

Malpractice Considerations: New Concerns on the Horizon

Social networking and digital technology have altered the legal environment.

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Allegations of negligence are a major concern to practicing physicians. A general definition of malpractice is the breach by a member of a profession of either a standard of care or a standard of conduct. Malpractice refers to negligence or misconduct by a professional person, such as a doctor. The failure to meet a standard of care or standard of conduct that is recognized by a profession reaches the level of malpractice when a patient is injured or damaged because of physician error.

The litigious nature of American society is influencing the field of medicine. An overwhelming major-

ity of practicing physicians believe that their concerns regarding medical malpractice liability impair their ability to provide quality care, and also cause them to order unnecessary tests and make unnecessary referrals.

tential malpractice risks is a physician's best risk management strategy. We present some new malpractice concerns and discuss how to avoid them in today's medical practice environment. The malpractice threats

Understanding these new threats will reduce a physician's risk for liability exposure in today's constantly changing digital medical care landscape.

Many nurses and hospital administrators share this belief. Furthermore, a large majority of physicians, nurses, and hospital administrators believe that these extra tests, referrals, and procedures significantly contribute to escalating healthcare costs.

Physicians practicing medicine face many risks on a daily basis, but many of those can be avoided. Knowing and understanding the po-

we consider include the following:

- Why clinical practice guidelines are a double-edged sword;
- How Accountable Care Organizations (ACOs) may heighten your malpractice exposure;
- Why teams of healthcare professionals may raise liability dangers;
- The perils of social media and smartphones;

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- The new dangers inherent in electronic medical records;
- Why telemedicine lawsuits are expected; and
- Why complaints to state boards are as damaging as lawsuits.

Clinical Practice Guidelines: Shield or Sword

Physicians in today's medical practice arena are expected to follow evidenced-based medical guidelines produced by specialty societies, payers, hospitals, and clinical decision support systems in electronic health records (EHRs). Specialty societies issue medical guidelines to protect physicians against unpredictable standards of care promulgated by expert witnesses engaged by plaintiff attorneys. Unfortunately, this attempt at shielding physicians can become a double-edged sword. Studies have been published supporting the thesis that medical guidelines are used more frequently against doctors than in service of them.¹

Courts still seem wary of guidelines. The courts seem to interpret medical guidelines as hearsay unless introduced by an expert witness. Courts look to expert witnesses to vouch for the standard of care, defined as reasonable and ordinary care exercised by physicians in the same specialty and under like circumstances. The problem with medical practice guidelines is they are ambitiously trying to capture best practices. They are trying to define the optimal level of medical care, which has the potential of requiring the physician needing to meet an even higher standard of care in a malpractice case. Beyond that is the basic problem that medical practice guidelines are variable and frequently fail objective tests of reliability. In 2013, the *Journal of the American Medical Association* assessed several guidelines on the basis of eight standards for creating medical guidelines set by the Institute of Medicine (IOM) and found that none of the guidelines met all eight standards.² Even medical guidelines fashioned by organized medicine do not escape criticism. In a study in 2012 only about one third of medical

guidelines produced by subspecialty societies satisfied more than 50% of the IOM standards.³

The American Board of Internal Medicine Foundation has an initiative called Choosing Wisely⁴ that has persuaded many specialty societies to identify tests and procedures they consider unnecessary or overused. The problem is that many of the medical guidelines "subject practitioners to a low but significant risk for missing serious disease" if the guidelines were followed to the letter. Choosing wisely provides a disclaimer at the end of each guideline: "Use this report at your own risk."

What can the practicing physician do about this risk? Just be aware

ACOs may provide malpractice threats for a number of reasons:

- Because the new organizational structure yields higher expectations of practitioners;
- Because more clinical information is available for plaintiff attorneys to use;
- Because the defined mission of ACOs is to produce savings; and
- Because there is a lack of legal protection that is available to health maintenance organizations.

It will take another year or more for cases to arise and wend their way through the courts so we have precedents available to formulate risk management strategies.

What can the practicing physician do about this risk? Just be aware that medical practice guidelines are not an ironclad safeguard against malpractice allegations.

that medical practice guidelines are not an ironclad safeguard against malpractice allegations. The take-home point is that clinical practice guidelines must be considered judiciously within the context of the entire clinical situation. A single clinical approach does not fit all patients.

Accountable Care Organizations

New medical organizational structures may create liability risk. ACOs represent a new frontier in malpractice law. Defined and incentivized under the federal Patient Protection and Affordable Care Act, ACOs allow hospital groups and other medical facilities to partner with smaller healthcare provider groups and individual medical professionals. This is the government's attempt to move healthcare delivery away from fee-for-service reimbursement models toward payment structures governed by the quality and cost-effectiveness of treatments that patients receive. ACOs are in an "embryonic state" and have not existed long enough to generate legal decisions; therefore, we have a paucity of legal precedent to formulate risk management strategies.

Risk for allegations of negligence is inherent in the expectation of higher levels of care within ACOs. In ACOs, physicians must develop individualized medical care plans for patients that are more comprehensive than what is typically committed to the patient record. Federal regulations mandate a defined process to meet the higher standard for patient communications and state that clinical knowledge must be presented in a way that takes into account a patient's unique needs, priorities, and preferences. This Federal regulation-mandated language has inherent risks for the practicing physician, because patients' unique needs, preferences, and priorities are open to variable interpretation.

The individualized patient care plans, patient assessments, ACO application materials, procedures, and protocols create a gold mine of material for the plaintiff attorney to inspect for inconsistencies. Additionally, federal regulations direct that an ACO must report internally on quality and cost metrics. The idea of increasing quality while containing costs is fraught with many potential

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inconsistencies. Whenever quality and cost intersect, there is potential for allegations of negligence. Plaintiffs' attorneys could cite the ACOs' mandates to produce shared savings to demonstrate that corners were cut on patient care for cost savings. The cost-cutting argument

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is persuasive to many juries. HMOs enjoy legal protection against arguments that they skimped on care to save money, but ACOs do not have that protection, because they are involved in the actual provision of medical care.

What can physicians do about these possible risks? Be aware, and remember they have not materialized yet. The best protection for a physician working in an ACO is

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to adhere strictly to all the mandates and recognize that attention to detail can be a lifesaver for the patient and the physician.

Healthcare Professional Teams' Liability Concerns

ACOs, Patient-Centered Medical Homes, and hospital systems are increasingly using teams of healthcare professionals to provide care to a patient. The involvement of multiple caregivers in patient care may create the potential for liability risk. The obvious danger is that no single person is in charge of the patient's care. The doctor-patient relationship gets diluted, because no one doctor is accountable to the patient's overall medical care. Even when a physician is not directly involved in a patient error, there is the potential for liability under the concept of vicarious liability. Emanating from vicarious liability is the notion that you are only as good as your weakest link. Additionally, a problem arises when there are conflicting views of what medical care the patient needs. A 2015 study⁵ found that physicians caring for critically ill patients often do not feel the responsibility to act because they have a different view of treatment than the physician in charge.

A major risk for liability and an opportunity for "finger pointing" occurs at the time a patient is "handed off" from one team member to the next. When a malpractice issue surfaces, there can be a wide discrepancy between team members as to what was said regarding patient management issues. To limit the potential for conflict between care providers, there must be a team member "in charge" of overall patient care, and all involved in that patient's care must adhere to the defined management strategy. In addition, patients must be reached out to post-appointment or post-hospitalization to ensure that

The rise of smartphone technology and use has created a new malpractice risk called the "distracted doctor."

communication has been effective and to avert mistakes if there was a breakdown in the communication between the healthcare team and the patient. An article published in the *Journal of the American Medical Association* in 2012⁶ articulated a take-home message that medical care teams should develop clear lines of accountability for patient care. Team members must have clear roles, mutual trust, effective communication, and shared goals. If the team does not develop such clear lines of accountability for patient care, there is a high risk for poor outcomes and associated liability risk.⁷

The Risks of Electronic Communication

Everywhere you look, people are peering down at their smartphones reviewing a text, e-mail, or the latest Facebook post. In the hospital, it is common to see physicians lost in their smartphone world. The rise of smartphone

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technology and use has created a new malpractice risk called the “distracted doctor.” When physicians and other medical personnel are engaged with their smartphones, they are no longer fully present in the patient’s room. In

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one example that illustrates the severity of the problem, an anesthesiologist was named in a malpractice case involving a patient’s death during heart surgery.⁸ The defendant was alleged to have been looking at his iPad while he failed to notice plummeting oxygen saturations.

Despite the dangers of using smartphones in the clinic or hospital, there are very few regulations on their use in the medical work world. In 2013, the Emergency Care Research Institute (ECRI) listed cell phone distractions as one of the top 10 technology risks to patient safety.⁹

The best approach to lowering this risk for healthcare professionals is to establish policies that prohibit the use of phones for personal matters at work. There could be dedicated telecommunication devices that can be used for work issues only. The benefit from these types of policies would be that they would eliminate distractions that lead to mistakes that potentially can harm patients. Human beings function best when engaged in the task at hand. Multitasking is just asking for allegations of negligence.

Social Media and Malpractice Risk

Facebook, Twitter, and Snapchat have become the dominant media for social interaction. Social scientists have a name for this sort of incessant online contact: they call it ambient awareness. It is, they say, very much like being physically near someone and picking up on their mood through the little things the person posts or tweets. Facebook is no longer alone in offering this sort of interaction online. In the last year, there has been a boom in tools for posting frequent tiny updates on what one is doing. The phenomenon is quite different from what we normally think of as blogging, because a blog post usually is a written piece, sometimes quite long: a statement of opinion, a story, or an analysis. But these new updates are something different. They are far shorter, far more frequent, and less carefully considered. One of the most popular tools is Twitter, a website and messaging service that allows its more than two million users to broadcast to their friends updates limited to 140 characters, as brief as a mobile phone text message, on what they are doing. Other services permit users to report where they are traveling or quickly toss online a stream of the pictures, videos, or websites they are looking at. There are even tools that give

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your location. When the new iPhone, with built-in tracking, was introduced in July 2008, one million people began using Loopt, a piece of software that automatically tells all your friends exactly where you are.

Physicians are as entrenched as anyone else in social media.¹⁰ Physicians must remember that anything they post on Facebook or other social media can be used against them in a malpractice proceeding. Plaintiff attorneys want to portray a defendant physician in a bad light and constant Facebook postings give them ample opportunity. The plaintiff attorney can use any acrimonious postings to establish character deficits. The best advice is to keep personal and professional lives separate and limit access to Facebook postings to family and trusted friends.

Electronic Medical Records: A Malpractice Paradox

Electronic medical records (EMRs) are a medical practice paradox. The new wealth of clinical information available in the EMR increases malpractice risk. The story is just starting to evolve. Since EMRs did not become common until 2011, when the Meaningful Use program was initiated, the malpractice law in this area is in its infancy. The cases that have arisen since 2011 have included computer systems that were not inter-operable, tests results not properly routed, faulty data entry, and misuse of copy-and-paste functions. Clearly, when there are so many boxes to check, there is a risk of mistakes and errors that can lead to allegations of negligence.¹¹ EMRs provide plaintiff attorneys with a treasure trove of new evidence for their malpractice cases. Unlike a paper

visits can be handled over the phone. The use of telemedicine is common and is here to stay. What malpractice risks does it present to physicians?

Telemedicine is another area new area of healthcare for which there are few legal precedents. A large area of

Physicians must understand the malpractice risks associated with a digital relationship.

concern is the reduction in the personal connection between the physician and the patient, which may increase the likelihood of a malpractice action. When the doctor has not talked to and examined the patient in person, it is harder to defend against alleged allegations of negligence. Additionally, telemedicine involves physicians remotely supervising technicians on site, and when concerns develop, the doctor can be implicated on the basis of vicarious liability.¹²

What can the physician do to avoid the medical malpractice risk associated with the new world of telemedi-

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The best advice to physicians is slow down, despite the rapid-fire pace of today's medical practice.

trail, everything is recorded in the metadata, showing time stamps and individual keystrokes. The best advice to physicians is slow down, despite the rapid-fire pace of today's medical practice. It is imperative to edit and proofread any data you copy and paste. Check the system for errors, and do not sign any gag orders from vendors. The malpractice risk associated with EMRs is real for physicians. As the systems become more overloaded with data (as often is associated with regulatory mandates), the risks become greater for the physician.

Telemedicine and Potential Malpractice Risks

Telemedicine is possible thanks to telecommunications capabilities that allow patients to consult remotely with their doctors via two-way video, text, or e-mail. Many medical experts say that patients can receive some of the care they need from the convenience of their own office desks. More than 36 million Americans have used telemedicine in some way, and as many as 70% of doctor



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medicine? First, physicians must understand the malpractice risks associated with a digital relationship. If you assume that risk, it may be beneficial to take a course in conducting a tele-

ply comprehensive, detailed records outlining the patient’s history, physical examination, and plan of care.¹³

Conclusion

Physicians attempting to develop risk management strategies to pre-

The cause of increased filing of complaints is unhappy patients who find it easier to file a complaint than to convince an attorney that they have a meritorious case.

medicine session so you identify how to make it a personal experience. Second, recognize that you must carefully supervise technicians at remote sites. Last, but not least, make sure you have a malpractice policy that covers digital physician-patient relationships.

State Board Reporting as a Liability Risk

Patient complaints to the state medical board are on the rise and represent another liability concern that may be eclipsing malpractice litigation. These complaints can precipitate disciplinary actions against physicians that are just as hazardous as malpractice suits. A disciplinary action does not have to involve a patient injury, and there is no payout if the physician is censured. However, as with a malpractice suit, it can involve negligence and may be just as harmful to a physician’s reputation. Both licensure actions and malpractice actions must be reported to the National Practitioner Data Bank. The cause of increased filing of complaints is unhappy patients who find it easier to file a complaint than to convince an attorney that they have a meritorious case. The confounding factor for physicians is that board actions are based on allegations of impropriety that might not meet the threshold of malpractice.

The best way to prevent complaints to the state board is by maintaining a quality physician–patient relationship based on adequate time spent with the patient, effective communication, and comprehensive follow-up. The best approach when responding to the medical board is sup-

vent allegations of negligence in the new digital medical world must understand the new horizon of potential malpractice allegations. Physicians must understand:

- Why clinical practice guidelines are a double-edged sword;
• Why and how ACOs may heighten malpractice exposure;
• Why and how teams of health-care professionals may raise a few liability dangers;
• Why social media and smartphones pose new malpractice perils;
• Why there are new malpractice dangers inherent in EMRs;
• Why telemedicine lawsuits are expected; and
• Why complaints to state boards are as perilous as malpractice lawsuits.

This understanding will reduce the likelihood of being named in a malpractice action that harms one’s reputation as a physician. PM

References

1 Overlooked and underused: clinical practice guidelines and malpractice liability for independent physicians. Social Science Research Network. http://insurancejournal.org/wp-content/uploads/2014/06/6-Avraham.pdf. Accessed August 6, 2016.
2 Ransohoff DF, Pignone M, Sox HC. How to decide whether a clinical practice guideline is trustworthy. JAMA. 2013; 309:130-140.
3 Kung J, Miller RR, Mackowiak PA. Failure of clinical practice guidelines to meet institute of medicine standards: two more decades of little, if any, progress. Arch Intern Med. 2012;172:1628-1633.
4 ABIM Foundation. Choosing Wisely. www.choosingwisely.org/. Accessed October 4, 2016.

5 Oerlemans AJM, van Sluisveld N, van Leeuwen ESJ, Wollersheim H, Dekkers WJM, Zegers M. Ethical problems in intensive care unit admission and discharge decisions: a qualitative study among physicians and nurses in the Netherlands. BMC Med Ethics. 2015;6:9.

6 Wynia MK, Von Kohorn I, Mitchell PH. Challenges at the intersection of team-centered and patient-based healthcare: insights from an IOM working group. JAMA. 2012;308:1327-1328.

7 Ngo E, Paterick ZR, Patel N, Waterhouse B, Sanbar, Tajik AJ, Paterick TE. Professional liability pertinent to graduate medical education: the intersection of medical education, patient care, and law. J Med Pract Manage. 2016;31:233-237.

8 Nicholson E. Dallas anesthesiologist being sued over deadly surgery admits to texting, reading iPad during procedures. Dallas Observer. April 1, 2014; www.dallasobserver.com/news/dallas-anesthesiologist-being-sued-over-deadly-surgery-admits-to-texting-reading-ipad-during-procedures-7134970. Accessed October 4, 2016.

9 Sack E. ECRI Institute’s top 10 health technology hazards for 2013. ECRI Institute. April 9, 2013; www.healthcareitnews.com/press-release/ecri-releases-top-10-health-technology-hazards-2013.

10 Brown J, Ryan C, Harris A. How doctors view and use social media: a national survey. J Med Internet Res. 2014; 16:e267. December 2014; https://www.jmir.org/2014/12/e267/.

11 Ruder DB. Malpractice claims analysis confirms risks in EHRs. Patient Safety & Quality Healthcare. February 2014; www.psqh.com/analysis/malpractice-claims-analysis-confirms-risks-in-ehrs/.

12 Vinck I, De Laet C, Stroobandt S, Van Brabant H. Legal and organizational aspects of remote cardiac monitoring: the example of implantable cardioverter defibrillators. Europace. 2012;14:1230-1235.

13 Ngo N, Patel N, Chandrasekaran K, Tajik J, Paterick T. The importance of the medical record: a critical professional responsibility. J Med Pract Manage. 2016;31:305-308.

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