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# 10 New Malpractice Concerns, and How to Avoid Them

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## Risks Arise, but Many Can Be Avoided

The news on the malpractice front is still somewhat upbeat: Physicians are far less likely to be sued than they were a decade ago. However, several new concerns appear on the horizon—threats that are either brand-new or were largely unfamiliar years ago. Some of these concerns may not apply to you; a few others are still only conjecture and may not materialize, but it's worth knowing about them.

Here's a list of 10 new threats, and what you can do about each one.

**1. High Deductibles Are a Growing Danger**

High-deductible insurance policies, which leave patients on the hook for from $1000 to about $6000 before coverage kicks in, have become common only in the past few years, and they loom as major malpractice risks for doctors.

In a 2014 survey[1] by the Commonwealth Fund, 43% of low-income respondents said they had delayed or skipped needed care because of deductibles, copayments, and other out-of-pocket costs. Even among those with moderate incomes, one half said their deductibles were difficult to afford.

When patients forgo care owing to cost, physicians are not off the hook, says James W. Saxton, a malpractice attorney with Saxton and Stump in Lancaster, Pennsylvania. "Doctors should follow patients to make sure they come in for annual examinations, and they need to tell them when they're due for preventive tests, such as colonoscopies and mammograms," he says.

In one reported case, a doctor saw the patient for years but never offered him a full physical exam. The patient was ultimately found to have stage IIIB colon cancer. After his death, his family sued the doctor. The doctor claimed that the patient was only seeing him for blood pressure checks and did not want a "full examination," but the court didn't buy that argument.[2]

What can you do about this risk? Saxton advises that you always need to document your instructions to patients, and instructions should include telling patients about the implications of nonadherence. "The implications of noncompliance —that's what these cases are about," he says.

Saxton also recommends following up by sending an "at risk" letter to the patient, which restates the implications. "More often than not, patients comply when they get these letters," he says. "It's not a 'gotcha'; it's actually a patient compliance strategy."

It also helps to discuss barriers to care with the patient and try to come up an alternative. "Point out that there may be low-price alternatives available at clinics or through programs from pharmaceutical companies," Saxton says.

## Certain Risks Require Careful Attention

**2. You Can't Totally Rely on Clinical Practice Guidelines**

More than ever, doctors are expected to follow evidence-based guidelines laid down by hospitals, payers, patients, and even clinical decision-support systems in electronic health records (EHRs). But malpractice attorneys say you should do so at your own risk. Guidelines are a weak defense against lawsuits.

There's an irony here, says Joseph McMenamin, MD, a healthcare attorney in Richmond, Virginia. Specialty societies issue guidelines so as to protect physicians against unpredictable standards of care coming from expert witnesses engaged by plaintiffs' attorneys. But this shield is also a sword. "There's evidence that guidelines are used more frequently against doctors than in favor of them," he says, pointing to several studies of their use in malpractice cases, including one[3] from

last year.

Courts are still wary of guidelines, viewing them as hearsay unless introduced by an expert witness. Courts normally look to the expert witness to vouch for the standard of care, defined as "reasonable and ordinary care" exercised by a physician in the same specialty, in a similar community, and in like circumstances.

Many guidelines, however, are "aspirational," Dr McMenamin says. "Typically, they are trying to capture best practices. They're looking to define the optimal level of care." That means the physician has an even higher standard to reach in a malpractice case. "Through that lens, he might not look very good," Dr McMenamin says.

But there is an even more basic problem with guidelines: Their quality is variable, and virtually all of them flunk objective tests of their dependability. A 2013 study[4] published in *JAMA* assessed several guidelines on the basis of eight standards for creating guidelines set by the Institute of Medicine (IOM), and found that not one of them met all eight standards.

Even guidelines created by organized medicine do not escape censure. In another study[5] from 2012, barely one third of guidelines produced by subspecialty societies satisfied more than 50% of the IOM standards.

"Guidelines may be outdated, too general, too vague, or too narrow," says William Sullivan, DO, an emergency physician who is also an attorney. He wrote a critique[6] of guidelines, published on Medscape in January, that received a very high number of comments. "For example, the guideline may apply to 'uncomplicated' cases," which may not apply to many situations, Dr Sullivan says. "Or there might be a lot of qualifiers, and you would have to follow all to them to the letter, and in the end they may only apply to a small group of patients."

Dr Sullivan focuses much of his critique on Choosing Wisely®, an initiative of the American Board of Internal Medicine Foundation that has persuaded many specialty societies to identify tests and procedures they consider unnecessary or overused. The problem is that many of the guidelines "subject practitioners to a low but significant risk for missing serious diseases" if they were followed to the letter, Dr Sullivan says.

What can you do about this risk? Just be aware that guidelines are not an ironclad shield against malpractice charges. Even Choosing Wisely provides a disclaimer[7] at the end each guideline: "Use of this report is at your own risk." Even so, Dr Sullivan says the media "often present guidelines as an imperative—doctors shouldn't be doing these things," even though that's not what the guidelines say.

And if you do have a malpractice charges filed against you, Dr McMenamin advises against citing Choosing Wisely as a reason for not ordering a test. "Confronted with an injured, sympathetic plaintiff, juries probably wouldn't be impressed with the argument that most patients wouldn't need the test," he said. "Juries are not interested in population health."

## New Organizational Structures May Create Risk

**3. ACOs May Heighten Your Exposure**

Accountable care organizations (ACOs) represent a new frontier in malpractice law. "They haven't been around long enough to have generated legal decisions yet," says Christopher E. DiGiacinto, a medical liability defense attorney and partner at Kaufman Borgeest & Ryan in Valhalla, New York.

Among the possible malpractice threats from ACOs, attorneys cite higher expectations of caregivers; more information available for plaintiffs' attorneys to use; ACOs' mission to produce savings; and lack of protections enjoyed by other entities, such as HMOs.

It will take a while for lawyers to know whether these risks are serious, according to Julian "Bo" Bobbitt, Jr, senior partner and head of the Health Law Group at the Smith Anderson law firm in Raleigh, North Carolina. He predicted that the first malpractice cases involving ACOs could be filed within the next 12 months, but then it would then take another 2 years or so for the cases to wend their way through the courts, go through appeals, and establish new precedents.

Keeping in mind that malpractice law on ACOs is still at an embryonic stage, here are some possible dangers that could

emerge:

**Higher expectations of care.** In ACOs, doctors must draw up individualized care plans for patients that are more comprehensive than what doctors usually commit to the patient record, DiGiacinto says. Bobbitt adds that physicians must adhere to higher standards for patient communication. Federal regulations mandate a "defined process" to meet this requirement, and that clinical knowledge must be communicated in a way that takes the patient's unique needs, preferences, and priorities into account, he says.

**More evidence for plaintiffs' attorneys.** This includes individualized care plans; patient assessments; and ACO application materials, procedures, and protocols, DiGiacinto says. Also, federal regulations direct that an ACO must "report internally on quality and cost metrics," he says.

**Focus on savings could backfire.** Plaintiffs' attorneys could cite ACOs' mandate to produce shared savings to show that they are cutting corners with patient care. Bobbitt believes this issue is "a red herring." ACOs have taken many steps to ensure that cost-consciousness does not impair quality. "The doctor doesn't get a penny until patient satisfaction and quality goals have been met," Bobbitt says. However, he's concerned that the cost-cutting argument might sway some juries.

**ACOs might be more easily sued.** In addition to lawsuits against individual physicians working in ACOs, lawsuits could be filed against the ACOs themselves, DiGiacinto says. HMOs enjoy legal protections against lawsuits alleging that they skimped on care to save money, but these protections don't apply to ACOs. " HMOs don't get involved in the provision of care, but ACOs do," he says.

What can you do about all of these possible risks? Keep in mind that none of these concerns have materialized yet, and perhaps they never will. Indeed, Bobbitt believes ACOs will generally lower doctors' malpractice risks, in part because they'll be required to adhere to evidence-based guidelines that are designed to improve quality.

## Team Care Could Pose a Threat

#### 4. Growing Use of Team Care May Open New Risks

ACOs, patient-centered medical homes, and hospital systems are increasingly using teams of healthcare professionals to provide care to a patient, and this raises a few possible liability dangers.

One danger is that sometimes it may seem as though no one is in charge. "The old model of a single doctor participating heavily at each step of treatment is giving way to expanded-care teams," says Kevin Bingham, a casualty actuary at Deloitte Consulting based in Hartford, Connecticut. "The doctor/patient relationship has been diluted. No one doctor is answerable."

Even when a doctor is not involved in an error, membership on the team may create a liability, says DiGiacinto, the New York defense attorney. A plaintiff's attorney could use the legal concept of vicarious liability to hold that physician liable. " The notion is you're only as good as your weakest link. If another physician is not good at documenting the case, then you may be liable," he says.

Furthermore, team members sometimes pass off responsibility because they have conflicting views on what care is needed. A 2014 study[8] on team care found that "with complex patients treated by different physicians, it sometimes happens that a physician does not feel the responsibility to act because he has a different view of the treatment than the physician in charge."

One area of concern is poor handoffs, says Thomas R. McLean, MD, an attorney who is CEO of American Medical Litigation Support Services in Shawnee, Kansas. McLean says that when members of a team are defendants in a malpractice case, the can be a lot of "finger-pointing" about what was said and what was not said.

Also, patients who are confronted by many different people taking care of them may not have a bond with anyone. "There is a danger of losing the personal connection, which is how most med-mal claims start," Bingham says.

How big of a risk are these new concerns? Bingham thinks many teams have already addressed such concerns as poor

communication. This involves taking a few simple precautions, such as designating nurses or other professionals to be the go-to person for the patient. Reaching out to patients after appointments and hospitalizations, this person can avert mistakes that arise when communication among team members breaks down.

A 2012 article[9] published in *JAMA* shows how to deal with the legal challenges of team care. Above all, teams should develop clear lines of accountability for patient care. "Team members should have clear roles, mutual trust, effective communication and shared goals," the article states.

**5. Smartphones Distract Doctors**

The rise of smartphones in the past decade has created a new malpractice risk—the distracted doctor. When doctors and other medical staff are on their smartphones, "they are no longer in the room," says Peter J. Papadakos, MD, an anesthesiologist at the University of Rochester Medical Center, who has been pioneering safer use of the devices.

Dr Papadakos says anesthesiologists in particular are prey to smartphone use. "They sit in the operating room and there's not much going on, so they start to look at their smartphone," he says. An anesthesiologist was named in 2014 malpractice case involving a patient death during heart surgery in 2011. According to depositions[10] in the case obtained by a Dallas newspaper, the surgeon in the case accused the anesthesiologist of looking at a cellphone or tablet and failing to notice the patient's low blood-oxygen levels for 15-20 minutes. The outcome of the case has not been reported.

A 2012 study[11] demonstrated the dangers of smartphone disruptions for surgeons. Residents were asked to perform simulated surgery and were then interrupted by a cellphone call or someone asking about complications with a previous patient. When they returned to the simulated surgery, more than 4 out of 10 made serious errors.

Smartphone distractions also affect primary care physicians. "A patient might be telling you something about their health, and your smartphone goes off, Dr Papadakos says. John Halamka, MD, a Massachusetts healthcare IT guru, reported a case[12] involving a resident who failed to complete an order to stop a heart drug for a patient because she was distracted by a text message inviting her to a party. The patient underwent open-heart surgery owing to the mistake, but survived.

In 2012, the ECRI Institute listed[13] cell phone distraction as one of the top 10 technology risks to patient safety. But a 2011 study[14] showed that medical staff tend to downplay the problem. A survey of perfusionists found that although almost all of them said they'd never been distracted while using cell phones at work, one third said they have seen colleagues distracted by them.

Despite the dangers, Dr Papadakossays there are still very few regulations on use of smartphones, and many hospitals don't have policies on them. "All this technology came down so fast that we weren't able to figure out what the rules should be," he says. The iPhone®, which greatly expanded the uses of cell phones, was introduced just 8 years ago.

What can you do to mitigate the dangers of smartphones? Dr Papadakos provides several recommendations:

**Establish a policy.** The policy adopted by the University of Rochester Medical Center in 2012 requires staff to silence their cell phones when working with patients and forbids using phones for personal matters at work.

**Provide dedicated devices for work use.** Dedicated devices with limited access mean that patients can still use the technology, but only for work.

**Identify and help addicted users.** Dr Papadakos thinks there is such a thing as smartphone addiction. He says a simple test can identify it, and high-scorers can get confidential help.

**Tell the patient what you're doing.** When you're using a smartphone or tablet in front of patients, make sure to inform them about what you're doing. "They might think you're booking an airline ticket," Dr Papadakos says. Suspicions that you're not interested in them can destroy the bond of trust and motivate lawsuits.

## Social Media Rears Its Head

**6. The Perils of Social Media**

Doctors are by no means removed from social media. In a 2014 Australian study,[15] three quarters of doctors said they had used social media privately and almost 20% had received a friend request from a patient.

But keep in mind that anything you say on Facebook or other social media can be used against you in a malpractice proceeding. "Even if your behavior has nothing to do with the lawsuit, it can affect the outcome," says DiGiacinto, the New York defense attorney. All the plaintiffs' attorneys wants to do is put you in bad light, and constant Facebook postings give them plenty of opportunities.

For example, in the malpractice case of the Dallas anesthesiologist who used his smartphone during surgery, plaintiff's attorneys found postings on his Facebook page that painted a picture of an unsympathetic and sloppy caregiver. "After enduring the sh--tiest Friday I've had in a while," he wrote, "I just found out my next patient has lice. Freakin live." And in another posting showing his patient monitor with data on it, he wrote: "Just sittin here watching the tube on Christmas morning. Ho ho ho."

Another risk of social media, DiGiacinto says, is opening a feud with others on sites for all to see. The acrimonious back-and-forth "can be used by a plaintiff's attorney seeking to establish your character," he says. "You're giving the plaintiff ammunition. You are someone who loses his temper and is seen cursing and using bad words."

What can you do to avoid these risks? If you still want to use social media, keep a couple of things in mind. " Don't post photos that can get you into trouble, and limit access to your Facebook page to just your family and very close friends," DiGiacinto says. Guidelines[16] on online medical professionalism issued by the American College of Physicians and the Federation of State Medical Boards in April 2013 contain similar advice: "Physicians should keep their professional and personal personas separate."

**7. EHRs Bring Added Safety, but Also New Dangers**

EHRs introduce a medical malpractice paradox: They reduce liability by providing more clinical information, but this new wealth of clinical information also increases risk.

"EHRs could be a Pandora's box of malpractice dangers that create more problems than they address," says Sharona Hoffman, a law professor at Case Western Reserve University who has written[17] on EHR liability. Because EHRs didn't take off until 2011, when the meaningful use program started, much of the malpractice law in this area still has to be worked out, she says.

Problems with EHRs have already been cropping up in many malpractice cases. Last year, CRICO, the medical malpractice insurer for the Harvard medical community, reported[18] 147 malpractice cases involving EHRs over a 5-year period, representing $61 million in direct payments and legal expenses. The problems included computer systems that weren't interoperable, test results not routed properly, and faulty data entry and use of copying and pasting functions.

EHRs can be confusing. "When there are lots of boxes to check, it's easy to check them off incorrectly," Hoffman says. "All the alerts and reminders can be distracting, and copying and pasting might introduce mistakes into the record if the text is not carefully edited."

DiGiacinto, the malpractice attorney, says EHRs' access to huge amounts of data, which could do so much to reduce errors, can be a distinct disadvantage in a malpractice case. "Doctors are expected to know more about what is going on with the patient," he says. " If information from other caregivers on the team is just a few clicks away, there is a greater assumption that you should have known about it."

This concern that benefits could be canceled out by liabilities was shared by authors of a 2010 study[19] published in the *New England Journal of Medicine* reviewing the malpractice liabilities of EHRs. " It is unclear whether use of EHRs will increase or decrease overall malpractice liability," they stated.

The time-saving capabilities of EHRs also get doctors into trouble. DiGiacinto says doctors create a lot of errors when they copy information from one file and paste it into another. If physicians don't edit the pasted information, it may include old test results that mislead caregivers and cause errors that could be the basis for malpractice suits, he says.

EHRs also provide plaintiffs' attorneys with a treasure trove of new evidence for their malpractice cases. Unlike a paper trail, everything is recorded in the metadata, showing time stamps and even individual keystrokes. "The metadata can show that the physician went back in to the medical record and tried to clean it up," DiGiacinto says. "Covering up what you did is worse than the initial error."

EHR systems themselves can introduce errors that could harm patients, but vendors often indemnify themselves against malpractice lawsuits in their contracts with users. Hoffman adds that some vendors even make users sign gag provisions barring them from revealing problems with the system.

What can doctors do to prevent EHR risks? Always edit material that you copy and paste. Be sure to thoroughly check the system for information that you might have missed. And don't sign any gag provisions with vendors.

## Telemedicine Brings Mixed Blessings

**8. Telemedicine Lawsuits Are Expected**

Telemedicine is another area of healthcare that is so new that there aren't many legal precedents yet. And like many other areas, it presents a trade-off between new benefits and new risks, according to Kevin Bingham, the casualty actuary at Deloitte Consulting.

"Even though telemedicine could improve the quality of care—for example, by putting renowned specialists at your fingertips—it can also reduce the personal connection between doctor and patient, which may increase the likelihood of being sued," he says.

"When the doctor isn't able to touch and feel the patient, it's going to be a little harder to defend the case than if the patient was seen in the exam room," says Jeffrey Segal, MD, a lawyer who is CEO of Medical Justice Services in Greensboro, North Carolina. "The more information the doctor has, the better."

Telemedicine is now common in radiology and has expanded into other specialties, such as primary care and psychiatry. "The remote radiologist who reads the scan is generally not the one who is sued," Dr Segal says. "Rather, the doctors who ordered the scan are sued—often because they failed to act on the results in a timely manner."

Telemedicine also involves doctors remotely monitoring medical devices being operated by technicians on site, which can implicate the doctor on the basis of vicarious liability. In a malpractice case[20] reported by a Boston law firm, a technician overseeing intraoperative neurophysiologic monitoring during spinal surgery was supposed to be supervised remotely during surgery by a neurologist via real-time transmission of the waveforms. However, the technician failed to transmit any data in real time to the neurologist, meaning that the technician lacked required supervision. The case was settled for an undisclosed amount.

What can you do to avoid this risk? Keep in mind that you are going to have to make up for the lack of face-to-face contact in a digital relationship. You will have to double-check what you thought you heard from the patient. Also, the rules of supervising technicians also apply to remote relationships.

Before getting involved in telemedicine, take a course in conducting a telemedicine session and make sure you have malpractice coverage for it. In some cases, you'll need to buy extra coverage in an "endorsement" policy, but a lot of policies now cover it, according to Steve Fargis, senior vice president of Professional Risk Associates, an insurance broker for doctors in Midlothian, Virginia.

**9. Employed Physicians Are Less Capable of Defending Themselves**

Hospital employment of physicians is now common. One in five physicians are hospital employees, and numbers of hospital-employed primary care physicians doubled from 10% in 2012 to 20% two years later, according to a survey[21] by Jackson Healthcare.

This trend has created a new problem for significant numbers of physicians. Employed physicians have less control over their defense in a malpractice case than an independent physician would have.

Steve Fargis, the Virginia insurance broker, says that hospital-employers prefer to have tight control over their employed physicians' med-mal insurance policies. He says hospitals usually buy policies for their employed physicians, and these policies don't tend to have a "consent to settle" agreement, which specifies that the physicians must authorize any settlement made on their behalf. These clauses are standard in individual physicians' policies. (Some states regulate the use of "consent to settle" agreements: Maryland and Florida ban them, whereas California requires them in all doctors' malpractice policies.)

Often, the hospital and doctor are both named in the same lawsuit, but the hospital has different goals, Fargis says. Hospitals are more likely to want to settle, because taking a case to court means more legal fees and possibly a higher payout than a settlement would require. Physicians, on the other hand, have strong reasons to pursue a case into the courts if they think they have a change of winning. That's because even settlements go onto their permanent record and are reported to the National Practitioner Data Bank (NPDB).

Employed physicians have one other disadvantage: Hospital systems often run their own captive malpractice insurance carriers, which means they can also choose the attorneys who represent the employed doctor. Fargis says the hospital tends to assign the same attorney for both the doctor and hospital. Hospitals usually frown on doctors having separate attorneys, because "the hospital's concern is that the doctor might want to mitigate his fault and assign blame to the hospital," he says.

Hospitals' tactics of forcing physicians to settle and denying them a separate attorney come up in physician surveys on malpractice litigation. In a 2013 Medscape survey,[22] 9% of physicians with malpractice payouts said they were required to settle. In addition, 7% said they were "disappointed by how the attorney handled me and my case," and 1% said the attorney had ruined the case.

What can physicians do about this risk? Before agreeing to hospital employment, understand that you are giving up some control in this area. If you still want to go ahead, there may be some ways to maintain some control. For example, Fargis says employed physicians may be able to buy their own malpractice insurance separate from the hospital. "Hospitals don't want to pay the physician the value of the malpractice and let them go out and buy it on their own," he says. "But we have worked on securing coverage that costs less in the commercial market than what the hospital captive would charge."

## Watch Out for State Boards

**10. Complaints to State Boards Are as Perilous as Lawsuits**

Even though the chances of physicians being sued for malpractice are considerably lower than they were a decade ago, another liability concern is eclipsing malpractice litigation—patient complaints to the state medical board. These complaints can prompt disciplinary actions against physicians that are just as hazardous as malpractice suits.

Dr Sullivan, the Illinois attorney, says malpractice cases and disciplinary actions are closely related. A disciplinary action doesn't have to involve an injury and there is no payout if the physician is censured, but like a malpractice suit, it can involve negligence or wrongdoing, and it is just as harmful to a doctor's reputation.

Both licensure actions and malpractice payouts must be reported to the NPDB. Trawling through the rich information of the federal data bank, Dr Sullivan found that the number of state licensure actions reported to the federal board in 2013 was almost four times greater than the number of malpractice payouts, including both judgments and settlements. Moreover, although the number of malpractice payouts fell by 57% from 2001 to 2013, the number of state licensure actions more than doubled.

What's causing this huge increase in disciplinary actions? Part of the rise, Dr Sullivan says, may be due to heightened vigilance by medical boards for specific misconduct, such as inappropriate prescriptions of painkillers. But many complaints come from patients who are unhappy with a doctor's care. It is thought that as patients seek more empowerment, they are becoming more aware of the option of filing a complaint with the medical board.

In fact, it's easier to file a complaint than to file a malpractice lawsuit, Dr Sullivan says. Registering a complaint involves filling out a report and sending it in, but filing a lawsuit means convincing an attorney that you have a promising lawsuit and gathering the evidence.

In many cases, Dr Sullivan suspects, patients first consulted plaintiffs' attorneys and filed a complaint only after failing to get them interested. For example, in a recent case he handled, several law firms requested a patient's medical record but none of them filed a lawsuit, and then a complaint was filed with the state medical board.

If the board does take disciplinary action against the doctor, however, it may be too late for the patient to go back and file a malpractice suit, Dr Sullivan says. The board's disciplinary process takes a great deal of time, often surpassing the statute limitations on a malpractice suit.

Some states allow complaints to be anonymous. A cursory review of state medical board websites shows that California, Maryland, and Georgia allow anonymous complaints but discourage this option, saying that it's harder for board investigators to collect information for a case. On the other hand, North Dakota, Alabama, and Texas prohibit anonymous complaints.

As in a malpractice proceeding, the board investigation involves determining whether physicians met the standard of care in their specialty and their community, and boards consult with physicians in the same way that courts use expert witnesses.

Doctors who face disciplinary actions should take them just as seriously as malpractice suits, Dr Sullivan says. In fact, in some ways, physicians are at a greater disadvantage in a disciplinary hearing, he says. "A lot of the board actions are based on allegations of impropriety that might not meet the threshold of malpractice," he says. Also, it's not necessary to show evidence of harm.

What can you do to safeguard against formal complaints? Above all, take them as seriously as a malpractice lawsuit. Do not disregard notices from the medical board. Also, make sure your malpractice policy covers your defense in a disciplinary action; many policies will do so.

One other piece advice from Ofer Zur, PhD, a forensic consultant in Sebastopol, California: Don't contact the patient who filed the case. "Any contact with the client after you get notified that he/she has filed a complaint can be easily viewed as an attempt to intimidate or harass the client," he writes[23] on his website.

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