

The survey also found that 17 percent of members experienced problems paying medical bills, while 63 percent described their premiums as reasonable.

Four in five respondents said they had seen a doctor at least once since joining the plan. Thirty-one percent of those surveyed, however, said they had been told by a doctor that their insurance wasn't accepted, and 23 percent were turned away by doctors not accepting new patients.

A third of members said they had received emergency room care in the past year, largely because they needed care outside of normal business hours.

The telephone and mail survey of 695 Commonwealth Care members was conducted between Oct. 19 and Nov. 30, 2010 and carries a 3.7 percent margin of error.

Boston center tackles health care inequities

A Boston-based community health center has launched a program aimed at fighting hypertension and depression specifically among Boston public housing residents.

The Whittier Street Health Center has unveiled the "Vibrant Communities in Boston Public Housing" in an effort to reduce the widespread physical and psychological ailments affecting low-income individuals and families.

Frederica Williams, president and CEO of the center, said 1,800 families will benefit from the program, which will provide preventative health services and offer training on how to lead healthier lifestyles.

As part of the effort, Whittier will hire five social health coordinators, one for each of the five public housing developments targeted under the program.

The program was made possible by a $750,000 grant from the Kresge Foundation, a $3.1 billion national foundation based in Detroit, Mich., that focuses on helping organizations cater to the needs of poor, disadvantaged and disenfranchised communities.

Report: Mass. doctors outperform nation

Massachusetts medical providers largely outperformed the national average in delivering services ranging from colorectal and breast cancer screenings to testing children for strep throat, but quality of patient care can vary widely from doctor to doctor and hospital to hospital, according to a new report.

The report by Massachusetts Health Quality Partners found that within Metro Boston, for example, some medical groups perform long-term monitoring of depression medication for 75 percent of patients on those med-

AMA releases first-ever app for CPT billing codes

The American Medical Association has introduced its first-ever app designed specifically to allow physicians quick access to Current Procedural Terminology billing codes, according to Physicians News Digest. The app is now available for free through the iTunes store.

Developed for physicians by the AMA, the CPT evaluation and management quick reference app is an on-the-go reference guide that is compatible with Apple iPhone, iPod Touch and the iPad. It features both decision-tree logic and quick-search options, allowing physicians to digitally track CPT codes and e-mail them anywhere. Physicians can also save their most frequently used codes by location or type of service.

The AMA also launched the 2011 AMA App Challenge, calling on physicians, residents and medical students to submit new app ideas. Two winners will be selected – one from the resident/fellow or medical student category and one from the physician category – with each receiving $2,500 in cash and prizes, plus a trip for two to New Orleans for the grand unveiling of their winning idea at the AMA's November meeting. Participants can submit their ideas online through June 30 at: http://www.amaidealab.org/.

icines, while other medical groups only monitor 33 percent. Overall, the report found that gaps in medical performance are closing and overall performance is improving. In 24 of 26 measures of care procedures – such as cancer screenings, appropriate imaging for lower-back pain, blood sugar, proper use of antibiotics for bronchitis, cholesterol screenings and Chlamydia testing – Massachusetts outperformed the national average.

In women's health, improvements have been strongest, according to the report.

The report is the seventh annual by MHQP to measure quality of care. Data for more than 150 medical groups and 4,000 physicians were compiled using data from five major Massachusetts insurers: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England and Tufts Health Plan.

Union launches new quality care campaign

The largest health care union in Massachusetts has launched a campaign focusing on payment reform and raising awareness of service and technical workers who union members say are often overlooked as part of the care delivery team.

The "Voices of Quality Care" campaign by 1199SEIU United Healthcare Workers East kicked off in April with a television ad promoting a new website, www.VoicesOfQualityCare.org.

1199SEIU caregivers support legislation that improves health care quality while reducing costs. However, they say that in order to succeed, it must address the low Medicaid reimbursement rates to hospitals. Workers say inadequate Medicaid reimbursement rates for "safety net" and community hospitals create a "cost-shifting" problem that forces hospitals to charge private insurers and consumers more to make up the difference.

1199SEIU members also say further training and an increased role for frontline caregivers could help reduce long-term costs by improving patient care coordination and reducing errors. Caregivers say workforce training will also be needed to help health care workers transition from some of the old health care model jobs to the health care jobs of the future that will be spurred by the reforms.

Study: Doctors vital to economy

A study released by the American Medical Association shows that physicians play a vital role in the Massachusetts economy by contributing $31.7 billion in economic output, representing 8.7 percent of the state's GDP, and support more than 112,000 jobs in the state.

The study, The State-Level Economic Impact of Office-Based Physicians Report, was done for the AMA by The Lewin Group, a national health care policy research and management consulting group based in Virginia. It reported on the economic impact of nearly 20,000 office-based physicians in the Commonwealth for 2009.

The research found that 19,550 Massachusetts office-based physicians:

- Supported 112,224 jobs, with an average of 5.7 jobs supported per physician;
- Supported $23.5 billion in total wages and benefits; and
- Generated $1.5 billion in total state and local tax revenues.

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Bills, Rules & Regs

From Beacon Hill

Programs for elderly, disabled get reprieve

Service providers and clients of programs for the elderly and developmentally disabled received a reprieve after the governor suspended $10 million in MassHealth cuts that were to take effect last month, according to The Cape Cod Times.

Areas threatened by the budget axe are adult day health, which provides care to elderly patients to keep them out of institutions; day habilitation programs that provide clinical care and occupational therapy for the developmentally disabled; and adult foster care, which provides 24-hour service to the elderly and developmentally disabled adults.

The cuts affected by the 11th-hour postponement in March are for the remainder of the fiscal year. Adult day habilitation providers would have lost 4.1 percent in rate reimbursements, roughly $5.2 million annually; adult day health providers would have seen their rate reimbursements fall 7.8 percent, a $3.3 million annual cut; and $4 million in annual cuts to foster care would have taken 6.2 percent of the program's budget.

The cuts could still be made for the remainder of the year, the Times reported.

DPH releases priorities list

The Massachusetts Department of Public Health – facing a $25 million cut in funding next year that's expected to eviscerate a number of key programs – has drawn up a short list of priorities on which the agency will focus over the next four years, according to the Worcester Telegram & Gazette.

DPH officials said they plan to concentrate on:

- promoting wellness programs;
- fighting to cut the rate of chronic diseases, such as diabetes and asthma, that severely afflict Massachusetts residents;
- reducing the disparity in health woes between whites and racial minority groups;
- working to bolster local public health authorities through regionalization and other programs; and
- continuing to smoothly implement state health care reforms.

Docs, sheriffs push for HIV test consent bills

Doctors and sheriffs joined AIDS activists at a hearing earlier this month to urge the Joint Committee on Public Health to approve laws that would increase testing for HIV/AIDS.

Along with eliminating written consent requirements, the bills, sponsored by Sen. Patricia Jehlen, D-Somerville, and Rep. Bryon Rushing, D-Roxbury, would increase routine screening by requiring every primary care doctor, including obstetricians and gynecologists, to offer HIV tests.

Lisa Ehle, the director of program services for the March of Dimes Foundation, said some pregnant women have HIV and don't know it until after their baby is born. Mothers could prevent transmitting the disease to their unborn babies if they receive the right treatments, she said.

Dr. Jonathan Davis, the chief of newborn services at Tufts Medical Center, added, "We have the best chances of preventing the spread of HIV when the baby is still in the womb."

Another bill seeking more HIV/AIDS testing came from local sheriffs and public safety officials. Sheriffs asked the committee to consider a bill to allow public safety officials to have prisoners tested for HIV/AIDS after an incident where an officer is exposed to a prisoner's bodily fluids.

Officials debate new global payment plan

State and hospital officials are debating legislation filed by Gov. Deval L. Patrick calling for a global payment system in Massachusetts that's years ahead of plans for such a change nationwide, according to The Cape Cod Times.

Under the global payment model, insurers would give individual health care providers a pool of money annually to divvy up among themselves instead of reimbursing for each X-ray, surgery or other incident of care.

Proponents say that the plan would rein in costs and help patients by improving coordination among practitioners from pharmacists and doctors to hospitals, nursing homes and visiting nurses. Critics say it's the same practice that gave managed care a bad name, and that it displaces the risk of costs associated with providing care from insurers to physicians and other practitioners.

Health care providers would be grouped into Accountable Care Organizations that share the same pool of patients and work more as a team to reduce unnecessary tests and promote preventative care, according to Lynn Nicholas, president and CEO of the Massachusetts Hospital Association.

Patrick claims the new payment method is necessary to control spiraling health care costs, and that doctors would communicate better with hospitals, who would communicate better with nursing homes. The governor predicts most insurance markets in Massachusetts will be organized around global payments and ACOs within three years, the Times reported.

From Capitol Hill

Senate passes first repeal of health law

Congress sent the White House its first rollback of the new health care law earlier this month, a bipartisan repeal of a tax reporting requirement that was widely unpopular with businesses.

The Senate voted 87 to 12 to repeal a requirement that would have forced businesses to file tax forms for every vendor selling them more than $600 in goods each year, starting in 2012. Although not specifically related to health care, the requirement would have generated a projected $25 billion to pay for part of the law.

President Barack Obama supports the change, which was approved by the House in early March.

Republicans hope the bill is the first of many measures that will ultimately result in the dismantling of the entire health care law. Democrats say it is part of inevitable revisions needed to improve the measure.

Medicare panel: Give docs pay raise in '12

Congress should boost Medicare physician payment rates by 1 percent in place of a steep scheduled cut set to take place Jan. 1, the Medicare Payment Advisory Committee recommended in its annual March report to federal lawmakers.

MedPAC released its report March 15, just days after the Centers for Medicare & Medicaid Services announced that a Medicare physician payment cut scheduled to occur Jan. 1 would be 29.5 percent – the highest to date.

The American Medical Association and 130 state and specialty societies sent letters March 10 to the U.S. Senate and House of Representatives calling for a permanent solution this year to Medicare's physician payment problem.

"The AMA concurs with MedPAC's conclusion that the nearly 30-percent cut built into Medicare's payment system for 2012 would jeopardize access to physician services for many patients and should be replaced with a positive update to help offset increases in practice costs," AMA President Cecil B. Wilson said in a story by American Medical News.

U.S. issues rules on insurance waivers

The Departments of Health and Human Services and the Treasury have proposed new rules outlining the steps states may pursue in order to receive a State Innovation Waiver under the Affordable Care Act.

State Innovation Waivers, which would allow states to pursue their own strategies to ensure quality, affordable health insurance for their residents, would be available to those states that:

- Provide coverage that is at least as comprehensive as the coverage offered through Health Insurance Exchanges;
- Make coverage at least as affordable as it would have been through the exchanges;
- Provide coverage to at least as many residents as otherwise would have been covered under the Affordable Care Act; and
- Do not increase the federal deficit.

State Innovation Waivers will be available in 2017. President Barack Obama supports bipartisan legislation that would make them available beginning in 2014.

HHS unveils new 'quality strategy'

The Department of Health and Human Service has released a national quality strategy for improving health care, as called for under the Patient Protection and Affordable Care Act.

The strategy focuses on three specific areas:

- Better care, by improving overall quality and by making health care more patient-centered, reliable, accessible and safe;
- Healthy people and communities, through improving health and supporting proven interventions to address behavioral, social, and environmental determinants of health care; and
- Affordable care, through reducing the cost of quality healthcare for individuals, families, employers and government.

The new quality strategy is to work in tandem with other provisions included in health care reform, such as the new Center for Medicare and Medicaid Innovation, which will test innovative care and service delivery models to see if they will improve care quality of care and reduce program expenditures for Medicare and Medicaid.

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Patient's family wins $9.5 million in bedsore case

By Sylvia Hsieh

Plaintiffs' attorneys, Arch Farrar, Kenneth D. Bruce and William L. Lundy, Jr. (left to right) won a $9.5 million verdict on behalf of the family of Charlotte Pauline Dean (right), who died after developing bedsores at Country Crossing Assisted Living.

A team of attorneys in Georgia has won a $9.5 million verdict on behalf of the family of a 51-year-old patient at a private care home who died after developing bedsores.

Two sets of photos of Charlotte Pauline Dean helped proved their case.

One set showed an outgoing woman who in spite of her cerebral palsy, which kept her in state institutions most of her life, enjoyed dancing and flirted through her eyes since she could not speak.

The other photos, taken by the Georgia bureau of investigation before her autopsy, showed an emaciated corpse riddled with nine bedsores on her tailbone, hips, shoulders, inner thighs and ears.

The photos made the story believable, but the lawyers said common sense was their most persuasive argument in the wrongful death suit against the private care home, Country Crossing Assisted Living, and the home health care agency, Hutcheson Home Health, that sent nurses to care for Dean every week.

The defense claimed she had only one bedsore and the rest developed in the last eight days of her life.

"The jury simply didn't believe them. It just was not common sense," said William Lundy, lead plaintiff's counsel, who practices in Cedartown, Ga.

Defense attorneys Robert Berry and Hugh Kemp did not return a call seeking comment about the case.

5 months, 8 days, 2 nurses

After living at Country Crossing for more than four years, Dean developed a bedsore on her tailbone in August 2005.

Her doctor ordered Hutcheson Home Health to provide two nurses to treat her.

On Jan. 18, 2006, Dean was rushed to the emergency room from the Country Crossing facility and died the next day.

According to Lundy, the emergency room doctor reported "multiple foul-smelling decubitis ulcers," and Dean's guardian, a family relative, insisted that the state perform an autopsy.

The autopsy photos of the ulcers belied the records of Country Crossing and Hutcheson Home Health nurses, who mentioned only the one ulcer on her tailbone.

The last dated records were Jan. 10, eight days before her death, and said nothing about other bedsores.

At trial, the plaintiffs' lawyers argued that the defense's theory that the bedsores developed during the last week of her life simply was not credible.

The records, for example, indicated that her ears were in perfect condition eight days before her death.

At death, her right ear was almost completely deteriorated and her left ear had lost part of its flesh, according to Kenneth Bruce of Bruce & Thompson, who also represented the plaintiffs.

Several witnesses, including family members of Dean and members of a local community services organization that places people in home care, testified that they saw her ears bandaged or covered up by a toboggan cap when they visited her.

Two substitute nurses, who also worked for Hutcheson Home Health but came in only when the regular nurses were on vacation, noted a stage two ulcer on Dean's right hip in the records.

The plaintiffs' team portrayed the facility, owned by an individual who worked full time as a building contractor, as a chronically understaffed operation with an absentee owner and high turnover of employees.

A defense expert from Vanderbilt University testified that the bedsores could have developed within eight days, but Lundy cross-examined her using deposition testimony from previous cases involving bedsores in which she had offered the opinion that bedsores take time to develop.

Expert rate

In closing arguments, the plaintiffs' attorneys told the jury it had a clear choice in deciding who was telling the truth: the witnesses who recounted seeing Dean with her ears bandaged and hidden, or the defense's paid expert.

As for damages, Lundy gave the jury a yardstick for measuring pain and suffering, asking jurors to use the hourly rate the defense paid their expert witness.

"They hired an expert and paid her $2,500 per hour to protect their money, so we asked the jury to use [the same rate] for the 157 days that Pauline had multiple ulcer sores by their own records," totaling $9.4 million, said Lundy, who added that the defense's highest offer to settle during mediation was $100,000.

On the wrongful death claim, Lundy offered another calculator, telling the jury that the defendants were paid $110 by Medicare for each 20-45 minute visit to treat Dean.

"We asked the jury to use $110/hour for the 25 years [we claimed she would have lived]," totaling almost $25 million, said Lundy.

After less than four hours of deliberations, the jury found the facility 55 percent at fault and the home health agency 45 percent liable, and awarded $9.5 million total ($4 million for pain and suffering and $5.5 million for wrongful death), though Lundy had requested $35 million. The plaintiff's attorneys didn't seek punitive damages, but as a symbolic gesture, the jury awarded $2,683 to cover Dean's funeral expenses.

In post-trial comments, one of the jurors signaled they may have awarded more in better times, telling the lawyers, "We're in a bad economy. We couldn't give you $35 million." **MMLR**

Questions or comments can be directed to the writer at: sylvia.hsieh@lawyersusaonline.com

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Managing risk when prescribing painkillers for patients

Continued from page 1

handled med-mal cases in his former career.

For example, many doctors fail to take a complete patient history – including consulting with prior treating physicians – to determine if the patient has had substance abuse issues in the past. Or sometimes they get the records, but fail to consult them, or fail to document the steps they took.

"Then a patient overdoses and the family sues for inappropriate opioid prescribing because you made no effort to ascertain the history," says Michna.

Another issue is the failure to spot the red flags that should create suspicion, says Huben-Kearney. These include patients claiming to be allergic to non-narcotic medications, people from out of town asking for a specific medication or patients complaining of oral pain with no dentist available.

Some doctors fall into the trap of stereotyping to determine whether someone is a potential abuser.

"[The drug-seeking patient] isn't necessarily someone of a lower socioeconomic status – it can be anyone coming in for that purpose, so have the same level of diligence with everybody," Huben-Kearney advises.

Michna urges doctors to use their receptionists to help predict whether patients might misuse narcotics.

"Patients may be on good behavior in the examining room, but the receptionist out front sees them having behavioral issues and making different types of comments," he says.

Wong adds that doctors need to take different approaches with acute and chronic pain patients. With an acute-pain patient, the doctor needs to determine how long the pain is likely to last and prescribe only for that period of time.

"A lot of doctors … [[continue to prescribe] when the patient asks for it without evaluating the situation and reassessing," he says. "If a physician isn't paying attention because he's overworked or overstressed, he may fail to realize this is the fourth refill as opposed to the first."

Electronic medical records and electronic prescribing can be helpful because they have mechanisms to keep track of such things, says Wong.

Meanwhile, with chronic patients, he says, the doctor needs to monitor the patient with such tools as urine testing and pill counting to ensure he or she is using the medication as directed and not abusing or diverting.

However, says Michna, very few doctors are using the available screening tools – like urine testing and detailed patient self-reporting – to monitor for abuse.

"I saw a recent paper indicating that utilization in the primary-care community was 8 to 12 percent," he says. "That just identifies the lack of uptake and knowledge among primary care providers about what to do with these patients and how to manage them."

If a physician does determine that a patient is addicted to opioids, he or she is required under federal law to refer that individual to a certified pain specialist, cautions med-mal defense lawyer Martin Foster of Foster & Eldridge in Cambridge.

"If you don't, it's a deviation from the standard of care," Foster said.

- **Enter into pain-management contracts with patients.**

Foster says the most important thing a physician can do to protect against lawsuits or disciplinary actions is use pain-management contracts that incorporate detailed instructions and limitations on usage.

"The pain-management contract serves a dual purpose: to try and manage the patient's use and abuse of the prescription and to serve as an informed-consent pathway," says Foster.

If a physician does not properly instruct a patient about side effects and proper use of the medicine, it's a lawsuit waiting to happen.

For example, says Foster, the Supreme Judicial Court ruled several years ago that the parents of a boy who was struck and killed by a motorist who had been taking a variety of medications associated with his cancer treatment could sue the physician, who had allegedly failed to adequately warn the motorist against driving while using the drugs.

The failure to properly instruct on usage can also lead to overdoses, says Wong. For instance, a patient taking a long-acting narcotic like OxyContin might not realize that cutting his pills in half will alter the pill, potentially releasing or dumping medication into the system too quickly, causing a damaging or fatal overdose. And certain pills might change their profile when interacting with alcohol, and the effect can be lethal, he says.

"All physicians probably understand not to use narcotics with alcohol, but they may not recognize that they should really emphasize this when there's a hint the patient may be using alcohol intermittently," says Wong. If such instructions are documented in the informed-consent agreement, the doctor has a strong defense against such lawsuits, as long as he or she was meeting the standard of care by prescribing the medication in the first place.

A contract also provides an avenue for physicians to guide the patient's conduct after receiving the medication. For example, the patient might agree to get his or her prescriptions from a single pharmacy and to get prescriptions in a one-month supply. A patient also might pledge to pick up prescriptions personally, take the medication as prescribed and undergo unannounced blood and urine testing.

Other conditions include agreements that "lost" medicine won't be replaced and that patients will not receive "emergency" refills of medications on nights, weekends or holidays.

"This eliminates the risk of on-call physicians having to deal with drug-seeking behavior," says Foster.

These contracts aren't difficult to draw up, either, says Michna. The National Association of Medical Boards has sample agreements online, as do all the pain societies, he says.

"There's a lot of variability between practices, so to be totally careful, you might run one of these by an attorney," he says. "But most are pretty standard."

- **Maintain a sensible "exit strategy."**

A lot of physicians might instinctively want to terminate their relationship with a patient at the first sign of abuse or misuse. But this is the wrong approach, warns Wong.

"Cut the patient off, but still continue to treat him appropriately," he says. "Perhaps give him another analgesic, but not a narcotic. That way the patient can't file an abandonment claim."

Huben-Kearney adds that you can't just stop cold when a patient is on opioid therapy. Instead, physicians need to wean the patient to prevent withdrawal complications that can sometimes be lethal.

"If that happens, the doctor is considered negligent," she says. "Or God forbid they're in so much pain that they're suicidal. The physician is negligent, too."

Michna agrees, and further advises physicians to understand the limitations of drug-screening technology. For example, a doctor might not understand the limitations of urine drug screens and accuse a patient of diverting his or her prescription if the test turns out negative.

"If you're not savvy about the tests, a false accusation can potentially result in a patient filing suit," he says.

- **Avoid tunnel vision.**

Wong says some physicians become so fixated on treating the pain itself that they discount other potential issues – such as psychological issues – that might be influencing the pain.

"The primary care provider might … end up prescribing lots of narcotics when really there's mild-to-moderate pain and lots of depression," he says. "The trap is addiction or health complications because they're not treating the appropriate thing."

On the other side of the coin, ignoring or downplaying pain can be equally dangerous, says Huben-Kearney. She tells of a situation where a woman complained of worsening headaches and told her doctor she was afraid she had a brain tumor. The doctor discounted her fear. When the headache persisted despite increasingly potent medication, the doctor referred the patient to a psychologist. Weeks into therapy, the patient died from what the autopsy indicated was a brain tumor.

"Needless to say, there was a lawsuit and the family alleged negligence on the part of the primary-care physician," she says.

In light of all the dangers associated with treating with narcotics, some physicians may decide to limit their exposure to liability by refusing to prescribe them altogether, says Foster. But this version of tunnel vision deviates from the standard of care.

Of course, damages in such cases are so subjective that most plaintiffs' lawyers won't see the value of bringing an action. But the Board of Registration will.

"A case like this is made-to-order for a plaintiffs' attorney to decline and recommend that the patient pursue it with the Board," he says. "And the Board's policy is that it's not appropriate to undertreat or refuse to treat pain." **MMLR**

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

CMS issues long-awaited Medicare ACO regulations

Continued from page 3

- Whether ACOs will have enough data, from internal and external sources, and analytic capabilities to support the envisioned improvements in clinical care delivery;
- Whether antitrust violations will occur;
- Whether small providers will be able to afford to participate; and
- Whether attribution of patients and incentive structures will succeed.

Other commentators have noted challenges related to the application process and meeting Medicare requirements and predict that relatively few organizations will participate. CMS anticipates 75-150 nationally, and I would expect Massachusetts to have a disproportionately large share of ACOs, given the integrated and high-quality health care organizations in the state.

Another issue is "retroactive assignment." CMS would not assign a Medicare beneficiary to an ACO until the end of the year, based on where he or she received the most care. This means, in effect, that the ACO would have to treat all beneficiaries as if they are part of their ACO throughout the year, just to be on the safe side.

The opportunity for risk sharing has surprised some analysts, as the regulation appears to go beyond the statute's shared savings approach, and may make certain potential participants wary. There is also a requirement that over 50 percent of the physicians in an ACO be meaningful electronic health record users, which will be a high bar to reach for many practices. This is another example where Massachusetts providers are better positioned than those in other states.

Clearly there are substantial challenges for CMS and for potential ACOs. However, for those of us who have been encouraging transformation of the delivery system to be more patient-centered and of the payment system to reward value rather than volume, the proposed ACO rule is an exciting development in the effort to achieve a more integrated and effective health care system.

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

Good Medicine

What doctors are talking about now

Q: A new model to transform medical liability, based on the concepts of disclosure, apology and offer, is being proposed to improve patient and provider trust, reduce fear and enhance patient safety. It works in Michigan. Can it work in Massachusetts?

"Nobody can argue with a system that encourages transparency, disclosure and early resolution of medical negligence resulting in a patient's injury. After all, immediately after the injury occurs is when the needs of injured patients … and their families are the highest. Questions I have include: Is the medical community ready and willing to give up the secrecy of 'peer review'? Peer review causes physicians and nurses to insulate themselves, increase secrecy and avoid learning from their mistakes. Could it be that the charitable immunity limiting hospital liability has removed the incentive to build safer systems? Why is it that the same hospitals that are protected are the ones that own the professional liability insurance companies that insure the 'deep pockets' in Massachusetts?"

—Max Borten, partner at Gorovitz & Borten, represents plaintiffs, Waltham

"The Agency for Healthcare Research and Quality is currently funding seven demonstration projects and 13 planning projects to allow states and health care systems to develop, implement and evaluate evidence-based patient safety and medical liability models. Four of the demonstration grants and two of the planning grants are examining various aspects of disclosure and offer models. One of the planning grants entitled, 'Removing Barriers to Disclosure-and-Offer Models' (Principal Investigator Kenneth Sands, M.D., M.P.H., Beth Israel Deaconess Medical Center, Boston), is exploring the very question being asked. Preliminary results from all these grants would seem to indicate that disclosure and offer programs can work well outside of the state of Michigan, including in Massachusetts."

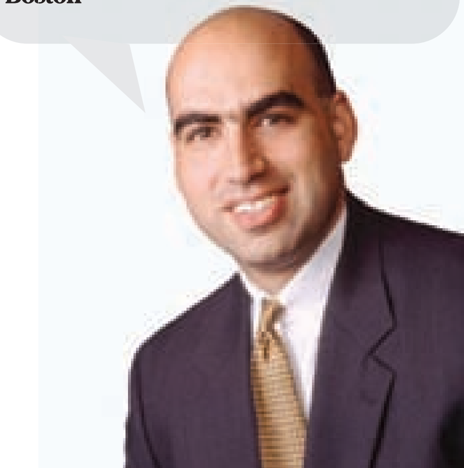
—William Munier, Director of the Center for Quality Improvement and Patient Safety, Department of Health and Human Services, Washington, D.C.

"The answer is mostly yes. The logic, ethics, respect for patients, honesty and outcomes [from using the Michigan] are quite compelling. But, just as checklists are more than checking off little boxes on a form, this effort also represents a more profound cultural shift in the way team members – including patients and families – work together, especially to learn from and prevent errors. We have assembled a statewide PROMISES AHRQ-funded coalition to complement disclosure/apology/offer activities statewide and believe that more transparency, particularly in the outpatient setting, can go a long way to addressing patients' concerns."

—Gordon Schiff, Associate Director, Center for Patient Safety Research and Practice Division of General Internal Medicine, Brigham and Women's Hospital, Boston

"I believe that any change that serves the dual purpose of 1) empowering the patient by being more transparent and providing the patient more information and 2) allowing the provider to serve that purpose by minimizing or eliminating the fear of retribution/punishment through the legal system can only serve to improve patient and provider trust, reduce fear and, most importantly, enhance patient care and safety. The medical profession already, more than any other, engages in critical self-evaluation on a constant basis in an effort to improve patient safety. In my opinion, to allow the patient to participate in that endeavor, with safeguards in place for the provider to allow this to happen, would be a welcome step."

—A. Bernard Guekguezian, partner at Adler, Cohen, Harvey, Wakeman & Guekguezian, represents defendants, Boston



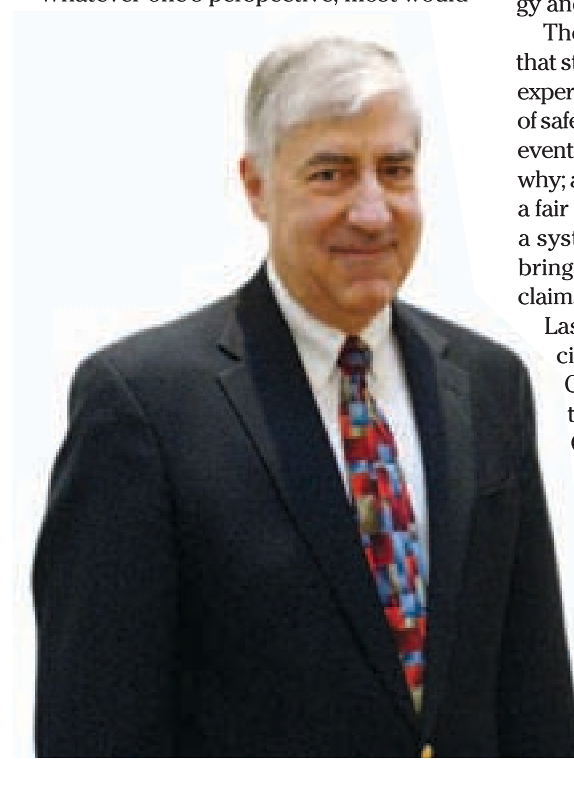
Medical liability: It's time for a new approach

By Alan Woodward, M.D.

Physicians' criticisms about our medical liability system have long been loud and clear: it leads to frivolous lawsuits, undermines patient safety, reduces access to care, creates a "culture of silence" between physicians and patients, burdens doctors with high premiums and encourages defensive medicine, driving health costs higher. In short, doctors say, the system is dysfunctional and ill serves patients, physicians and our health care delivery system.

Some attorneys argue that fairness for patients should be paramount, that the rights of those who have been harmed must be preserved in redressing treatment that doesn't meet accepted standards of care. Insurers urge caution and sometimes silence; patients who have been harmed get caught in years of litigation.

Whatever one's perspective, most would agree that the current medical liability system gets low or failing grades, and has for some time.



Six years ago, The Joint Commission, the independent nonprofit organization that sets standards and accredits health care organizations in the U.S., said: "There is in fact a fundamental dissonance between the medical liability system and the patient safety movement. The latter depends on the transparency of information on which to base improvement; the former drives such information underground. As a result, neither patients nor health care providers are well served by the current medical liability system."

Doctor's Rx

The good news is we can fix the system through a DA& O model – disclosure, apology and offer.

The DA&O model includes four elements that studies show are the priorities of patients experiencing harm: setting a "baseline culture of safety" to prevent the recurrence of adverse events; full disclosure of what happened and why; and for avoidable events, an apology and a fair and timely offer of compensation. Such a system will not deny patients the right to bring a legal action, but would make tort claims a last resort.

Last July, the Massachusetts Medical Society and Beth Israel Deaconess Medical Center received a planning grant from the Agency for Healthcare Research and Quality – part of the president's Patient Safety and Medical Liability Initiative – to create a roadmap to advance a DA&O model in the Commonwealth. With BIDMC as lead investigator, representatives from all key stakeholder groups were interviewed, including physicians, attorneys, legislators, public officials, patient safety experts and patient advocates. They were asked to identify obstacles in implementing such a model, as well as appropriate strategies to overcome those obstacles. Their responses were encouraging and consistent with experience elsewhere.

The University of Michigan Health System, for example, has proven the value of this approach. Within six years of establishing such a program in 2001, UMHS had reduced its annual claims from 262 to 73 and its open cases from 300 to 80. The average time to resolve cases dropped from 20 months to eight months, with transaction expenses cut from $48,000 to $20,000 per case. Court cases were reduced more than 90 percent, and incident reporting – critical to improving patient safety – multiplied. Surveys have demonstrated overwhelming satisfaction with the program.

Attorney Rick Boothman, UMHS chief risk officer and the architect of this approach, is blunt about the need for change: "Medicine needs to reclaim ownership of its problems and the responsibility for fixing them. Failing to honestly confront medical mistakes that cause injury, or to explain honestly to patients why the injury is not the result of medical error, is why we have litigation. Refusing to change is why we can't fix the problem." The Joint Commission is also direct: "The axiom, 'you learn from your mistakes' is too little honored in health care."

Change doesn't come easily, however, and stakeholders interviewed for our project identified several barriers to this new approach.

Discomfort with disclosure and apology exists on the part of both physicians and hospitals. Small and rural hospitals may lack the resources to enact such programs. Attorneys on both sides may not believe a new model will benefit their clients.

Insurers have concerns about potential negative economic impact and cases involving multiple defendants who are covered by more than one company. The current charitable immunity law in the state, limiting hospital liability to $20,000, may make physicians, seeing themselves as the "deep pocket" targets, reluctant to participate.

Additional obstacles include the lack of "enabling legislation" to protect apologies from being used in lawsuits and provide for a mandatory pre-litigation period to complete the DA&O process and for sharing of pertinent medical records with all involved parties.

These concerns are understandable but not insurmountable, and our research led us to conclude that the DA&O model holds wide appeal among stakeholders in Massachusetts. They believe it has potential to serve patients better, reduce legal costs and risks, improve the culture within hospitals and enhance patient safety. Significantly, the most often cited advantage was ethical and professional considerations: that it's simply the right thing to do.

One goal of this approach is to reduce physicians' fear of being sued, which has been a consistent finding in local and national research examining the practice of defensive medicine.

The Joint Commission has recognized this effect as well: "The stifling specter of litigation results in the under-reporting of adverse events by physicians and avoidance of open communications with patients about error. … An unintended consequence of the tort system is that it inspires suppression of the very information necessary to build safer systems of health care delivery."

It is time for a better way to serve patients and improve patient safety. We believe the status quo is unaffordable, unsustainable and undesirable, and we invite all stakeholders to join us in fixing a system long overdue for reform.

Alan Woodward, M.D. is a past president of the Massachusetts Medical Society, Vice Chair of its Committee on Professional Liability, and the MMS representative in the BIDMC/MMS patient safety and medical liability initiative.

Verdicts & Settlements

Crucial vein torn during patient's back surgery

The patient, 51, was undergoing back surgery when her inferior vena cava was torn.

Subsequent to the tear, anesthesia machine monitors showed no blood pressure reading and no oxygen saturation reading. The patient's expert anesthesiologist testified that these changes in vital signs were consistent with bleeding and hypovolemia, and that the anesthesiology team did not communicate the vital sign changes to the surgeon in a timely manner, resulting in a delay in performing an emergency repair.

The patient suffered acute renal failure, myocardial infarction and permanent anoxic brain damage. She was disabled from her position as a bank manager and requires assistance in her daily activities. A verdict for the patient was returned against both the anesthesiologist and his anesthesiology group. The total award was $3.77 million.

Action: Medical malpractice
Injuries alleged: Brain injury, renal failure, heart attack, multiple infections and other damages
Date: Dec. 16, 2010
Submitted by: John B. Flemming, Boston and Andover; Elise A. Brassil, Andover; and Camille Sarrouf, Boston (for the patient)

Nursing home found not responsible for resident's death

An 86-year-old nursing home resident suffered a fall from a wheelchair in the hallway of the facility.

The resident had been identified as a high risk for falls, and her care plan called for 15-minute checks and a personal alarm. In the moments prior to the accident, a staff nurse

Two doctors miss suspicious spot on mammogram

The patient was a 59-year-old woman who had been diagnosed with breast cancer in 1993. She was successfully treated and had remained cancer-free for many years. As a result of her diagnosis, however, she became vigilant about breast cancer screening with mammography and had many years of clear films.

In December 2002, her mammography was interpreted by a doctor as free of any evidence of malignancy. The patient's expert reviewed these films and was prepared to opine that the physician failed to identify and report a suspicious spot on the left breast, and that he failed to recommend or perform further imaging and/or diagnostic studies to rule out cancer, such as spot compressions, magnification views and ultrasound.

The doctor maintained that his interpretation was correct and retained an expert to support that assertion. The following year, a second doctor interpreted the patient's new mammography and found it to have a "stable" area of asymmetric density, which he did not think was new and did not report as being suspicious for malignancy. The patient's expert was prepared to claim that this was the same area of suspicion and that the second defendant likewise failed to identify and report.

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The patient was diagnosed with recurrent breast cancer in August 2004. An oncologist agreed that this was a recurrence of cancer and that treatment would not have led to a cure even if an earlier diagnosis had been made, as the cancer was already outside of the primary site from 1993.

However, the oncologist noted that the delay of 10 to 20 months in treating this recurrence cost the patient longer-term survival. Conversely, the defendants' oncology experts indicated that the treatment and the outcome would have been the same even with earlier diagnosis because the patient's response to treatment would have been the same.

The patient still suffers from breast cancer. The case settled for $1.75 million.

Action: Medical malpractice
Injuries alleged: Delayed diagnosis of metastatic breast cancer
Date: November 2010
Submitted by: Andrew C. Meyer Jr. and Adam R. Satin, Lubin & Meyer, Boston (for the patient)

Verdict & Settlement Reports

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

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

Florida jury awards $19 million for infant given overdose

By Kimberly Atkins

A Florida jury has awarded $19.2 million to the family of a child who suffers from cerebral palsy and other life-altering conditions after being given a nearly lethal overdose of neonatal nutrients and trace elements in the hospital.

But now, the plaintiffs must ask the Florida state legislature to lift the $200,000 damages cap that limits recovery because the hospital is covered by sovereign immunity.

"They have a full understanding that at the end of the day they may not see anything," said Craig R. Stevens, the Fort Myers, Fla. attorney who represented the plaintiffs. "And $200,000 isn't going to make a difference in [the child's] care."

'Enough for a 160-pound person'

Kiarra Smith was born prematurely – just shy of 25 weeks – at HealthPark Medical Center in Fort Myers, Fla. During her hospitalization, she was given a combination of nutrients and trace elements often given to preemies.

But due to an error, the dosage of the formula was 100 times the proper amount.

"It was enough for a 160-pound person," Stevens said.

Subsequently, Kiarra suffered pulmonary arrest and cardiac arrest, and underwent 13 minutes of resuscitation efforts. She survived, but due to the prolonged lack of oxygen, she suffered cortical blindness, spastic quadriplegia and cerebral palsy, and was left developmentally delayed.

"She will never get better," Stevens said. "She will need constant care for the rest of her life."

Her parents, Jeffrey and Melissa Smith, sued the medical center for negligence. While the hospital admitted an error occurred, it asserted that the cause of Kiarra's injuries was her premature birth, not the overdose.

Kiarra's family and their attorneys wanted to pursue the claim, though they were fully aware that they may get little to no recovery due to the state's sovereign immunity statute, which limits negligence damage awards to $200,000.

"We thought it was a really bad injustice, and we thought the family deserved to get something in court," Stevens said. "We thought we had a good case, and the family wanted us to pursue it."

Treating doctors' testimony key

Because of the cap on damages, Stevens said, the hospital never made any settlement offers before or during trial.

Of all the experts, exhibits and other evidence offered during the two-week trial, Stevens said the most persuasive thing the jury members heard were the words of the doctors that cared for Kiarra.

"The [testimony of] the treating doctors supported our claim that the majority of [Kiarra's] injuries were due to the overdose," Stevens said. "That testimony was because they were the doctors that treated her. They said the majority of the damage - not 100 percent, but the majority – was due to the overdose."

It took the six-person jury only four hours to reach a verdict of $19.2 million in the Smiths' favor – $5.2 million in economic damages for Kiarra's care and $14 million for pain and suffering.

The win was important to the family, despite their knowledge that the verdict may never be collected. And after the post-trial motions are completed, the next step will be going to the Florida state house.

Plaintiffs' attorney Craig R. Stevens represented the infant's family.

The plaintiffs must submit a proposed legislative measure called a claims bill to state lawmakers, who must vote to approve the measure lifting the damages cap for the plaintiffs to receive the full verdict amount, Stevens said.

Messages seeking comment from the defense attorneys in the case were not returned.

After the verdict, Lee Memorial Health System, which includes HealthPark Medical Center, issued a statement.

"We acknowledge that a serious error occurred," the statement read. "Medical experts who reviewed the matter at our request believe that the child's condition is a result of complications related to her extreme prematurity because she was born three months early and weighed one-and-a-half pounds." **MMLR**

Questions or comments can be directed to the writer at: kimberly.atkins@lawyersusaonline.com

positioned the resident in her wheelchair after noticing that she was leaning forward. The resident fell less than one minute later.

The plaintiff's nursing expert testified that the nursing home failed to provide enough direct supervision and that the resident should have had a pressure alarm in her chair, as well a tab alarm and possibly a self-release seatbelt. The plaintiff also contended that the alarm did not work.

The defendant's nursing expert testified that the seatbelt suggested by the plaintiff would have been an inappropriate restraint. She opined that the nursing home had developed an appropriate care plan and provided appropriate supervision.

The nursing home won the case with a defense verdict.

Action: Medical malpractice
Injuries alleged: Multiple fractures and death
Date: March 2011
Submitted by: Joseph M. Desmond, Morrison Mahoney, Boston (for the nursing home)

Woman left blind after gastric bypass

The patient, a 39-year-old woman, had gastric bypass surgery in 2003 because she was "extremely overweight." She was injured following a series of invasive procedures to manage a narrowing of the connection between her stomach and small intestine. All five surgeries were performed by a gastroenterologist.

The first of these endoscopic balloon dilatation procedures was done using conscious sedation only, with no anesthesiologist, intubation or fluoroscopy. After the patient became "uncooperative" by moving, the surgeon needed to repeat the procedure so that further scar tissue didn't form and make the problem worse.

After similar difficulties during a repeat dilatation, the surgeon noted it was unwise to continue without the benefit of fluoroscopy. His notes state that "[i]n the future, this should be done with [Monitored Anesthesia Care] and Fluoroscopy."

The doctor performed a third and fourth dilatation under general anesthesia without complication.

But for the fifth dilatation, the surgeon reverted to conscious sedation without fluoroscopy. The patient became agitated, her pulse dropped and her breathing became labored. Her oxygen saturation also dropped. A CT scan showed air bubbles in the region of her liver. Later that night, she experienced seizures secondary to encephalopathy.

The patient was rendered legally blind and cannot drive or read, and became disabled from her job. She is able to navigate her home without assistance and can see well enough to walk outside in her neighborhood. The use of both her left arm and left leg is diminished.

The patient claimed that the absence of general anesthesia caused her to become agitated and caused the doctor to push an air embolus into a vein in the area of her liver, resulting in her decompensation and lack of oxygen to her brain.

The doctor maintained that the perforation, which is a well-known and recognized risk of the procedure, happened before any agitation, as evidenced by the patient's vital signs having changed before the agitation began.

The case settled for $1 million.

Action: Medical malpractice
Injuries alleged: Neurologic impairment
Date: March 2010
Submitted by: Andrew C. Meyer Jr. and Adam R. Satin, Lubin & Meyer, Boston (for the patient)

Are your coding and billing practices safe from audit?

Continued from page 1

gets billed out under his or her name. It's not going to be a defense to say, 'I hired a billing manager,'" said Abby Pendleton, a co-founder of The Health Law Partners in Southfield, Mich. and co-chair of the firm's Medicare and RAC practice group.

The exposure for a false claim is three times the amount of damages owed to the government plus civil monetary penalties of over $10,000 per claim, she added.

David C. Harlow, a health law consultant at The Harlow Group in Boston, says the best offense is a good defense: "I would recommend any physician practice take a good hard look at the way it is coding now, even if nobody has knocked on your door. Because they will."

The federal health care law will mandate compliance programs, such as some type of internal checks and balances, for physicians and other providers as a condition of enrollment in Medicare, said Pendleton, who noted that details are expected in forthcoming regulations.

Looking for outliers

The stepped-up auditing activity is aided by data analysis to spot deviations from normal patterns.

"CMS is data mining. Its contractors are data mining," said Wachler.

"Based on the data analysis, they are auditing physicians and looking to see if providers are outliers," said Pendleton.

The most common coding errors occur in evaluation and management codes for new or returning patient office visits.

A typical mistake is coding at a certain level without meeting all the different components that are required for that level.

The three components that make up an evaluation and management code – patient history, examination and medical decision-making – all have to match, said Michelle Mudge-Riley, a physician in Richmond, Va. who advises other doctors on business development and compliance.

For example, certain service codes require a specific level of supervision by a physician – whether by phone, on the premises or in the patient's room, said Wachler.

Another common error is "unbundling," or billing a service as multiple procedures that should be billed as a single code with multiple views, such as a scan with two angles of the same limb.

"That would result in being paid more than a provider is 'entitled to' under the contract," said Harlow.

To complicate matters, the rules for coding change frequently, with new codes added every year.

"Inaccuracies can result from the proliferation of new codes. There may be a code a physician has used for years and years and this year there's a new code," said Harlow.

In an effort to err on the side of caution, many physicians are underbilling, not only leaving money on the table but subjecting themselves to a possible audit for improper coding, says Mudge-Riley.

"A lot of people think they're not going to be in trouble for undercoding, but in fact not coding correctly is a problem," she said.

Mudge-Riley believes the push toward electronic medical records can exacerbate errors because it creates a temptation to cut and paste from a patient's earlier visit into a new record.

Another problem with electronic records is some programs contain generic menus, said Wachler.

"It can look like everyone is presenting the same way and can cause a provider to lose credibility. The key is to individualize each record – don't just pull from a menu," he said.

But Harlow said that some systems allow providers to block the cut-and-paste capability and electronic records will make it easier to cross-check data between health records and billing records for coding errors.

Steps to take

In addition to reviewing coding and billing practices, physicians need to train their in-house or outside coding and billing companies.

"Your billing staff needs to be continually trained and updated, and alert to what services are being provided," said Harlow.

One way to be proactive is to preempt a government audit and do it yourself first – either with a self-audit or by hiring an auditor.

"If a RAC audit comes down the pike, and they find some discrepancy in prior years, the fact that you are doing an audit now militates in your favor and allows you to say, 'I know I had problems before but we fixed it,'" said Harlow.

In one case, Pendleton was brought in to conduct a preemptive audit and found that the doctor was not reviewing changes made by a billing company.

"The billers were changing the physician's codes, because they didn't understand the type of procedure. He didn't know they were changing his codes until a compliance audit uncovered it a year later," said Pendleton.

Whether a physician checks off the code him or herself, or gives the medical notes to a coder to determine the proper code, Pendleton recommends that physicians set up a process with periodic review.

"Do you have to have a formal policy and procedure? Not necessarily. But it's a good idea to walk through the process, then reduce the protocol to writing," she said.

Some doctors are taking matters into their own hands and taking courses on medical coding.

Mudge-Riley advises that doctors get trained by their peers. One organization, Code Blue Coding in Richmond, Va., was started by a neurologist who quit practicing medicine so he could learn medical coding and now teaches it to other doctors.

"He's not only mastered it; he's developed a special way of explaining it to doctors using their own language to teach them. Their eyes light up as they finally get it," said Mudge-Riley. **MMLR**

Questions or comments can be directed to the writer at: sylvia.hsieh@lawyersusaonline.com

Governor's apology bill would protect physicians

Continued from page 1

significant decrease in the number of new claims filed.

Charles P. Reidy III, a veteran med-mal defense lawyer, conceded that the language in the governor's bill is broad but necessary to encourage health care professionals to speak candidly with patients.

"This is a wonderful attempt to allow doctors to express human concerns to patients without worrying about the consequences of their words being taken out of context," said Reidy, who practices at Martin, Magnuson, McCarthy & Kenney. "Without a statute that protects a wide range of conduct, the reality is that doctors won't be protected."

Although he called Patrick's goals commendable, Kevin J. O'Leary of Coughlin Betke in Boston, who handles civil cases for plaintiffs and defendants, predicted that the bill will fail.

"If the aim of this law is to reduce medical malpractice [lawsuits] by getting rid of bad cases [with questionable liablity], it will fail miserably because the only cases it's going to affect are the ... ones where a doctor has made an admission of negligence," he said. "Those are certainly not the cases that are creating the problems."

Patrick filed the bill on Feb. 17 and it is expected to be taken up by the Legislature this spring.

Unfair protection

Catalano contended that the measure would give doctors and hospitals accused of negligence a protection no other litigant in Massachusetts enjoys.

"Could you imagine if an accountant, financial advisor or attorney had the luxury of being able to admit their mistake to a client knowing it couldn't be used against them in litigation? There would be extreme outrage," Catalano said.

Barry D. Lang, a medical doctor and Waltham lawyer who represents med-mal plaintiffs, said he agrees with the governor that juries should not be privy to expressions of sympathy or condolence by physicians.

But Lang takes exception with portions of the bill that seek to exclude physicians' statements admitting fault or explaining to patients and their families what went wrong.

"This would be perfectly acceptable if the words 'mistake' and 'error' weren't in [the bill]," Lang said. "But they are. To immunize doctors when they admit fault is to unfairly single out the medical profession, once again, for special treatment."

If the bill passes, Catalano said it would make it nearly impossible for a plaintiff to win a med-mal case.

"If you have a case where a doctor tells a patient that he mistakenly cut the sciatic nerve during hip surgery, that is often going to be your best smoking-gun evidence of what happened in the operating room," he said. "With this bill, it would be gone." **MMLR**

Questions or comments can be directed to the writer at: david.frank@lawyersweekly.com

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- Review some of the landmarks in the development of end-of-life legislation.
- Explore the concepts of living wills, health care proxies, power of attorney and DNR/DNI.
- Discuss the attributes of Medical Orders for Life-Sustaining Treatment forms (MOLST).

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Bibliography – see page 15

The importance of discussing end-of-life care with patients

By Jane Pribek

A few years ago, Dr. Prescott Lee, a geriatric medicine specialist in Peabody, discussed end-of-life care with a married couple in their late eighties who were both patients. They were "hearty octogenarians," and because they were so robust, it took him a while to get around to discussing it.

But he did. Surprisingly, he learned they'd never talked to a doctor about it previously. They later created advance directives, including Do Not Resuscitate orders.

Not long after that, the husband was diagnosed with aggressive cancer. He opted for hospice care and died peacefully.

While the wife is still grieving the loss of her husband, she has expressed her gratitude to Lee that he spoke to them about end-of-life care before her husband's illness was diagnosed.

"Although the situation was obviously very challenging, I think the decisions that were made beforehand helped make it easier, rather than her having to make tough decisions on the fly," Lee said.

The story illustrates the need for physicians to engage their patients in these discussions.

"The primary care physician should discuss end-of-life issues with all patients, not just with the frail elderly," said attorney Regina S. Rockefeller, a partner at Nixon Peabody LLP in Boston who concentrates in health care law for providers. "Many end-of-life court cases have involved young people injured in accidents or who experience strokes, not people who have lived long lives."

A non-reimbursable topic

On Jan. 1, a new Medicare regulation briefly took effect that listed "advance care planning" as one of the services that could be offered in the "annual wellness visit" for Medicare patients.

Just a few days later, President Barack Obama dropped that language from the regulation, with an administration official observing that, "This should not affect beneficiaries' ability to have these voluntary conversations with their doctors."

"It's true that you don't get reimbursed [by Medicare] for it," said Lee, "but it's still the right thing to do."

Dr. Stancel Riley, executive director of the Massachusetts Board of Registration in Medicine, said, "We would encourage everybody to have this conversation. Things can happen to all of us in the form of accidents."

Rockefeller

While a number of states have enacted "natural death acts" – codifications guaranteeing the right to refuse life-sustaining medical technology – there's no such statute in Massachusetts, said Stancel.

But patients can elect this outcome, or something else, by creating the appropriate legal documents.

A health care proxy is a document where a patient designates someone else to make health care decisions if the patient is unable to make or communicate his or her own decisions. The proxy or agent cannot be an "operator, administrator or employee" of a hospital or nursing home where the patient is receiving care. The proxy is valid in Massachusetts if executed in conformity with MGL c. 105D, which requires that two witnesses also sign it.

A living will is a written statement of the patient's wishes for end-of-life care, in the event that he or she cannot make health care decisions or communicate them directly.

Living wills may be considered evidence of a person's end-of-life wishes. But according to Rockefeller, "Strictly speaking, in Massachusetts, living wills do not have the statutorily conferred authority of a health care proxy."

The conversation

In the June 2010 issue of Health Policy, researchers at the Johns Hopkins Bloomberg School of Public Health in Baltimore reported that just 34 percent of respondents said they have an advance directive.

Lee, who also chairs the Massachusetts Medical Society's Committee on Geriatrics, said that in his experience, many people don't have them. But over the last five years, he's seen an increase in patients who do, something he regards as a positive trend.

Lee typically talks to patients about end-of-life care within the first six months of seeing them. "In the beginning I was very uncomfortable, because I was not accustomed to being as blunt about the subject with somebody who was well. But I've become more comfortable with the subject," he said.

"I suspect that as my patients become more familiar with me, when I introduce the subject solely as a precaution so that I may deliver the type of care they want, they're less uncomfortable with it," Lee added.

He previously worked in a hospital setting and said it's harder to raise the topic there, when the physician might be treating someone for the very first time and death is a more imminent possibility.

The need to talk about these issues early in treatment is especially great if a patient might have competency issues. Lee advises having the conversation in the office rather than the hospital setting, and in the presence of the proxy and/or family, to make sure everyone's on the same page.

He might start the discussion by giving patients what's colloquially called "the blue form," a one-page form created by the Massachusetts Department of Public Health Office of Emergency Medical Services that defines and elaborates what "Do Not Resuscitate" means, principally so that EMTs and other first responders know a patient's wishes.

In addition, he often refers patients to the Massachusetts Medical Society website, which provides a health care proxy form and instructions. Further, Aging With

Continued on page 14

Resources on the web

- **Massachusetts Medical Society Health Care Proxy form and instructions:** http://www.massmed.org/AM/Template.cfm?Section=Search&CONTENTID=2570&TEMPLATE=/CM/ContentDisplay.cfm
- **Massachusetts Comfort Care/Do Not Resuscitate Order Verification:** http://www.mass.gov/Eeohhs2/docs/dph/emergency_services/comfort_care_form.pdf
- **Massachusetts Commission on End-of-Life Care:** http://www.endoflifecommission.org/end_pages/about.htm
- **Massachusetts Medical Order for Sustaining Life (Worcester County):** http://www.molst-ma.org/forms

— Jane Pribek

The importance of discussing end-of-life care with patients

Continued from page 13

Dignity's website offers a "Five Wishes" form for patients. The Massachusetts Trial Court Library is another useful resource.

The big picture

From a public policy standpoint, there's a lot going on with regard to end-of-life issues in the Commonwealth, said Riley.

Evidence of this is Chapter 305, Sec. 42 of the Acts of 2008, which charged the state's Executive Office of Health and Human Services to convene an expert panel on end-of-life care, to identify best practices and make recommendations.

Riley, a member of that panel, said, "The focus was not just on patients with serious, life-threatening illnesses, but on all patients and providing them with a full range of options for end-of-life care, from aggressively prolonging life on one end of the spectrum, to focusing almost exclusively on comfort as the inevitable takes place."

The panel completed a 40-plus page report in the fall of 2009. However, its public release has been delayed. Riley hopes the report will be released soon.

In addition to creating the panel, that same law called for a public awareness campaign to highlight the importance of end-of-life planning.

And it created a pilot project to measure the effectiveness of the Medical Orders for Life-Sustaining Treatment (MOLST) form.

The MOLST, in conjunction with a proxy, goes beyond the blue form, informing health care providers what the patient wants to happen in various circumstances, discussing resuscitation, intubation and ventilation, hospitalization, respiratory support, dialysis support, and artificial nutrition and hydration. It's two pages long and must be signed by both the physician and patient, or his or her proxy and/or guardian.

According to Riley, the MOLST has been used in Worcester County for over a year, has been deemed a successful experiment, and will likely be used elsewhere in the coming months and years.

Finally, Riley said continuing medical education on end-of-life care will likely become a licensing requirement for all physicians in Massachusetts within the next year or so. **MMLR**

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

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Avoiding liability in handling end-of-life care

In a perfect world, every patient would have clear, concise documents that designate a proxy who communicates his or her end-of-life wishes.

In the real world, however, this doesn't always happen. Here are answers to some key questions to help physicians avoid legal liability in situations when the path is not entirely clear, from Boston attorney Regina S. Rockefeller of Nixon Peabody LLP, who represents and advises health care providers.

Q: What if the physician questions the authenticity of end-of-life documents?

A: Under Massachusetts law, a health care proxy requires the signature of the principal and two adult witnesses. The document does not need to be notarized. If the health care provider is suspicious of the document's authenticity, then he or she can, in some circumstances, compare the patient's signature on the health care proxy or living will with another signature of the patient known to be authentic (such as a driver's license, passport, medical consent forms or letters to the physician) to see if the signatures match.

Q: What if there are two health care proxy documents?

A: Look at the dates of execution. Usually the more recent document will, by its terms, revoke and supersede a prior health care proxy.

Q: Can/should health care providers disregard these documents if they were created in another state?

A: No. A physician should respect a document created in another state if it was valid under the laws of the state where it was executed.

Q: What should the physician do if a living will's instructions are contrary to a patient's present stated wishes and there are signs that the patient's competency is questionable?

A: A competent patient can revoke a health care proxy or living will. A physician should start with the presumption that the patient before him or her is currently competent, even if the patient may be slipping a bit. The patient's currently stated oral wishes will, in most circumstances, govern until such time as the patient is legally declared incompetent by a court having jurisdiction or, if the patient has a health care proxy, until two physicians declare the patient unable to make health care decisions such that the authority of the designated proxy takes effect.

Q: What should be done if the living will calls for an outcome that's contrary to what the proxy is now saying should be done, and the patient is unable to communicate?

A: In Massachusetts, if a patient with a health care proxy has been declared by two physicians to no longer be able to make health care decisions, then the proxy holder will usually have the authority to make health care decisions for the patient. A physician can rely upon the decision of the proxy holder even if the proxy holder's decision is at odds with the patient's living will.

Q: If there are no advance directives, can a physician forgo life-sustaining treatment if the patient cannot communicate that this is his or her wish, and a spouse or other family member says that it's the patient's actual or probable wish?

A: Yes. In some circumstances, where there is no advance directive, the physician can recommend that life-sustaining treatment be forgone.

Q: What should the physician do if the patient cannot communicate, there is no health care proxy, and family members disagree on the level of life-sustaining treatment to be administered?

A: The physician should consider involving his or her hospital's ethics committee for guidance. The physician should not just err on the side of sustaining life. Rather, the substituted judgment of the patient – what the patient would have wanted in these circumstances if the patient were suddenly lucid and able to communicate – should be discerned. In rare and highly contentious circumstances, seeking court approval may be considered.

Q: Can a physician order the withholding or withdrawal of artificial fluids and nutrition from a terminally ill patient or permanently unconscious patient, if that's what an advance directive calls for?

A: Yes. The physician can rely upon the judgment of the proxy holder, who should make this decision based upon his or her best judgment of what this particular patient would have wanted in the circumstances that the patient now occupies. Physicians also should become knowledgeable about the nutrition and hydration policies of the hospital, especially a religiously affiliated hospital, in which the patient seeks treatment.

Q: Should the physician consult with the health care facility's risk managers in all instances before ending life-sustaining treatments?

A: For the physician's own protection in difficult cases, consulting with the facility's ethics committee or risk managers may be advisable when ending life-sustaining treatment for a hospital inpatient. Strictly speaking, such prior consultation is not legally required but is often helpful.

Q: Do you have any other advice or thoughts on end-of-life issues for physicians with regard to reducing their legal exposure in difficult cases?

A: If the physician is uncertain about an end-of-life decision in a particular case, the physician may protect himself or herself by involving others in the process and by documenting the deliberative process and the factors considered. The physician can talk to a competent patient, a health care proxy, a patient's spouse/life partner, adult children, adult children of a deceased child of an incompetent patient, other physicians, hospital administrators, hospital legal counsel, the hospital's ethics committee and risk managers, and/or clergy for the patient.

— Jane Pribek

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The Physician's Corner

Legal and ethical considerations in end-of-life care discussions

By Henry Tulgan, M.D. FACP

It wasn't all that many years ago that end-of-life meant just that and prompted little discussion among patients, families and caregivers. After all, one-third of hospitalized patients with acute myocardial infarction succumbed, pneumonia was "the old man's friend" and other infectious diseases carried similar grave prognoses. A diagnosis of diabetes had ominous projections and cancer carried with it poor hopes for long-term survival.

Statistics indicate that at the beginning of the second half of the 20th century, 80 percent of patients died at home. But the significant advances in pharmacotherapy, surgical technology, monitoring and interventional methodologies have changed this radically.

Recent data indicate a massive shift in the location of death, with more than 80 percent of terminal care now given in hospitals (over 10 percent of that care in Intensive Care Units), nursing homes or similar rehabilitation settings. Therefore, it is now not only incumbent on providers to discuss and document end-of-life planning with their patients and families, but also essential to encourage patients and families to do so amongst themselves and communicate those decisions to their physicians.

In the end-of-life communication arena, there are also legal implications about which we must all be cognizant.

Credit for the concept of a living will is attributed to a Florida attorney, Luis Kutner, in 1967, around the time of the proliferation of Coronary Care and Intensive Care Units. The first state to legalize them was California in 1976. By 1992, all 50 states and the District of Columbia had enacted forms of such advance directives.

We all followed with great interest test cases in state courts, such as the one involving Karen Quinlan in New Jersey. The U.S. Supreme Court then essentially decided in favor of advance directives in the Cruzan case in 1990.

Simply stated, living wills express in writing the wishes of an individual for end-of-life care. A health care proxy is a document in which a patient names someone else who understands his or her wishes to make these decisions when and if that patient is unable to do so.

A patient's proxy is often, but not always, a relative. It may never be anyone in a position of care in the facility where the patient is situated and requires two witnesses. Health care proxies may vary in wording somewhat from state to state, but must be respected wherever care is rendered.

Another recommended legal document is a Durable Power of Attorney which, in the case of an incapacitating illness, provides another person rights to a patient's key financial transactions.

As proactive as many of us have been in recommending these advance directives, some data suggests that more than 65 percent of Americans still do not have such documents in place.

An organization called National Healthcare Decisions Day, which appeals to people to make advance directives, is having its fourth national day in April 2011. In situations where these documents do not exist and there are no family members, or where controversies arise from existing the health care proxies, physicians may have to involve hospital Ethics Committees or the courts to assist and protect them in making decisions.

We have now become quite familiar with "the blue form" that expresses Do Not Resuscitate (DNR) and Do Not Intubate (DNI) instructions, along with Comfort Care Only measures to guide EMTs and hospital caregivers.

Now, in Massachusetts as well as a number of other states, such directives are becoming even more clearly defined. In 2008, a Massachusetts state law convened an end-of-life care expert panel to identify best practices and make recommendations.

One result has been the implementation of a successful pilot program in Worcester County called MOLST (Medical Orders for Life-Sustaining Treatment).

This is a two-page form that defines many more decisions beyond DNR/DNI and has check boxes for such things as decisions on hospitalization, dialysis, nutrition and hydration. This form, in addition to the signatures of the patient or proxy, contains the signatures of the physician, nurse practitioner or physician's assistant and leaves room for periodic review. Similar programs have also been started in Delaware, Maryland, New York, Ohio and Oregon.

Continuing Medical Education on end-of-life care is a requirement for medical licensure by many state medical boards and may soon be a requirement by the Massachusetts Board of Registration in Medicine. (http://www.fsmb.org/directory_smb.html)

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National Healthcare Decisions Day
http://www.nhdd.org

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Please submit your test along with a check (see course fees below) made payable to the Massachusetts Medical Society, P.O. Box 9155, Waltham, MA 02354-9155, (phone: (781) 434-7306, fax: (781) 642-1246, email: continuingeducation@mms.org.)

Participants seeking *AMA PRA Category 1 Credit*™ will receive a confidential report of their examination score and the correct answers. A score of at least 70% is required to receive *1 AMA PRA Category 1 Credit*™.

Course Fees

Massachusetts Medical Society (MMS) Member:	$10 ($10 per credit)
Non-MMS member:	$20 ($20 per credit)

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Please answer the following questions. A score of at least 70% is required to receive 1 *AMA PRA Category 1 Credit*™. Deadline for completing the exam is April 28, 2012. Please make a copy for your records.

1. A competent patient can revoke a health care proxy or living will.
   - ○ a. True
   - ○ b. False

2. Physicians in Massachusetts are under no obligation to honor a living will executed in another state.
   - ○ a. True
   - ○ b. False

3. Researchers at John Hopkins Bloomberg School of Public Health reported that ______ percent of respondents said they have an advance directive.
   - ○ a. 60%
   - ○ b. 34%
   - ○ c. 25%
   - ○ d. 71%

4. MOLST forms include information about what a patient wants to happen in various circumstances.
   - ○ a. True
   - ○ b. False

Please complete the evaluation portion of this activity. Your feedback is important in developing future educational programs. Please send additional comments to continuingeducation@mms.org.

Did this activity meet the stated objectives?
- ○ Yes
- ○ No

How do you rank the effectiveness of this activity as it pertains to your practice?
- ○ High
- ○ Average
- ○ Low

Will you make any changes in your practice as a result of participating in this CME activity?
- ○ Yes
- ○ No

If yes, please explain.

____

How do you rank the quality of this education program?
- ○ High
- ○ Average
- ○ Low

Did you perceive any evidence of bias for or against any commercial products?
- ○ Yes
- ○ No

What are your topics of interest for future CME activities?

____

Save the Date:
November 4, 2011
7:30-9:30 AM

Awards Ceremony and Breakfast

presents

Rx FOR EXCELLENCE
honoring best practices in medicine

NOMINATIONS DUE JUNE 1, 2011

Eligible nominees include:

Physicians

Hospital and Health Plan Administrators

Risk Management Professionals

Insurance Company Professionals

Researchers

Nurses

Attorneys

Others

Nomination criteria

Massachusetts Medical Law Report's 4th Annual Rx for Excellence Awards will honor individuals in Massachusetts health care in two categories.

The Leaders in Quality Award will honor professionals whose unique efforts have helped advance safety, quality and/or risk management for many patients and/or health care providers in the state.

The Hero from the Field Award will honor unsung heroes of their profession. They are individuals who lead by example, demonstrating the highest quality of work in their field.

In 300 words or less, please describe what the nominee has done to deserve one of these awards.

Submit your nominations today.

Go to www.surveymonkey.com/s/rxforexcellence2011

If you have questions, please contact Reni at 617-218-8142 or reni.gertner@mamedicallaw.com.

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