

## Physician licensure targeted: Why doctors object to a pending health plan bill



By Eric T. Berkman

Doctors and health care attorneys are up in arms over a bill pending in the state legislature that would tie physician licensure to participation in a proposed affordable medical plan for small businesses.

They contend that such a change could drive doctors into bankruptcy while exacerbating the already dramatic shortages of Massachusetts physicians in critical specialties.

Meanwhile, advocates for the insurance industry say the bill – which would also tie reimbursement under the plan to Medicare rates – is a necessary measure to address the crushing burden that health care costs are placing on small businesses.

“This proposal is designed to give almost immediate relief to small business,” said Dr. Marylou Buyse, outgoing president of the Massachusetts Association of Health Plans (MAHP). “It’s designed so that it’ll decrease premiums up to 22 percent. That’s a huge cost savings at a time where the economy is challenging and healthcare costs are on the rise.”

But Massachusetts Medical Society President Mario Motta, a Salem cardiologist, blasted the plan as a “ruse by insurance companies” to get the government off their backs.

“We all know small businesses are hurting and need some relief,” said Motta. “But [the insurance industry] created this problem and now they want to shift blame to somebody else. I find this a bit of offensive, to be frank.”

The bill, S. 2170, was introduced in July with the support of MAHP.

It would create a new “Affordable Health Plan” for businesses with fewer than 50 employees. The product would provide benefits equivalent to the Commonwealth Choice “Bronze” plan, the most basic level of coverage available above the young adult plan.

The bill would also require any provider that already participates in an existing health plan to participate in this new plan. Additionally, it would cap reimbursement under the plan at 110 percent of Medicare rates while barring providers from balance-billing to recoup costs. Providers failing to comply

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## Health providers facing stiff HIPAA regulations

By Sylvia Hsieh

In the coming months, health care providers and contractors to the health industry can expect broader HIPAA coverage, beefed-up enforcement and stiffer civil penalties for violations.

Some of the changes have already taken effect; others will soon.

The changes to the Health Insurance Portability and Accountability Act were passed under the HITECH (Health Information Technology for Economic and Clinical Health) Act as part of the economic stimulus legislation earlier in 2009.

Steep new fines, which can reach \$1.5 million, were clarified in an interim final rule from the Office of Civil Rights that took effect Nov. 30, 2009.

However, the rule did not elaborate on or alter the statutory penalties that technically went into effect upon enactment in February 2009, according to health care attorneys.

They are warning health care providers to expect a heavier hand on HIPAA enforcement.

“I think the Office for Civil Rights is staffing up to take a more proactive approach to enforcement,” says Kelly Hagan, a health care attorney and shareholder at Shwabe, Williamson & Wyatt in Portland, Ore., who noted that the statute also calls for the fines collected to be put back into more enforcement.

One major change is that employees of health care providers can be held personally (and criminally) liable for violations.

State attorneys general are also authorized to bring civil suits on behalf of a patient or other individual whose data is breached by a HIPAA violation to recover statutory penalties and attorney fees.

In addition, the statute requires that rules be promulgated within three years to allow individuals harmed by a HIPAA violation to receive a percentage of any civil monetary penalty, said Amy Fehn, an associate at Wachler & Associates in Royal Oak, Mich., who represents health care providers.

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## Insurer can require that chiropractor be deposed

By Jack Dew

An insurance company could deny reimbursement to a chiropractor who refused to answer questions under oath about his treatment of two small children involved in a car accident, a state District Court judge has ruled.

Personal injury attorneys say the decision is a new application of the language in the standard personal injury protection, or PIP, policy. And they warn that the ruling could have ramifications for health care providers who seek payments directly from PIP insurers.

In this case, a chiropractor had sent bills totaling \$3,655 to Premier Insurance Co. for the treatment of two toddlers who had been involved in a collision. Since the accident had not resulted in any serious injuries, Premier challenged the bills, asking the chiropractor to answer questions under oath.

But the chiropractor refused,

arguing that he was not a party to the patients’ insurance contract and thus not obligated to answer questions. When the insurance company refused to pay his bill, he sued.

Braintree attorney Bruce Medoff filed a motion for summary judgment in Salem District Court on behalf of Premier.

Medoff argued that the chiropractor could legally be denied payment because he failed “to perform conditions precedent to recovery” and failed “to cooperate with [the insurer] in regard to its investigation.”

Judge Richard A. Mori of the Salem District Court agreed and found that the chiropractor’s suit could not go forward.

### A frequent issue

Medoff said this issue comes up frequently in personal injury cases. “Providers direct-bill [insur-

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**Rx FOR EXCELLENCE**  
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**SAVE THE DATE:** 3rd Annual Rx for Excellence, September 16, 2010

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# Celebrating best practices, year after year

It is quite humbling each year to stand in front of the room at our annual Rx for Excellence Awards.

It is not every day that hundreds of physicians, nurses, risk managers, attorneys and their colleagues gather to celebrate the delivery of safe health care – especially given the difficult environment they typically face.

At this year's breakfast, I just couldn't help but think about the incredible breadth and



depth of accomplishments of the individuals in front of me – not to mention the sorts of serious health care issues we might solve if we all put our heads together.

With such a vast patient safety-focused medical community in the state – and so many medical professionals whose patients and colleagues easily see the degree of pride they take in their work – it is clear why it is so difficult for our panel of judges to select each year's winners.

For a glimpse into the celebration, please check out our 2009 photo spread on page 10.

And as one celebration comes to a close, it's never too soon to get a start on next year.

Today I am pleased to open the nomination process for the 3rd Annual Rx for Excellence Awards.

As you may already know, we honor professionals in two categories.

Our Hero from the Field award winners are the unsung heroes of their professions. They are the doctors and nurses whose patients regard them highly, the practice managers who make sure their offices run smoothly, the nurses who go an extra mile to make a patient comfortable in his or her hospital bed and the

health care attorneys who are highly regarded by the clients they represent, among others.

Our Leaders in Quality have championed successful efforts to enact change for large

groups of patients or health care providers that improve patient safety and quality. They include hospital quality managers that have enacted innovative safety programs,

government officials whose daily work focuses on improving patient safety and physicians whose work in their field exemplifies best practices that others should emulate.

Do you know someone who belongs in either of these categories? Do you belong in one of these groups?

Please submit your nominations now.

Go to [mamedicallaw.com](http://mamedicallaw.com) for more information. Or go to [events.lawyersweekly.com](http://events.lawyersweekly.com) and click on "Nominate." All nominations are due by April 1, 2010.

Also, please mark your calendar for our 2010 Rx for Excellence Awards, which will be held on Thursday morning Sept. 16.

We look forward to receiving your nominations, and to seeing you in September.

–Reni Gertner, MPH

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# Jury awards \$34.3M against hormone therapy drug makers

By Kimberly Atkins  
Staff writer

In one of two hefty verdicts against Pfizer within a month, a Pennsylvania jury handed down a \$34 million award, finding that the drug maker willfully failed to warn patients of cancer risks associated with the hormone replacement drugs Premarin, Provera and Prempro.

The jury awarded \$6.3 million in compensatory damages and \$28 million in punitive damages to Donna Kendall, a Decatur, Ill., woman who developed invasive breast cancer leading to a double mastectomy after taking the hormone replacement drugs from 1991 to 2002.

"Both she and her doctor believed at the time that the drugs were good for the heart, good for osteoporosis prevention and good for use in the long term," said Tobias Millrood of the Conshohocken, Pa., law firm Pogust Braslow & Millrood, lead trial counsel for Kendall.

The plaintiff claimed that Pfizer failed to conduct studies on the long-term effects of the drugs, and downplayed reports of cancer links in an effort to continue marketing them.

"The company [told doctors] that the benefits outweighed any risks and that these drugs should be taken long-term," Millrood said.

The same day the Kendall verdict came down, a jury award in a similar case was unsealed, revealing a \$75 million punitive damages award in favor of an Illinois woman who developed cancer after taking the drug Prempro.

These are the first verdicts among a number of cases pending over the drugs, which are still on the market.

Kendall took Premarin (an estrogen replacement) and Provera (a progesterone supplement), manufactured by drug company Upjohn, for six years before taking Prempro – a combination of the two drugs manufactured by Wyeth – for five years.

Upjohn merged with Pfizer in 2000, and in 2009 Wyeth merged with Pfizer.

Pfizer says it is considering all options, including an appeal.

"We are disappointed with the verdicts in these cases," Pfizer's statement said. "The company believes that neither the awards of punitive damages nor the liability verdicts were supported by the evidence or the law."

## Failure to study long-term risks

Millrood said that Kendall and her physician had no idea that taking the hormone replacement therapy medications over the course of years put her at risk until she was diagnosed with invasive breast cancer in 2002.

After she learned that the cancer had spread to five lymph nodes, Kendall underwent a mastectomy of the left breast, followed by painful and debilitating radiation therapy that severely damaged her skin and internal organs.

"The radiation caused such burns [to her skin] that not only did the skin break open and her chest bleed, but ultimately when a future heart surgery was needed, the preferred artery [for surgery] was useless because it was burned to crisp," Millrood said. "It was shriveled from radiation burns."

The burns also prevented successful reconstructive surgery after the mastectomy, according to Millrood.

"Not only did they take her breasts, they took her femininity and her dignity," he said.

In addition, Kendall's doctors have told her that the cancer could return.

"She is not out of the woods," said Millrood.

He noted that the plaintiff's experts predicted a 50 percent recurrence rate, and that the defense expert put the potential of recurrence even higher, at 75 percent.

But the key evidence, he said, was contained in documents showing that the drugs were approved by the FDA provisionally, on

the condition that Wyeth and Upjohn conduct studies of the drugs' long-term effects. Yet the defendants failed to do so.

Millrood also presented evidence that Wyeth and Upjohn officials discouraged the use of oncology experts at continuing medical education programs associated with the drugs for fear that other studies linking them with cancer would surface. In one instance, a Wyeth executive expressly prohibited an oncology expert from speaking at a CME event.

"We had handwritten comments from an executive at Wyeth [in response to another] executive who recommended an oncologist as a potential speaker. And the handwritten feedback was: 'NO! NO! NO! NO! And NO!' all in caps and with a string of exclamation points."



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Millrood said that not only did the defense decline to make a settlement offer, but the plaintiff's demand – \$6.5 million – was also only slightly different from the ultimate compensatory award.

"We felt the demand was really reasonable given the damages that Donna had," Millrood said. "It was very reaffirming that the jury saw the case the same way."

He was disappointed in the company's vow to appeal in lieu of compensating the remaining plaintiffs whose claims are pending.

"With one win and another and then another, you would think they would get the message and give these women reasonable compensation," said Millrood. **MMLR**

Questions or comments can be directed to the writer at: [kimberly.atkins@lawyersusaonline.com](mailto:kimberly.atkins@lawyersusaonline.com)



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# Listening In

The news beat  
of the medical profession

## Six Mass. hospitals named to Top 45 list

Six Massachusetts hospitals have been named among the country's top 45 hospitals by a leading patient safety group.

The Leapfrog Group – a coalition of large employers that conducts the only national public comparison of hospitals on key issues including mortality rates for certain procedures, infection rates, safety practices and efficiency – included Baystate Medical Center in Springfield, North Shore Medical Center - Union Hospital, Norwood Hospital, Beth Israel Deaconess Medical Center, Brigham and Women's Hospital and Children's Hospital Boston on this year's list.

The 45 hospitals met the following standards: Their doctors and nurses use computer systems to order medications, which has been shown to reduce drug errors by up to 85 percent; they meet performance standards for high-risk procedures, such as performing a minimum of 450 heart bypass operations in a year; and they staff their intensive care units with critical care specialists.

The hospitals also scored in the top 10 percent in the country for efficiency, using a formula that includes readmission rates, among other measures, to test the cost-effectiveness of care.



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## Fired doc sues Lahey, alleges undue pressure

A former cardiologist at Lahey Clinic claims in a lawsuit against the hospital that he was fired for resisting pressure from two other top doctors to use a particular brand of stent, even though it might not have been best for some patients.

The Boston Globe reported that Dr. David Gossman, who worked at Lahey for more than 20 years, alleges that Dr. Richard Nesto and Dr. Thomas Piemonte pressed him and other cardiologists to use Medtronic Inc. stents, because they thought if the hospital used more of the product, Medtronic would allow Lahey to participate in clinical trials for a new heart valve.

Gossman also claims that Piemonte has financial ties to Medtronic.

A spokesman for Lahey says Gossman's claims are "totally groundless" and that he was fired for unrelated misconduct, the Globe reports.

## Patients discharged from hospital likely to suffer adverse events

A recent report issued by an expert panel of internists, hospitalists and emergency physicians indicated that one in five patients discharged from the hospital experiences an adverse event within three weeks, according to American Medical News.

The Transitions of Care Consensus Policy Statement was issued by the American College of Physicians, the Society of Hospital Medicine, the Society of General Internal Medicine, the American Geriatrics Society, the American College of Emergency Physicians and the Society for Academic Emergency Medicine.

The report indicated that two-thirds of the reported outcomes are drug-related, with many of them potentially avoidable.

The groups stressed the im-

portance of faster communication of vital information from hospital to patient, asserting that electronic medical records and payments rewarding the medical home model could help address the problem. However, the groups said that physicians and hospitals should not wait before making changes on their own.

President Barack Obama has proposed bundling payments for hospitalization and care delivered within 30 days after discharge, thereby penalizing hospitals with high one-month readmission rates. The administration says the move would save \$8.4 billion and give hospitals more financial incentive to reduce the 20 percent 30-day readmission rate among Medicare patients.

## Study: Patients are waiting too long in ER

A recent study published by the Archives of Internal Medicine found that delays in treatment in emergency rooms nationwide are worsening.

Researchers found that 75.9 percent of all patients in 2007 were seen within the recommended time, down from 80 percent in 1997.

Dr. Renee Y. Hsia and Dr. Jeffrey A. Tabas of the University of California, San Francisco, described the overcrowding as a worsening problem that could "cost lives."

Experts have recommended a variety of solutions, including

condensing the number of questions asked by triage nurses, having patients see the doctor and nurse at the same time after passing through triage, equipping ERs with bedside supplies that address the most common reasons for emergency room visits and having information such as patient identification and insurance collected at bedside, once the patient is already being seen.



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## AMA issues several new policies

The American Medical Association has updated its policies regarding drivers' use of cell phones, online professionalism and the armed forces' "don't ask, don't tell" policy regarding sexual orientation in the military.

The AMA announced that it supports legislation that would ban the use of hand-held devices while driving. Another new policy calls on the AMA to initiate discussions with partner organizations regarding online professionalism to develop a consensus

useful for medical schools and for updating the AMA's Code of Medical Ethics.

The AMA also voted to oppose "don't ask, don't tell" and declared that gay marriage bans contribute to health disparities. The nation's largest doctors' group stopped short of saying it would seek to overturn marriage bans, but its new stance angered conservative activists and provides a boost to lobbying efforts by gay rights advocates.

## 'Patient safety events' cost billions

"Patient safety events" cost the Medicare program \$6.9 billion and resulted in almost 93,000 potentially preventable

deaths from 2005 through 2007, according to a recent study by HealthGrades.

The study documented 913,215 total patient safety events among 864,765 Medicare beneficiaries over the span, which represents 2.3 percent of the nearly 38 million

Medicare hospitalizations. The overall incidence rate remained virtually unchanged compared to the previous study.

However, eight indicators showed improvement from the previous year's study, accounting for 14.5 percent of the total patient safety events: complications of anesthesia; death in

low mortality DRGs; failure to rescue; iatrogenic pneumothorax; selected infections due to medical care; postoperative hip fracture; postoperative hemorrhage or hematoma; and transfusion reaction.

Seven indicators worsened over the course of the study, accounting for 85.5 percent of the total patient safety events: bed sores; post-operative physiological and metabolic derangements; postoperative respiratory failure; postoperative pulmonary embolisms or deep vein thrombosis; postoperative sepsis; post-operative abdominal wound dehiscence; and accidental puncture.



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## 'Disruptive behaviors' persist in health care settings

A national survey conducted by the American College of Physician Executives reveals that disruptive behaviors persist among physicians and nurses at hospitals, group practices and other health care facilities, according to American Medical News.

The survey of 13,000 physician and nurse executives, which was published in the Physician Executive Journal, comes almost one year after the Joint Commission began requiring health care facilities to implement zero-tolerance policies that define intimi-

dating and disruptive behaviors. The commission also required that facilities establish disciplinary procedures for medical staff and other health care professionals who violate the standards.

Ninety-seven percent of anonymous respondents experienced unprofessional outbursts, with most saying that these happened several times a year and sometimes even weekly.

Forty-eight percent said doctors and nurses were equally culpable for the conflicts, but 45 percent said doctors were mostly to blame.

# Physician licensure targeted: Why doctors object to a pending health plan bill



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would be subject to loss of their medical license.

If the proposal passes, it would sunset upon implementation of sufficient recommendations from Gov. Deval Patrick's commission that is currently examining health care costs.

## The wrong approach

Either way, the bill's critics contend that it's the wrong approach to a legitimately serious problem.

For one thing, said Charles Alagero, general counsel of MMS, it's completely inappropriate to tie licensure to participation in an insurance plan.

"What does an insurance contractual matter have to do with one's license?" Alagero said. "Tying a license to a contractual matter seems fundamentally counter to what licensing is all about, which is protecting the public and ensuring competency."

At the same time, said Motta, the bill puts doctors in a financially untenable position.

"What they're saying is, if you take any insurance product, we're forcing you by law to take another product you didn't negotiate for at a rate below the cost of doing business or else you can't have a license in this state," he said. "There has to be some reality testing here. To mandate anything tied to Medicare rates – where you make no profit at all or even lose in many cases – means there is no profit. You have to make a profit somewhere if you're going to stay in business."

Attorney William S. Mandell of Pierce &

Mandell in Boston agreed. He also said that it's particularly risky to add another condition to licensure in a state that already places disproportionate conditions on doctors' licenses.

"What good is access to health insurance if you cannot find a primary care physician or get an appointment with a specialist for three months for a serious condition?" said Mandell, who advises medical practices. "We are near meltdown conditions with our physician supply in Massachusetts and this bill could be a shock that the system will not be able to endure."

Mandell also questioned the wisdom of tying reimbursement to Medicare rates before examining the impact of radical changes to Medicare's specialist reimbursement schedules that take effect in January.

## One of many products

Buyse downplayed these concerns, noting that this product would be one of many in the marketplace.

"We don't expect that there are a large number of people who would even take this product," said Buyse. "Even though [the "Bronze" level plan] is the most popular in the Healthcare Connector, it still has a total now of only 35,000 people."

Further, Buyse said, the rate paid under the pending bill would cover physicians' costs and "give them a small margin."

"Most physicians, if not all, accept Medicare," she said. "I admit [this plan would reimburse] less than commercial plans, but [if such rates were so unprofitable] we'd see physicians not accepting Medicare."

Buyse also rejected suggestions that the

bill was an effort to shift the burden of cost-cutting to doctors without requiring insurers to cut their own allegedly bloated administration and marketing costs.

"This is the one proposal that goes directly to the heart of why health care costs are going up, and that's increased provider rates," she said. "Meanwhile, since health care reform [passed in Massachusetts], health-plan administrative costs have come down and profitability has gone down by more than a third. So I think insurers have already done whatever they can to make their administration as efficient as possible. I'm not sure that's true for the provider side."

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Questions or comments should be directed to the editor at: [reni.gertner@mamedicalaw.com](mailto:reni.gertner@mamedicalaw.com)



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# Bills, Rules & Regs



## From Beacon Hill

### Bill would punish doctors for failing to report deaths

A legislative proposal that would punish physicians who fail to report a patient's death in a timely manner has been blasted by advocates for hospice and end-of-life care.

Sponsored by Rep. Brian Dempsey, D-Haverhill, H. 2040 would slap physicians and agencies that care for terminally ill patients with a \$1,000 fine and put them at risk of a license suspension if they do not report a death to a funeral director within 16 hours.

Rigney Cunningham, executive director of the Hospital and Palliative Care Federation of Massachusetts, said doctors who specialize in hospice care would be dissuaded from making death pronouncements because of a fear that they may miss the deadline.

"It is central to the hospice philosophy to care for the family of the dying patient and that responsibility does not end with the patient's death," she said.

Cunningham said her organization represents 63 agencies that provide care to more than 21,000 terminally ill patients in Massachusetts.

"Adding additional responsibilities to already demanding jobs would be completely burdensome to hospice staff and a poor use of nursing resources," she said.

### Gov. pressed to adopt unused drug recycling

Gov. Deval L. Patrick vetoed a proposal to create recycling programs for certain unused medications, but supporters of the program in the state legislature are not giving up.

House Minority Leader Bradley H. Jones Jr., R-North Reading, wrote a letter to Patrick urging him to reconsider idea.

The program, which would allow residents and consultant pharmacists in health care facilities to return unopened and unexpired prescription drugs, was axed from budget-balancing legislation. Patrick said that instead, the Department of Public Health will examine the possibility of implementing the program under its existing authority.

But Jones is urging Patrick to reconsider. In his letter to Patrick, Jones wrote, "The fact that such a program does not already exist is a concern. I look forward to working with you to ensure that this creative option for reducing costs in the Commonwealth is neither disregarded nor ignored."

Jones said the program represented a new idea that would have generated "millions" of dollars in savings under Medicaid and eliminated the need for some budget cuts. He noted that 37 other states have similar laws on the books.

### MHA: Worst time for nurse-patient limits

The president of the Massachusetts Hospital Association told the Committee on Public Health recently that "there couldn't be a worse time" to impose limits on nurse-patient ratios in the state. Lynn Nicholas backs S. 876, a bill that would establish committees of nurses and other staff at every hospital to develop individualized staffing plans.

Advocates for registered nurses favor other proposals, H. 3912/S. 890, which would phase in nurse-patient ratios over two years for teaching hospitals and four years for community hospitals, and leave the determination of appropriate nurse staffing levels to the Department of Public Health.

Hospital managers argue that amid an economic downturn, financially strapped hospitals simply could not afford stepped-up staffing levels that could cost tens of millions of dollars.

Christine Schuster, CEO of Emerson Hospital, said, "In a busy day in our ICU, I'd rather have five senior registered nurses and support staff than seven new graduates." But Donna Kelly-Williams, the president of the Massachusetts Nurses Association, argued that incidences of hospital-acquired infection, pneumonia, deep-vein thrombosis and bed sores are a direct result of overworked nurses unable to provide adequate attention to patients, adding tens of thousands of dollars to patients' bills. "I would argue that hospitals truly cannot afford to continue these unsafe staffing practices," Kelly-Williams said.



## From Capitol Hill

### Physicians face pay cut for MRIs, CT scans

Federal health regulators have announced new rules that will result in reduced payments for doctors who use expensive medical-imaging machines to screen patients for diseases such as cancer and heart problems, according to The Wall Street Journal.

The rules will cut the reimbursements physicians receive for performing MRIs and CT scans by up to 38 percent.

The rule applies to the roughly one million doctors who are paid under the Medicare Physician Fee Schedule, which is run by the Centers for Medicare and Medicaid Services.

### Ban on travelers with HIV is removed

The federal government has overturned a 22-year-old travel and immigration ban on people with HIV entering the country.

The U.S. has been among a dozen countries that bar entry to travelers with visas or anyone seeking a green card based on their HIV status.

President Barack Obama called the travel ban "a decision rooted in fear rather than fact" that ran counter to efforts to reduce the stigma of AIDS and the nation's leadership in trying to stem the disease.

The law has kept out thousands of students, tourists and refugees and has complicated the adoption of children with HIV. No major international AIDS conference has been held in the U.S. since 1993 because HIV-positive activists and researchers have not been allowed to enter the country.

Obama said that by lifting the ban, the U.S. will take a step toward ending the stigma regarding people with HIV/AIDS. The ban removal will take effect early next year.

### House delays Medicare cuts

The House has approved a fiscal 2010 defense appropriations bill that includes a provision to delay Medicare physician payment cuts until March 2010, according to Modern Healthcare.

At press time, the Senate was scheduled to vote on the measure soon.

In November, the House passed H.R. 3961, the Medicare Physician Payment Reform Act of 2009, a stand-alone bill that would repeal the current physician payment formula in Medicare and set the stage for comprehensive payment reform for physician services.

That proposal would repeal what many in the health care industry regard as a flawed formula used to set Medicare physician reimbursement rates. The formula, instituted in 1997 and known as the "sustainable growth rate formula," dictates that the

amount Medicare pays to provide care for an average Medicare patient cannot grow faster than the economy as a whole.

Since 2002, the formula has called for cuts in reimbursements to physicians – with Congress stepping in each year at the 11th hour to defer the cuts to future years. At press time, the Senate had yet to vote on the measure.

Under the current system, Massachusetts doctors would see a 21 percent reduction in reimbursements beginning Jan. 1, 2010, rising to 40 percent by 2014, according to the 2009 Medicare Trustees report.

### AMA urges feds to re-classify marijuana

The American Medical Association is urging the federal government to reconsider its classification of marijuana as a dangerous drug with no accepted medical use, a significant shift in its view on the matter. The AMA has maintained since 1997 that marijuana should remain a controlled substance under Schedule I – the most restrictive category, which also includes heroin and LSD.

In changing its policy, the group said its goal was to clear the way to conduct clinical research, develop cannabis-based medicines and devise alternative ways to deliver the drug.

Several petitions have been filed to re-classify marijuana. The first, filed in 1972, bounced back and forth between the DEA and the courts until it died in 1994. A petition filed in 2002 is still under consideration.

### Study: Measurable BPA found in many food products

A recent study by Consumer Reports found that many food products, including canned soups, juice, tuna, packaged organic foods and items labeled "BPA-free," contained measurable levels of Bisphenol A.

The results of the test, reported in the December issue of the magazine, will also be announced by the Food and Drug Administration, which is currently reassessing the safety of the chemical.

The chemical is a strengthening agent that allows plastic to keep its clarity. In addition to baby products, BPA is often found in water bottles, jars and cans.

But many lawmakers, consumer groups and plaintiffs in a number of lawsuits have cited studies by medical journals suggesting a link between BPA exposure and a wide range of health problems including cancer, diabetes, hyperactivity, miscarriage and heart disease in animals and humans.

After initially finding that the chemical was safe at the levels found in most containers, including baby bottles and sippy cups, the FDA announced in June that it would revisit that conclusion after lawmakers urged the agency to do so. The new report is part of the data that the agency will assess.

The report shows that BPA was found in almost all of 19 name-brand products tested. The survey tested a diverse assortment of canned foods including those labeled "organic" and "BPA-free." Tests of a few comparable products in alternative types of packaging showed lower levels of BPA in most – but not all – cases, the report states.

"The findings are noteworthy because they indicate the extent of potential exposure," said Dr. Urvashi Rangan, Director of Technical Policy at Consumers Union, the nonprofit publisher of Consumer Reports, in a statement announcing the results. "Children eating multiple servings per day of canned foods with BPA levels comparable to the ones we found in some tested products could get a dose of BPA near levels that have caused adverse effects in several animal studies."



# Health providers facing stiff HIPAA regulations

Continued from page 1

## Hefty fines & fuzzy definitions

The new penalties for HIPAA violations are tiered based on “reasonableness” or “willfulness”:

- \$100 minimum per violation if the covered entity was unaware of the violation and would not have known by exercising reasonable diligence
- \$1,000 minimum per violation resulting from a “reasonable cause”
- \$10,000 minimum per violation for “willful neglect” that is corrected
- \$50,000 minimum per violation for “willful neglect” that is not corrected

Fines for multiple violations of an identical provision max out at \$1.5 million per calendar year.

But attorneys say the definitions are fuzzy.

For example, in order to show that a violation resulted from a “reasonable cause,” a covered entity would have to show that it was *unreasonable* to comply with the rule, said Fehn.

“That’s going to be a tough standard,” said Fehn, although she added that it might be possible to meet the standard if a covered entity did everything right but the violation occurred because of a rogue employee.

She also noted that while “willful neglect” could mean a conscious intentional failure, it could also mean “reckless indifference.”

Such an interpretation should worry small health care providers, many of whom do not have a policy in place.

“It’s a little fuzzy, and I would think a little



bit scary to small providers because that is the maximum penalty. ... If you don’t have a policy, is that considered to be reckless indifference? You could be on the hook for \$1.5 million,” said Fehn.

## Breach notification provisions

New breach notification provisions are another change to the rules.

If a breach of an individual’s protected health information occurs, a covered entity must notify the individual within 60 days.

The 60-day-period starts running when an employee or agent of the entity realizes a potential breach – not when the provider determines a breach has in fact oc-

curred after investigation, said Fehn.

“As soon as an employee finds out, ‘Oh gosh, I sent a medical bill to the wrong address,’ that’s when the 60 days starts to run. ... The problem is people often don’t want to report mistakes right away,” said Fehn.

Therefore, health care providers are strongly advised to have policies and training measures in place requiring employees to immediately report a suspected violation, she said.

Breaches involving more than 500 individuals, such as where a laptop or other mobile device containing private patient data is lost or stolen, must be reported to the Department of Health & Human Services and to a major media outlet in your area – in addition to notifying each of the individuals affected.

Entities must also keep a log of violations and report them within 60 days of the end of a calendar year.

A health care provider may not be required to report a breach if it determines the breach didn’t cause harm.

Such an example may occur where a bill was incorrectly sent but contained only an individual’s name, without additional private information, Fehn suggested.

“If you do risk assessment and decide there was not a great risk to the person of any kind of harm, technically you do not have to report it,” she said.

However, this exception has drawn protests from privacy advocates (and disagreement from some senators who wrote the HITECH Act) who say it should be up to the patient to decide if he or she was harmed, said Fehn. She noted that the provision may be changed in light of the controversy.

Even if the provision remains, a health care provider must weigh carefully whether to employ it.

This is because an entity could face a double penalty (the fines are “per violation”) – once for the privacy violation and again for not reporting it – if it turns out the violation should have been reported.

The breach notification provisions are in effect but will not be enforced until February 2010.

## ‘Business associates’ provision

HIPAA will directly cover “business associates” of covered entities beginning in February 2010.

Examples of entities that might fall under this newly-regulated category are vendors to the health care industry, such as IT providers, billing and phone services, third party administrators of health plans, and document or data storage companies.

“We’re getting a lot of calls from business associates,” said Fehn. “It’s the first time they’ve had to take [HIPAA] seriously. Before, it was just a contractual obligation [with the covered entity]. Now they will be subject to penalties.”

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Questions or comments can be directed to the writer at: [sylvia.hsieh@lawyersusaonline.com](mailto:sylvia.hsieh@lawyersusaonline.com)

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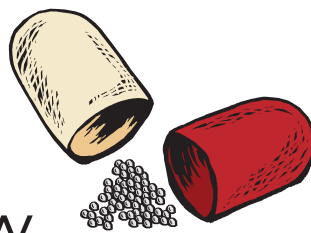
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# Good Medicine

What doctors are talking about now



**Q:** A state commission has recommended solutions to a reported epidemic of prescription drug overdoses and addiction, including tamper-resistant prescription pads, mandatory training licensed prescribers and limits on who may prescribe certain controlled substances. Are these reasonable approaches?

“Mandated training for all licensed practitioners is vital, as it will help with the etiology of the problem. Tamper-resistant prescription pads are useful, but they cannot be considered foolproof and will be no match for determined offenders. Pain is the most common reason for a visit to a doctor’s office and all physicians should be allowed to treat it, especially if properly trained. Consolidating certain medications to be prescribed by only certain practitioners will contribute to a siege mentality around pain treatment; negative ramifications could include delays in treatment, an undue burden on pain management practitioners and an unnecessarily complex system.”

— **Dr. Sanjeet Narang, anesthesiologist and pain physician, and Dr. David Hepner, anesthesiologist, Brigham & Women’s Hospital**

“The recommendations are a help, but each physician who holds a DEA license to prescribe this class of drugs would be better served by taking a few cautionary measures. The number of pills should be written in numbers and in words. To prevent six from being turned into sixteen or sixty, horizontal lines should be drawn beside the word. Numbered prescription pads with colored paper for Class II through IV drugs would not be exorbitantly expensive or difficult to produce. And it isn’t only society that needs the protection – it’s the physicians. No physician wants to be investigated . . . for writing prescriptions that have been misused or altered.”

— **Barbara H. Buell, partner, Smith & Duggan, Boston**

“Yes. Doctors have a responsibility to know their patient, the drug they prescribe and its effects. Many patients aren’t told that one possible large side effect to being pain-free with OxyContin is becoming addicted to a controlled substance. We need stricter regulations on prescribing and proper teaching for those who administer powerful Schedule II prescription or controlled substances. This session, I proposed “An Act Relative to OxyContin and other Schedule II Controlled Substances,” a bill that aims to put controls on the administering of such drugs. It is currently before the Joint Committee on Public Health.”

— **Rep. Vinny M. deMacedo, R-Plymouth**

“The commission makes a number of good suggestions. When we encountered cases where OxyContin was being diverted from dental prescriptions to street use, we met with a state dental organization to discuss providing objective education to counter the aggressive marketing of the drug in that area. The Drug Court session we helped implement in Norfolk County and our use of significant probation terms and split sentences show that the kind of long-term treatment and intervention in the lives of drug abusers the report recommends is important in helping arrest addiction. Arrest addiction and you will not need to re-arrest the addict.”

— **William R. Keating, Norfolk County District Attorney**



## A closer look at health care solutions for the drug epidemic

By **Alice Coombs, M.D.**

Following months of hearings and testimony, the Massachusetts OxyContin and Heroin Commission issued its report and recommendations in November.

The commission, created by the state legislature to assess the drug problem, was blunt in its description.

“The Commonwealth is in the midst of a serious and dangerous epidemic. . . . Prescription drug use is skyrocketing, opioid overdose deaths are steadily increasing. . . . Addiction is a medical disorder, and we have a public health epidemic on our hands that is larger than the flu pandemic.”

The problem is severe. Between 2002 and 2007, 3,265 Massachusetts citizens died of opiate-related overdoses. Further, the Partnership for a Drug-Free America estimates that every

day 2,500 teenagers use prescription drugs to get high for the first time.

While the causes of the problem are complex, the solutions must be implemented with a commitment to government fiscal allocations for prevention and drug treatment programs.

As substance abuse and addiction treatment research grows, the Commonwealth can be more effective in reducing these problems.

The commission offered recommendations in 20 areas of public policy, including education, criminal justice, law enforcement, job training, family issues and health care.

As the top three recommendations relate to health care, I would like to comment on those from a physician’s perspective.

### Prescription Monitoring Program

The commission recommended an “overhaul” of this program, saying its failure was a “consistent theme” at public hearings and that the “opiate crisis in Massachusetts is largely fueled by the misuse of prescription medication.”

The commission added: “In almost every case . . . in which these medications reach the street, the PMP could have acted as a preventive measure. . . . [T]he state’s inability to use this system to intervene in clear cases of prescription drug abuse, to reduce the frequency of ‘doctor shopping’ or use data from this program to target resources is, perhaps, one of the greater tragedies in this decade-long struggle with opiate abuse.”

gle with opiate abuse.”

If this program has failed, I submit it’s not due to system design. It contains adequate mechanisms and funding from prescriber fees to look for prescribing patterns and issue warnings. It’s capable of identifying patients who “doctor shop” and doctors who may be outliers in prescribing habits.

The system is sound and can be retooled with an appropriate focus on staffing and reallocation of resources. Further, opiate abuse is a significant public health problem, so monitoring should remain, as regulations stipulate, with public health professionals at the Department of Public Health. Moving monitoring to another state or non-governmental agency may have unintended consequences.

### Pain Management Training and Education

The commission stated that educating providers is “a major tool in fighting the legal prescription drug abuse trade” and that “the DPH and Board of Registration in Medicine should work closely together to further develop effective strategies to ensure physicians are properly and effectively trained.”

No profession believes more strongly in the value of training and education than physicians. But the unspecified nature of the recommendation precludes any legislative or regulatory mandate and provides more questions than answers.

Who would design and deliver the training? Who must be trained? Would lack of training prevent medical or nursing licensure? Where would training resources come from? Would the focus be pharmacology, addiction psychology, pain management, or would it tilt elsewhere, towards a law enforcement perspective?

More training and education – of physi-

cians, other providers, patients and the public – are desirable, as are better focus and more details for this recommendation.

### Tamper-Resistant Prescription Pads

Saying that “fraudulent prescriptions have become a growing problem,” the commission believes a fraud-resistant prescription pad program would allow “additional safeguards” for prescription delivery. It urges that all prescriptions for controlled substances be written on official state pads and that “no exemptions to this rule may exist.”

I make two points in response to this recommendation.

First, the federal government already requires tamper-proof prescriptions for Medicaid. What purpose would another state program serve and would it be compatible with the federal one?

Second, a paper system would create more bureaucracy (as well as more transportation storage and review costs) at a time when the health industry is moving – and being urged by the state to move – toward information technology and electronic prescribing methods.

I commend the commission for its comprehensive look at an intolerable situation and its dedicated approach to finding solutions. Its report heralds the magnitude of the problem, which is unacceptable.

While a multi-pronged approach is necessary, the results must be continuously studied to direct efforts for the greatest impact. But with state resources incredibly scarce and essential programs being cut, the attack on this epidemic from a health care perspective is best accomplished with full utilization of the well-designed resources we have in place and a rededicated commitment to protecting our patients.

*Alice Coombs, M.D., a critical care specialist and anesthesiologist, is president-elect of the Massachusetts Medical Society.*

## Doctor's Rx



# Insurer can require that chiropractor be deposed

Continued from page 1

ance companies] all the time, but [no one] has made this argument that it constitutes seeking payment under the policy, thereby obligating the provider to comply with the contract.”

Christopher S. Brown, an attorney at PIP Collect in Salem who represented the chiropractor, said that the judge “took a leap of faith with the PIP issue and saddled the doctor with a responsibility that, pursuant to the statute, is limited to the patient.”

While the PIP policy and the underlying statute clearly require an insured patient to cooperate with the insurer, answer its questions and, if necessary, undergo a medical exam with an independent physician, Brown said, those rules should not apply to the physicians who treat those patients.

“The doctor is not someone who witnessed the accident or has anything they can say under oath for the benefit of an investigation,” he said.

Due to the plaintiff missing an appeal deadline and other procedural issues, a higher court will not have a chance to consider the issue at this time.

If other courts agree with the logic in this case, it will place a significant burden on doctors who are usually not seeking large reimbursements, Brown added.

“One of the unfortunate conflicts we have to [manage] with PIP law is that the burden of trying to recover a relatively small amount of money is substantial,” he said. “Insurance companies can use onerous discovery tactics and that puts us in a position where doctors aren’t as inclined to seek recovery.”

Ralph F. Sbrogna, a lawyer at Fletcher, Tilton & Whipple in Worcester, said the ramifications of the decision could be complicated.



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“I suppose the chiropractor could go after the parents for the cost of the treatments. But what would the parents’ rights then be in relation to the insurer?” Sbrogna asked.

#### Details of the case

Felicita Muller was driving her 4-year-old and 2 ½-year-old on Jan. 8, 2006, when she was involved in a car accident. When she informed her insurer of the incident, she said she saw no visible signs of injury to herself or her children other than a bruise on one child’s cheek. While all three went to the emergency room, no X-rays were taken. They

were discharged and told to return if they felt any pain, according to Medoff’s motion in the case.

They did not return to the hospital but sought treatment from Fall River chiropractor Eugene Kramer, who billed Premier for his services. Premier asked Kramer to explain why and how he was treating the children and sought to question him under oath. He refused.

James F. Murray, a Saugus lawyer who was not involved in the case, said the unique facts likely played a role in the judge’s decision to bar the chiropractor’s suit.

“Children that age undergoing chiropractic treatment – I can see why it caught the eye of the insurance company and why the judge would be rather skeptical,” Murray said. “Had the children been older, the court might not have been as concerned.”

While Medoff agrees that the ages may have made the judge’s ruling easier, he contends that the duty of a health care provider to cooperate extends to anyone who seeks payment from a PIP carrier.

The standard Massachusetts Automobile Insurance Policy provides that the insurance carrier may “require you and any person seeking payment under any part of this policy to submit to an examination under oath at a place designated by us, within a reasonable time after we are notified of the claim.”

Medoff argued that language means that, “having submitted bills to Premier for payment, Dr. Kramer, necessarily, sought payment from Premier pursuant to the applicable policy of insurance” and thus was required to answer the company’s questions.

As long as the insurer’s request is “reasonable,” he said, the party seeking payment must comply.

Medoff said he does not believe that this case will discourage doctors from treating patients whose care will be reimbursed by PIP carriers.

“What the court really focuses on is that the request for an examination under oath still has to be reasonable,” he said. “I would submit that asking a chiropractor to discuss his basis for treating a very young child is not unreasonable.”

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Questions or comments can be directed to the writer at: [jack.dew@lawyersweekly.com](mailto:jack.dew@lawyersweekly.com)



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# Verdicts & Settlements

## Woman ejected from stretcher, sustains fatal head wound

On May 18, 2005, a 71-year-old woman with end-stage renal disease was being transported by an ambulance company from her dialysis center to her home.

As the ambulance employees were wheeling her on a stretcher through the parking lot, the wheels of the stretcher became stuck in a large rut in the pavement. The stretcher tipped over to the ground, causing the patient to fall and strike her head on the pavement.

The patient was secured with every available strap on the stretcher, including the shoulder straps, and was unable to protect herself from the fall. As a result of the incident, the patient sustained severe head injuries. She died three days later.

The decedent's daughter and administratrix of her estate claimed that her mother's injuries and death were caused by the negligence of the ambulance employees, who failed to avoid the obvious rut in the parking lot and prevent her from falling, and the negligent repair and maintenance of the parking lot by the owners and managers of the building.

The daughter claimed that despite their knowledge of the disrepair in the parking



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lot, both EMTs failed to maintain a proper lookout and navigate the conditions appropriately. She alleged that the property owners failed in their duty to maintain the property in a reasonably safe condition.

During discovery, the plaintiff found that a quality improvement manager from the ambulance company had written a report and determined that the accident was

caused by both the inattention of the ambulance personnel and the poorly designed and unsatisfactorily maintained parking lot.

The ambulance company maintained that its employees did all they could to avoid the incident in light of the condition of the parking lot. The property owners claimed that the cracks in the pavement were not substantial but nevertheless should have been obvious to the ambulance personnel.

The defendants jointly retained an expert nephrologist, who opined that the decedent's life expectancy was extremely short, and that had the accident not occurred, her quality of life would have remained severely limited, as it had been for a number of years prior to the accident.

The parties reached a settlement of \$750,000.

**Type of action:** Negligence & tort

**Injuries alleged:** Head trauma and subdural hematoma causing death

**Date:** August 2009

**Submitted by:** Neil Sugarman and Benjamin R. Zimmermann, Sugarman & Sugarman, Boston (for the plaintiff)

complicated and the patient went to postoperative care without difficulty. Later, when the patient failed to awaken, his medications were reversed without improvement.

Neurologic consultation and head CT scans indicated hypoxic damages to a number of significant areas of the brain. The damage worsened with subsequent brain herniation. A subsequent MRI of the brain showed bilaterally symmetric caudate nuclei consistent with anoxic brain injury. The patient died on Jan. 21, 2002.

The case settled prior to trial for \$1.5 million.

**Type of action:** Medical malpractice

**Injuries alleged:** Anoxic brain injury resulting in death

**Date:** July 2009

**Submitted by:** Elizabeth N. Mulvey and David Suchecki, Crowe & Mulvey, Boston (for the plaintiff)

## Second-shift doctor puts off preapproved Caesarean section

In August 2003, a patient, then 34, was expecting the birth of her first baby. All indications were for a normal vaginal delivery of a baby boy.

When the patient arrived at the hospital, her contractions had begun; a vaginal exam indicated that she was 4 to 5 centimeters dilated but that the baby was still very high in the womb. The obstetrician on call for the evening made the decision to use Pitocin to try to improve contractions and dilation, and bring the baby down.

Later that night, the physician told the family that there had been no further dilation. She was concerned that cephalopelvic disproportion likely existed, and if nothing changed within the next 90 minutes the plan would be to perform a Caesarean section, as trying to push the baby through the birth canal during CPD could cause trauma and hypoxia. The couple agreed.

The following morning, another physician took over and performed a vaginal exam. As the day progressed, the family asked why a C-section was not being initiated. The physician said that it was because there had been positive progress.

When the physician evaluated the situation at 12:00 p.m., she recognized that there had been no change in the last three hours and called for the C-section. The baby was delivered at 12:51 p.m.

At birth, the baby had a laceration on the left side of his forehead, significant caput, cephalohematoma, molding of his head and edematous eyes.

The following morning, he was noted to have apnea with lip smacking and left eye deviation as well as right upper and lower extremity tremors.

An EEG revealed seizure activity and the baby was given Phenobarbital. A head CT scan and MRI both indicated severe hypoxic ischemic encephalopathy and a left cerebral artery stroke. The baby's care was then transferred to another hospital where he was diagnosed with microcephaly, infarct and a seizure disorder secondary to his HIE. Today, the boy suffers from profound neurological injuries.

The plaintiffs' experts were prepared to testify that it was clear at 8:00 a.m. that the baby should not have been delivered vaginally. The experts were further prepared to testify that the defendant's attempts to reduce the cervix and push it out of the way to aid vaginal labor were unacceptable.

The defendant was prepared to testify that the labor had progressed after he assumed care and that the baby suffered a stroke at some point prior to the labor and delivery.

The case settled at mediation for \$3.25 million a week before trial.

**Type of action:** Medical malpractice

**Injuries alleged:** Brain damage

**Date:** February 2009

**Submitted by:** Andrew C. Meyer Jr. and Kryssia J. Syska, Lubin & Meyer, Boston (for the plaintiffs)

## Neurosurgeon wins harassment suit against hospital

A female neurosurgeon who specializes in spinal surgery was employed at Brigham and Women's Hospital for six years. She was born in India.

The surgeon alleged that the hospital discriminated against her by failing to promote her, support her research or pay her a salary commensurate with her male counterparts. She further alleged that the chairman of the neurosurgery department made disparaging comments about her and created a hostile work environment.

A jury found that the surgeon experienced harassment related to her gender and/or national origin and that she was forced to endure a hostile work environment.

The plaintiff was awarded \$1 million in damages against the hospital for a creating a hostile environment and \$600,000 for retaliation, as well as \$1 for retaliation under the Massachusetts Healthcare Whistleblower Act. She was awarded \$20,000 in economic damages against the neurosurgery department chairman and \$1 for both non-economic damages and slander.

**Type of action:** Civil rights

**Injuries alleged:** Ethnic and sexual harassment, retaliation

**Date:** Feb. 24, 2009

**Submitted by:** Margaret M. Pinkman, Camille V. Gerwin, Elizabeth A. Ritvo and Rachel A. Lipton, Brown Rudnick, Boston (for the plaintiff)

## Man may have been discharged during heart attack

On Feb. 2, 2007, a patient, 54, was taken by ambulance from a walk-in clinic to the ER. He had a two-day history of increasing shortness of breath, fever and non-productive cough.

The patient's medical history included insulin-dependent diabetes, chronic obstructive

pulmonary disease, hypertension and pneumonia, for which he had been hospitalized several times in the past year.

An internist admitted the patient with a diagnosis of pneumonia and COPD. Noting a "slight increase in CPK" and no acute EKG change, he wrote that the patient may have had slight ischemia secondary to respiratory distress. By the following morning, CPK-MB and Troponin-I test readings had increased; however, the internist felt that the patient's breathing had improved and coughing had decreased.

Another EKG was reported as borderline with normal sinus rhythm and possible left atrial enlargement. The doctor wrote that although the patient had a slight increase in cardiac enzymes, he had no symptoms, no EKG change and a normal echocardiogram in June 2006, and concluded that he probably had strain secondary to respiratory distress.

The patient was discharged that morning. Later that afternoon, his wife called the hospital to report that her husband had been taking a shower and was having difficulty breathing. A nurse said he probably over-exerted himself in the shower. His breathing improved within 20 minutes.

That evening, the patient suffered an acute myocardial infarction and was found unresponsive by his wife, who initiated CPR and called emergency medical services. He was taken by ambulance to the ER and was transferred to a tertiary hospital, where he remained on life support until he died three days later.

The widow's expert was prepared to testify that the defendant failed to comply with the standard of care. When deposed, the defendant conceded that the available information indicated that the patient may have been having an acute MI upon discharge.

The parties reached a settlement of \$650,000.

**Type of action:** Medical malpractice

**Injuries alleged:** Failure to diagnose and timely treat acute coronary syndrome, death

**Date:** May 2009

**Submitted by:** Patrick T. Jones and Donna R. Corcoran, Cooley Manion, Jones, Boston (for the plaintiff)

## Patient suffers fatal brain injury during heart surgery

The patient, a 39-year old husband and father of three, was experiencing symptoms including shortness of breath, fatigue and dizziness. An echocardiogram on Nov. 21, 2001 revealed 3+ aortic insufficiency. A cardiac catheterization showed normal coronary arteries.

He was seen in cardiac surgical consultation on Jan. 9, 2002. A composite root replacement with homograft tissue was planned with replacement of the aortic valve using a composite replacement as a conduit. Surgery was scheduled for Jan. 16.

The plaintiff alleged that during the procedure, the surgeon inappropriately advanced a cannula too far into the patient's subclavian artery, causing him to experience high left arterial radial line pressures, which were recognized by the perfusionist present for the operation.

The perfusionist testified at deposition that he alerted the surgeon as to the high pressures, but no action was taken. The operative report was dictated by the surgeon as un-

### Verdict & Settlement Reports

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

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## Course Information

### Intended Audience

This course is intended for physicians and allied health professionals.

### Course Objectives

- Describe the potential risks of compromising patient information on social networks.
- Identify ways to maintain professional boundaries in the physician-patient relationship on social networks.
- Cite reasons why a physician should monitor his or her web presence regularly.
- Define "anonymity" as it relates to social networking and the web.

### Course Credit

The Massachusetts Medical Society designates this educational activity for a maximum of 1 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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Kathleen Bellisle, Manager of MMS Distance Learning

## Bibliography – see page 14

## Social networking 101 for physicians

### Managing the risks of Facebook, Twitter and other social media

By Eric T. Berkman

The usefulness of online social networking is undeniable and it's no surprise that physicians are embracing it.

But lawyers and other experts warn that these tools present a minefield of legal and professional hazards for medical professionals who don't take the utmost care in how, what and where they post.

"If you can't do something at a cocktail party without people staring and looking at you strangely, you shouldn't be able to do the same thing online," says Jim Tobin, president of Ignite Social Media, a Cary, N.C., social-media agency that is developing a social-networking program for the Massachusetts Medical Society and its members.

Physicians are using these tools to discuss medical news, pick other doctors' brains about clinical or practice-management issues, market their practices or just generally feel connected.

In June, MMS polled approximately 800 of its members and found that the usage of social media grew 50 percent in the last year, with usage by doctors aged 45 to 54 tripling.

Whether blogging, participating in open networks like Facebook and Twitter, or visiting physician-only networks such as Sermo or iMedExchange, physicians can reduce their legal risk by doing the following:

#### • Be mindful of patient confidentiality.

Online networking presents a risk of a doctor compromising patient information and facing a compliance action under the Health Insurance Portability and Accountability Act (HIPAA) or a lawsuit.

Take, for example, a physician who shares a detailed anecdote about a patient on his or her personal Facebook page, or on Sermo.

The information a physician shares "needs to be generic enough that nobody can identify a patient in the course of reading a post," says David Harlow, a Newton lawyer and health care consultant who writes the blog HealthBlawg.

Though this sounds like common sense, the potential for carelessness is always present, says Kevin Pho, an internist in Nashua, N.H., whose 5-year-old blog, KevinMD.com, is one of the most popular health care blogs on the Internet, currently boasting more than 26,000 RSS subscribers.

"The easier it is to publish something, like a [Facebook] status update or a [tweet], the easier it is to slip up and give identifying information," says Pho, who has more than 500 Facebook fans and 14,000 followers on Twitter, a "microblogging" site where users can post 140 character "tweets" on issues of interest.

Daniel Palestrant, the Cambridge-based founder and CEO of Sermo, says the same is true for doctors posting on his site.

"Though Sermo is a secure site and we make every effort to keep

information in the community, there may be situations where information is cut and pasted out or someone is motivated to pull information out of the community in one way or another," says Palestrant, himself a physician.

Confidentiality issues may also arise when doctors allow patients to post on their websites or Facebook pages. A patient might be too open in a "wall" post and later realize he's made his own informa-

tion for failing to respond, he says.

While social media is obviously not a reliable means of clinical communication with a doctor, it's hard to tell where a jury's sympathies might lie.

"There are now more than 300 million Facebook accounts," says Harlow. "Do you run the risk of going to trial and facing a jury full of people who rely on Facebook as their primary means of communication? They might say someone



tion public. He might then blame – and perhaps sue – the doctor.

"Once a patient posts, [he or she has] essentially consented that it be public, but most [patients] won't view it that way," says Harlow.

There's no guarantee such a case would hold up in court. But to be safe, Harlow advises doctors to block patient access to their personal Facebook pages, and provide clear warnings on any public sites against posting medical information.

#### • Remember that your patients are not your 'friends.'

A physician who gets too close to his patients puts himself at risk.

That's why Cambridge internist Phoebe Cushman refuses to accept Facebook "friend" requests from current or former patients.

"I just hit 'ignore.' ... I think it's very important to have boundaries in the physician-patient relationship," says Cushman, who also maintains the strictest privacy settings on her account.

That's a good approach, says Harlow, suggesting that doctors set up a separate page representing their practice and enabling patients to become "fans."

"This is a way of connecting and allowing folks to follow your updates without blurring that personal/professional line," he says.

#### • Monitor your web presence regularly.

Harlow points out that the pervasiveness of social networking has resulted in some people transmitting all their communication through Facebook and Twitter and expecting others to be there to receive their messages.

Doctors who enable such communication without properly monitoring their sites run the risk of missing urgent messages or a patient's medical history details and possibly facing a malpractice ac-

count.

David S. Szabo, a partner at Edwards, Angell, Palmer & Dodge in Boston, agrees.

"If you start using [social media] as a means of regular communication or an element in how you communicate with people, perhaps you could be charged with at least looking at it on a reasonably regular basis and being aware of information sent that way," he says.

#### • Take advice from online doctors' forums with a grain of salt.

Physician-only discussion boards like Sermo have become a valuable replacement for the traditional "curbside consult" with colleagues about complex cases.

But Harlow warns that free advice is "worth what you pay for it" and thus "should be taken with a grain of salt." After all, relying on advice outside the standard of care could constitute malpractice.

Also, since all users post under pseudonyms, "you have to be confident that whoever's replying [to your inquiry] is who they say they are," says Pho.

Palestrant reiterates Sermo's extensive physician verification process, adding that when a user clicks on another member's profile, he or she can see the member's specialty, the history of his activity on the site, and his rating by fellow users.

Nonetheless, Palestrant adds, physicians should of course solicit information from multiple sources, such as journals, peers, or non-physician colleagues such as nurses and physician's assistants.

#### • Be aware that you're never truly anonymous on the web.

In 2007, a Boston-area pediatrician, known as "Dr. Flea," blogged about his ongoing med-mal defense, sharing candid musings on

# Social networking 101 for physicians

Continued from page 13

defense strategy, the jury, opposing counsel and the plaintiff's case.

He thought everything was safely cloaked in anonymity until his cross-examination at trial, when plaintiff's counsel – who had been following the blog and noting similarities – outed him to the jury. The case settled the next day.

Szabo says this is a cautionary

tale that anything posted on the web can be traced back, with severe consequences.

“When you start throwing in little details, if you have any connection to someone, it may not be too tough for that person to figure out who you are,” he says.

Pho adds that anything you write on Twitter or your blog is indexed by Google and kept permanently.

“So never write anything disparaging about your hospital, patients or other doctors, because it can be found,” he says.

Further, Szabo warns that Internet service providers, websites and social-networking companies are under no obligation to resist subpoenas in a civil lawsuit. Accordingly, they might decide to produce information like an IP ad-

dress or e-mail address that could identify the name of a person who posted offending content.

Finally, says Tobin, the existence of vehicles like Facebook and Twitter does not change existing copyright, slander and libel laws.

“We're under the same restrictions we've always been under,” he says. “The only difference is that saying something is much easier.

You can send a tweet or a Facebook status update in seconds. So you need to pause and think before you hit that ‘update’ button.” **MMLR**

Questions or comments should be directed to the editor at: [reni.gertner@mamedicalaw.com](mailto:reni.gertner@mamedicalaw.com)

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## The Physician's Corner

### Avoiding the legal risks of social networking

By Henry Tulgan, M.D., FACP

Now that online social networking has become so prevalent, it is hard to believe that it is mainly a product of the first decade of the 21st century.

Only as recently as 2004, three Harvard University undergraduates created Facebook, a website first designed to put students in touch with one another. The site rapidly spread to other college campuses, and it now includes anyone over the age of 13, recently reaching 350 million users.

Another familiar social networking site, MySpace, also dates back only to 2004, and Twitter, a microblogging site based on 140-character answers to a simple question – “What are you doing?” – started in 2006.

As social networking has become widespread, particularly over the past two years, numerous health care-related and physician-only networks have emerged. Indeed, social networks are heavily utilized in medical schools, both by students and faculty, in academic health centers and community hospitals, as well as by medical publications, libraries, pharmaceutical companies, nursing groups and health information

technologists, to name just a few.

The number of practicing physicians on the social networking bandwagon is growing daily. It seems that not a day goes by when I am not contacted by e-mail with a request to join a social network or physician forum.

However, the use of social networks also brings potential liability risks for physicians.

Perhaps the most important thing to be aware of is the need to maintain the confidentiality of patient information. Disclosure of any identifiable details may be a violation of the Health Insurance Portability and Accountability Act (HIPAA).

While this may seem like an obvious concern with the use of a public site such as Facebook – and legal experts advise that physicians block patients' and former patients' access to their personal sites – it is equally important to protect against a HIPAA violation when using a physician-only social network.

In addition, it's essential to regularly monitor all of your sites to avoid failing to respond to a patient question. Such a failure could result in a malpractice action.

When using online forums to discuss patient care, physicians

must also be mindful of employing suggestions that may not meet standards of care or may not be evidence-based.

I have visited several of these sites personally, and noticed that the posters usually use pseudonyms, and therefore it's not generally possible to know the skill level or background of the respondents.

Attorneys also caution that Internet service provider websites and social networks are under no legal obligation to hold back confidential and personal information if subpoenaed and thus such information could be used in a civil lawsuit.

Violation of confidentiality by office employees can also add to risk. And be aware that social networks do not protect against copyright, slander or libel suits.

Physicians should also have an understanding as to who will be responsible for defending them in case of legal action: the employer – a group, hospital or health system – or themselves.

Recently, physician recruiting has become another online use of this technology. Remember that information sent to one source may become widely disseminated.

Lastly, medical files have been

pilfered from social networking sites for the purpose of fraudulent billing of Medicare and Medicaid. Billing information must be carefully monitored to avoid this possibility.

Physician use of social networking is here to stay and is likely to grow. However, we should never let our enthusiasm to embrace this technology overshadow the legal risks that accompany it.

#### Risk management strategies

- Be mindful of patient confidentiality. Information must be generic enough that no one would be able to identify a patient by reading a post.
- Explain the risk of violating patient confidentiality to your office staff members if they participate in social networks and websites.
- Maintain professional boundaries in the physician-patient relationship with strict privacy settings on your account.
- Monitor your web presence regularly. Physicians who enable such communication without

monitoring their sites run the risk of missing urgent messages or a patient's medical history details and possibly facing a malpractice action for failing to respond.

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*Henry Tulgan, M.D., FACP is a clinical professor of medicine at the University of Massachusetts Medical School, a consultant to the MMS Committee on Sponsored Programs, which he formerly chaired, and Director of Medical Education at Wing Memorial Hospital in Palmer, Mass.*

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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 December 21, 2010. Please make a copy for your records.

1. Patient information is kept confidential on social networking sites.  
 a. True  
 b. False
2. Physician-only social networking sites provide an excellent source of standard of care information.  
 a. True  
 b. False
3. Social media is not a reliable means of clinical communication between a patient and his or her physician.  
 a. True  
 b. False
4. Material contained on social networking sites may be obtained by subpoena.  
 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](mailto:continuingeducation@mms.org).

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What are your topics of interest for future CME activities?

If yes, please explain.

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# Can pharmacies be sued for injuries caused by patients' drug abuse?

By Justin Rebello

As pharmacies gain increasing access to information about the medications patients are taking, they are growingly concerned that they could be sued when patients abuse prescription drugs and cause injury to third parties.

The increase in data comes in the form of pharmacy computer systems, a rise in state-based online databases that track prescriptions and the increasing implementation of electronic medical records in doctors' offices.

Prescription-tracking systems are currently operating in 33 states.

"It's all about finding out what a pharmacist knows and what steps they take when they find out a person is abusing narcotics," said plaintiffs' attorney John Day of Day Blair in Nashville. "[Pharmacists] have a duty as a matter of law to review all records and protect the patient and others."

Massachusetts' highest court considered a similar case in 2007, but in that case a physician was sued. The Massachusetts Supreme Judicial Court held that a man killed by a driver who was impaired by prescription drugs may be able to sue the doctor who treated him. (*Coombes v. Florio*, 50 Mass. 182 (2007).)

The court said that "[a] physician owes a duty of reasonable care to everyone foreseeably put at risk by his failure to warn of the side effects of his treatment of a patient."

Some attorneys are trying to extend that reasoning to pharmacies.

Liability in such a case will hinge on "the interaction between the pharmacist and the customer," said William Rose, an attorney at Tucker, Heifetz & Saltzman in Boston, who has represented doctors and pharmacies.

Rose also noted a 2002 Massachusetts case in which a man sued CVS after he was not warned that the side effect of priapism was associated with a prescription anti-depressant.

The pharmacy was found liable because the pharmacist in question had given the patient an information leaflet that listed the drug's side effects, but the risk of priapism was absent. (*Cottam v. CVS Pharmacy*, 436 Mass. 316)

"The pharmacist in that case very gave specific instructions to a customer," said Rose. "That's why [the pharmacy] lost even though there was no duty to warn."

The key piece of evidence in any case, said Day, would be the patient's medical records.

"Ideally you would like to find some kind of drug-related incident in the [abuser's] medical records, so you could prove" that the drug use caused the injury to the third party, said Day.

## Test case in Nevada

Nevada, one of the first states to implement a prescription-tracking system, is the setting for a closely-watched case before the state's highest court that could impose liability on a pharmacy for injuries to a third party.

Patricia Copening, a 35-year-old receptionist in Las Vegas, pled guilty to reckless driving after a June 2004 accident that killed one man and injured another. Police found that her vehicle contained prescription bottles and other assorted loose pills, including hydrocodone and other painkillers.

In addition to Copening, the driver's family sued several pharmacies that had filled her prescriptions for the painkillers.

According to the plaintiffs' attorney in the



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Nevada case, Phil Aurbuch, the argument against the pharmacies is based largely on evidence in the state's database that linked Copening to several of the painkillers found in her vehicle.

The suit alleges that 14 area pharmacies – including a Las Vegas-area Wal-Mart, CVS and Walgreen's – were notified of Copening's potential prescription drug abuse problems, but didn't heed the warnings that were available on the state's database.

"The pharmacies said they should be treated like bartenders," said Aurbuch, a partner at Marquis & Aurbuch in Las Vegas. "But a bartender's only duty is to check an ID. A pharmacist has 10-15 duties, including making sure the customer is not abusing."

Day agreed.

"You have to impose a higher responsibility on a professional whose job it is to handle these drugs than a 21-year-old college student tending bar part time," he said.

A decision in the Nevada case is expected in the coming weeks, Aurbuch said.

Regardless of how that court rules, Day he doesn't anticipate a flood of litigation in this

area because of the rarity of the situation.

"More often than not, if a pharmacy makes a mistake with a prescription, only the person taking the pills is getting hurt," he said.

In a statement commenting on an earlier ruling in the Nevada case, Wal-Mart said, "While we're sympathetic to those injured in Copening's car accident, we agree with the district judge's decision that our pharmacists fulfilled their legal duties."

## A pharmacy's duties

Prior cases vary as to whether pharmacies have a duty to warn patients about the adverse effects of a drug.

Christopher Pencak, a pharmacist and lawyer in Chesterfield, Mich., represented a pharmacy in a 1988 case, where the court ruled against imposing "a duty to warn on pharmacists when filling lawful prescriptions."

The plaintiff, Lincoln Adkins, Jr., sued Motor City Prescription Centers for supplying him with excessive amounts of prescription drugs over a six-year period. Adkins claimed that as a result, he became addicted to several narcotic substances, including Valium and Seconal.

Day handled one of the first cases to hold a pharmacy responsible for adverse effects a customer experienced after taking a prescription it filled. In that case, a Tennessee appellate court said that a pharmacist had a duty to warn the parents of a child who had been prescribed both theophylline and erythromycin, a combination that caused the child to suffer from severe neurological disorders.

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Questions or comments should be directed to the writer at: [justin.rebello@lawyersusaonline.com](mailto:justin.rebello@lawyersusaonline.com)

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