PHYSICIAN Risk Management

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Reported to the data bank? There's a lot you can do to mitigate damage

Make your side of the story clear

Once a report is filed with the National Practitioner Data Bank (NPDB), it is "virtually impossible to get rid of it, absent a provable error," says **Robert S. Iwrey**, JD, a founding shareholder with The Health Law Partners in Southfield, MI.

On the other hand, says **Cynthia Grubbs**, RN, JD, director of the Department of Health and Human Services' Division of Practitioner Data Banks, a NPDB report "isn't really the black mark that physicians make it out to be. It doesn't mean the physician won't ever get hired again. All it does is confirm what a practitioner would need to put on their application anyway." *(For more information about the content of NPDB reports, who reports to the NPDB, and who can access the reports, go to http://www.npdb-hipdb.hrsa.gov and select "About Us.")*

Medical malpractice payments aren't necessarily an indication that malpractice actually occurred.

If physicians apply or reapply for privileges, renew their license, or apply for a license in a new state, they'd be asked whether they have any open claims or have made any payments, says **Sharon C. Peters**, JD, an attorney with Williams Kastner in Portland, OR. The NPDB is "essentially a flagging system" to provide an additional layer of background checking for healthcare entities or hospitals when bringing on a new doctor, she says.

A plaintiff's attorney can access the NPDB only if there is evidence that a hospital failed to conduct a query that it should have as part of its credentialing process, adds Peters. "The attorney may be very interested to know if the doctor they are suing has been reported, but they cannot get that information," she says. "It all falls under the umbrella of confidential peer review."

Elise Dunitz Brennan, JD, a partner with Conner & Winters in Tulsa, OK, recommends that physicians query the NPDB on themselves. "See if there is anything in there you don't know about," she says. "The physician would have gotten notified and given an opportunity to dispute it, but may not have paid much attention to it if they were tangentially involved."

A physician's ability to practice isn't generally affected by a NPDB report involving

INSIDE

Enclosed:

Physician Legal Review & Commentary: Neonatal necrotizing enterocolitis; failure to diagnose fracture of cervical spine

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a medical malpractice payment, says **Harriett T. Smalls**, JD, an attorney with Smith Moore Leatherwood in Greensboro, NC.

It might be all business

Medical malpractice payments aren't necessarily an indication that malpractice actually occurred, and settlements often are made for business reasons, notes Grubbs. "We understand that at the data bank. We are not here to be the bad guy," she says. "We try to get the message out that just because you have a payment or even a couple, it doesn't make you a bad practitioner."

Most employers take into account that physicians in high-risk practices are more likely to be sued, adds Smalls, and they usually aren't overly concerned unless the care that led to the suit was egregious or there was a pattern of neglect.

Physicians should be far more concerned if an NPDB report involves denial or restriction of privileges, according to Grubbs. "Those are the actions that cause physicians the most concern. There really aren't many of those taken per year," she says. "Hospitals do take those very seriously when hiring or privileging."

Executive Summary

A National Practitioner Data Bank report on a medical malpractice payment doesn't necessarily affect a physician's ability to practice, while reports involving denial or restriction of privileges are taken more seriously by state licensing boards and employers. Take these steps:

- ✦ Add a statement to clarify your involvement.
- ✦ Negotiate the wording of the report.
- ✦ Don't withdraw applications for privileges during an investigation.
- ✦ If dismissed, be sure your name or identifying information isn't included in the judgment or settlement agreement.

Results can be severe

These reports can result in denial of credentialing, loss or limitation of privileges, exclusion from participation in health plans, loss or limitation of license, and increases in professional liability insurance premiums or even exclusion from coverage, says Smalls.

Physicians can add their own statement to the NPDB report, which goes out to anyone who queried the NPDB in the previous three years and every report sent out afterward, says Grubbs. Out of more than 800,000 total reports for all practitioner types captured in the system, only 44,273 included statements.

"If a report is filed, it's very important to take the time to thoroughly put in your response on the matter," advises Brennan. "Sometimes, physicians just let that go." Here are particularly important items to convey:

• Explain that multiple reports involved a single incident.

"Sometimes there is a 'piling on'

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effect," says Brennan. For example, if an adverse action at a hospital results in a physician's clinical privileges being terminated, this might then result in the state board of licensure restricting the physician's license. If the physician applies for privileges in another state, this might be denied because the multiple reports appear to involve separate incidents.

"In that scenario, you definitely need to get your statement out in front of future queriers," says Brennan. Explain that both NPDB reports involved the same incident and that the state board didn't have any independent knowledge of anything that was wrong, she recommends.

• Clarify your involvement.

If a malpractice settlement names multiple practitioners as defendants, each will be reported to the NPDB, even if not all were involved in the incident, says Brennan. In this case, a physician should include a statement such as "I was named in the lawsuit, but I was not the primary surgeon in this matter," or "I was not involved in the incident that led to the lawsuit," she advises.

"If a report is ÿled, it's very important to take the time to thoroughly put in your response on the matter."

"A third party looking at this file will realize the physician just got caught up in the whole process, but it wasn't his or her actions that caused the filing of the report," says Brennan. *(See related stories on preventing an NPDB report, below, and negotiating the wording of the report, p. 4.)*

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Actions might prevent needless data bank report

It might be advisable for you to retain an attorney

A physician dismissed from a lawsuit probably assumes he or she won't be reported to the National Practitioner Data Bank (NPDB), but this assumption isn't necessarily the case.

In some states, if a judgment is issued or the case later settles and the physician's name or information sufficient to identify the physician is contained in the release or judgment, the physician still will be reported to the NPDB, warns **Harriett T. Smalls**, JD, an attorney with Smith Moore Leatherwood in Greensboro, NC. "Be sure your name or identifying information is not included in the subsequent judgment or settlement agreement," Smalls advises.

Similarly, if a physician agrees to make a payment on the condition that his or her name not appear in the settlement, he or she might not realize that this payment is still reportable, she says. "If money is paid on behalf of a physician in response to a written demand, whether by a hospital, a professional corporation, or other business entity in which the physician is the sole practitioner, it must be reported even if it does not progress to an actual filed lawsuit," Smalls says.

Here are some other ways to potentially avoid NPDB reports:

• Retain an attorney to ensure that procedural aspects of the medical staff bylaws are complied with, such as the right to a fair hearing.

To avoid being reported to the NPDB, physicians must prevent any adverse actions that would be in effect for more than 30 days and fight any attempts to place restrictions or sanctions on their license by the hospital or professional societies, says Smalls.

Sharon C. Peters, JD, an attorney with Williams Kastner in Portland, OR, says that once the physician is under investigation, "an attorney may be advisable, particularly in situations that may lead to a contested disciplinary action."

• Consider using personal funds to make medical malpractice payments.

If a medical malpractice payment is paid by an insurer or any entity other than the individual physician, this information is reported to the NPDB regardless of the amount, notes **Robert S. Iwrey**, JD, a founding shareholder with The Health Law Partners in Southfield, MI. However, if the individual physician makes a medical malpractice claim out of personal funds, the payment is not reportable.

• Don't withdraw applications for privileges during an investigation.

If physicians are considered to be "under investigation" by the hospital as defined by medical bylaws, and they withdraw an application for privileges during the investigation, that information is a reportable event, says **Elise Dunitz Brennan**, JD, a partner with Conner & Winters in Tulsa, OK.

"When it comes to a doctor's attention that they might not be able to get privileges at a facility, they need to find out whether they can remove themselves from the situation without being considered as 'under investigation,'" she says. "If you know that is coming up but haven't gotten to that point yet, withdrawing to try to prevent a report is probably a good idea."

Once the investigation concludes, physicians always can resign if they choose, without being reported, if the findings are in their favor, says Peters. "Physicians really need to allow the peer review process to work and cooperate wholeheartedly, even if they believe the investigation has no merit whatsoever," she says.

• Attempt to rectify the matter with the reporting entity by requesting that the report be corrected or vacated due to error.

If the reporting entity is unwilling to do so, the physician may initiate a dispute of the report with the NPDB, which then becomes a part of the report, says Iwrey.

If the reporting entity declines to change the report, the physician may request a review of the matter by the secretary of the Department of Health and Human Services (HHS), but only for the accuracy of the factual information contained within the report and to ensure that the information in the report was required to be reported, says Iwrey. "There is no review available questioning the merits of a medical malpractice payment, or of the basis for a professional review or state licensing action," he says.

The only other recourse is to file for judicial review in a federal court, according to Iwrey. "At the review, the physician must establish that the secretary's decision was 'arbitrary and capricious' Ð a virtually impossible barrier to overcome," he says. ✦

Reports can do damage if 'severely worded'

You should provide input early on in the process

How much will a National Practitioner Data Bank (NPDB) report adversely affect a physician? That depends in large part on the underlying events and the wording of the report, according to **Robert S. Iwrey**, JD, a founding shareholder with The Health Law Partners in Southfield, MI.

Because state licensing boards routinely query the NPDB, Iwrey says that a severely worded report can trigger a licensing action against the physician's license to practice medicine. Physicians requesting staff privileges at hospitals or ambulatory surgery centers typically have to provide additional information regarding matters reported to the NPDB, he adds.

"If the report's wording is severe, no explanation or additional information may be enough," Iwrey says. "Severely worded reports can be the 'death knell' to a physician whose specialty requires him or her to have staff privileges at a hospital."

If a NPDB report cannot be avoided, physicians should attempt to have as much input into the process of wording the report as they possibly can, says Iwrey. It's also important to give input on the adverse action classification codes used, which are used to identify the action when submitting a report, such as probation, he says. Also, include the basis for action codes, which indicate the reason the action was taken, such as failure to comply with health and safety requirements, he advises.

"Physicians are well-advised to gain input into the process of selecting these codes, in order to mitigate the adverse impact of a report," Iwrey says.

Obtain an attorney fast'

Physicians should retain an attorney as soon as they are notified of an investigation by a healthcare facility or state licensing board, advises **Elise Dunitz Brennan**, JD, a partner with Conner & Winters in Tulsa, OK. Hospitals expect physicians to have medical malpractice actions and weigh the importance of these, she explains, "but if you're in there for a licensing or hospital action, that is pretty hard to explain."

Lawyers might be able to negotiate the wording of the report to allow the doctor to avoid future problems with obtaining privileges, such as the hospital putting in a statement that they didn't look at a radiologist's behavior if the report involves a surgical error that resulted from a misread X-ray, says Brennan.

Similarly, the hospital leaders might agree to say they made a decision without obtaining external medical experts, or that the medical expert focused solely on one issue and there was an extenuating factor that never was decided.

"If it's something that is factually correct, the hospital might agree to it. That could allow the doctor to say, 'This wasn't looked at,' down the road," says Brennan. ✦

Plaintiff can use EMR charting against you

'Unreasonable claims' from malpractice attorneys might be the result

Few physicians realize that using an electronic medical record (EMR) exposes them to an "Orwellian level of analysis," according to **Sam Bierstock**, MD, founder of Champions in Healthcare, a consulting company in Delray Beach, FL specializing in advising hospitals, physicians, and technology companies on implementing EMRs and healthcare information technology.

Audits of EMR logs can reveal how long it took a physician to act after an abnormal lab result came in, whether the physician checked an online reference before making a clinical decision, and even whether the physician scrolled down to read an entire document, he notes.

Attorneys might claim a doctor took too long to respond to a lab test result or phone call, failed to check an online reference, or didn't keep a screen displayed long enough. "In the case of litigation, over-aggressive audit capabilities may generate unreasonable claims from malpractice attorneys," warns Bierstock.

Anything in the record

If the plaintiff's attorney requests electronically stored information (ESI), Bierstock says this information covers any data that can be stored or read in a digital format.

ESI includes email, word processing files, web pages, documents scanned and stored in various formats, audio files, X-rays, and photographs Ð "in short, just about anything in the record," says Bierstock.

Physicians should keep in mind that everything entered into the EMR may be time-stamped, which tells a plaintiff's attorney when data was viewed and when an entry was made in response, he says. "Page views can be timed and documented, as well as scrolling and length of time displayed," says Bierstock. "Basically, every click and view generates a logged action."

Everything is chronicled

Michele Luckie, a senior risk management specialist at Texas Medical Liability Trust in Austin, says, "No matter what EMR software is being used, every entry will include a hidden audit trail that can be accessed."

> *"Page views can be timed and documented, as well as scrolling and length of time displayed."*

For example, says Luckie, EMR records can reveal what drugs were researched via an online reference, and whether radiographic images, imported documents, or emails regarding patient phone calls were reviewed.

"It is safe to assume that anything done in the EMR is being chronicled," says Luckie. To reduce legal risks involving EMRs, she says to use these practices:

• Develop EMR policies and procedures.

Luckie advises policies and procedures that include taking security measures, creating and storing a backup tape, tracking of pending labs and diagnostics, locking encounter notes, and entering an addendum in the medical record. *(See related story on late entries to EMRs, p. 6.)*

• Become as knowledgeable as possible about the software.

"It's in the physician's best interest to know if the EMR they are using has a component to track diagnostic test results," says Luckie. "If so, it should be utilized as intended."

Physicians should know how their encounter note information is categorized in its final format, adds Luckie. "In reviewing records, sometimes you see 'current complaint' information under the 'health history' heading. This can make the note appear unorganized," she says.

• Print out an entire medical record from time to time.

"Make sure it includes everything, from telephone communications to consult letters," says Luckie. "Some EMRs offer several different print options, and they don't all provide the same content."

Executive Summary

If a physician documents in an electronic medical record (EMR), a plaintiff attorney's audit might reveal deleted entries and the time data was entered and viewed. To reduce legal risks:

- ✦ Make addendums to the original note when making late entries.
- ✦ Remember that every page view and entry may be time-stamped.
- ✦ Be aware of how charting appears in its final format.

SOURCES

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Warning: Late entries on EMR leave legal trail

Defense can be problematic in defending a lawsuit

Days after seeing a patient for a checkup, a physician remembers a piece of information that should have been charted and adds it to the electronic medical record (EMR).

If a lawsuit is filed later, the plaintiff's attorney would be able to find out exactly what time the late entry was added to the patient's record, says **Michele Luckie**, senior risk management specialist at Texas Medical Liability Trust in Austin.

"A review of the audit trail Ð the 'metadata' Ð would show the late entry," she says. "An addendum to the original note is the appropriate way to add the additional information."

Most EMRs are designed to clearly designate any change to a record that has been closed, usually by the documenting clinician hitting the equivalent of an "enter" button, says **Sam Bierstock**, MD, founder of Champions in Healthcare, a consulting company in Delray Beach, FL. "Manipulation of a health record that has been closed Ð accepted by the clinicians doing the documentation Ð is clearly not an acceptable practice," he says.

If late entries to EMRs are not done properly, these are viewed as alterations to the medical record and can prove problematic in defending a lawsuit, warns Luckie. Late entries in an EMR might be discovered by 'data mining,' a technique that examines embedded information in the EMR's metadata, she explains.

"This process can reveal deleted entries, as well as when they were deleted and by which user," Luckie says. "Auditing an EMR and the metadata within it will provide an accounting of how a physician practices medicine." ✦

You may be wrong on which patients will sue

Research indicates that income not as important as respect

Although some physicians won't treat Medicaid or uninsured patients because of a perception that low-income patients are more likely to sue, new research shows the opposite is true.[1] Researchers reviewed studies on differences in litigation rates and found that socioeconomically disadvantaged patients were less likely to sue.

The results came as no surprise to orthopedic surgeons who treat patients who happen to be socioeconomically marginalized, according to **Ramon L. Jimenez**, MD, a senior orthopedic consultant at the Monterey (CA) Peninsula Orthopaedic and Sports Medicine Institute and past chair of the American Academy of Orthopaedic Surgeons' Diversity Advisory Board.

"We knew there was a prevalent myth that poor patients sue more," says Jimenez. "This is promoted by surgeons with an unconscious bias toward treating poor patients who may not be able to pay for services."

There is no solid evidence that a certain type of patient is more likely to sue, according to Jimenez, but patients who are dissatisfied with the services of their physician are more likely to do so. "It has been shown that physicians who practice good physician-patient communication skills experience less likelihood of being sued," he says.[2,3]

Physicians who don't treat Medicaid patients typically cite low reimbursement as the reason, says **Frank M. McClellan**, co-director of Temple University's Center for Health Law Policy and Practice in Philadelphia. "It was surprising to find evidence that when asked directly about concern for being sued, many physicians believed that poor people were more likely to sue them than people who were financially better off," says McClellan.

It also was surprising to discover studies revealing that a significant number of people on Medicaid who filed medical malpractice suits became eligible for Medicaid recently, he adds. "This was due to a radical change in their financial condition due to the medical accident that gave rise to the lawsuit against a healthcare provider," says McClellan.

Respect deters suits

Disrespect, poor communication, and a desire to get the truth about what caused an injury or death are major contributing factors motivating individuals to sue doctors and hospitals, according to McClellan.

While some physicians envision lawyers as eager to file a medical mal-

Executive Summary

Physicians might assume low-income patients are more likely to sue, but studies show the opposite is true. To reduce risks:

✦ Be aware that unconscious bias can lead to distrust.
✦ Realize that lawyers are unlikely to take contingency cases without credible expert testimony.
✦ Obtain training to increase cultural competency.

practice suit to obtain a large fee, contingency cases mean an attorney only gets paid if the case is won in court or settles, he notes.

Slip and fall cases and automobile accidents are usually not expensive to litigate, but medical malpractice cases are costly, risky, and hard fought because of the stakes to providers and patients, adds McClellan. Consequently, lawyers are reluctant to invest time and resources in medical malpractices cases on a contingent fee basis, without evidence based on credible expert testimony that there is a reasonable basis of winning the case if it goes to trial, says McClellan.

"Studies show that providers and insurers rarely pay substantial sums to settle frivolous medical malpractice cases," he adds.

If a physician harbors misconceptions about low-income or Medicaid patients being more likely to sue them, these misconceptions might result in disrespectful treatment and feelings of distrust, says McClellan.

"Improve relationships through training to increase cultural competency and communication skills," he advises. "The best deterrent to a lawsuit is to practice good medicine and respect patients." *(For more information on training programs, see resource box, below.)*

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RESOURCES/SOURCES

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- **Coaching physicians on communications skills** with one-on-one observation is available from the Center for Healthcare Communication. The cost for the three-phase process (extensive assessment, one full day of observation, and follow-up) is $2,500, with discounts for multi-physician projects. For more information, contact the center at: P.O. Box 18819, Cleveland, OH 44118. Phone: (800) 677-3256 or (440) 338-3056. Fax: (440) 338-3076. Email: info@CommunicatingWithPatients.com. Web: www.CommunicatingWithPatients.com.
- The American Academy of Orthopaedic Surgeons offers a four-hour interactive workshop, the **Communication Skills Mentoring Program**, in which physician-patient communication skills are learned and practiced. For more information, send an email to Rachal@aaos.org. To contact a mentor in your area, go to www.aaos.org. Select "Physician Education," "Communication Skills," and "Mentor Location Map." ✦

Patients will ask to record instructions

Legal risks may be overblown -- Recording can't be used in a court of law

"Do you mind if I record your instructions so I can remember them?" If a patient pulls out a tape recorder and asks this of her physician, the answer is likely to be "no," according to **Carolyn Oliver**, MD, JD, founder of the Oliver Center for Patient Safety and Quality Healthcare in Galveston, TX.

"Doctors are an incredibly risk-averse group. They are terribly afraid of doing anything that they haven't done before," she says.

The biggest grievance doctors have is that patients are non-compliant, Oliver says. "Yet, there are probably 50 studies that have been done over the last 30 years showing patients don't remember what their doctors tell them," she says. "I encourage doctors to look at the statistics."[1,2,3]

To improve patient compliance, Oliver developed "Your Doctors Advice," a website that allows patients to use any cell phone to easily record themselves repeating the advice given by the physician. "The patient just pulls out his phone and says, 'I'm going to make a note to myself of your advice,'" she says. *(For more information, see resource box, p. 8.)*

The recording doesn't increase legal risks for physicians, in part because it can't be proven in a court of law that it's a complete, accurate representation

Executive Summary

A growing number of patients are recording medical instructions given by physicians by using a cell phone application that records the patient's own voice repeating what the doctor told them.

✦ Statistics consistently show that patients fail to remember instructions given by physicians.

✦ Patients are recording themselves speaking instead of the physician.

✦ The recording couldn't be used in a court of law as it isn't a provably complete and accurate representation of what the doctor said.

of what the doctor said that day to the patient, according to Oliver.

Many oncologists have been allowing patients to tape detailed instructions for years, adds Oliver. "It may take 45 minutes to say it, so doctors want to say it once," she says. "Doctors do not have to be scared of it. They're going to get less callbacks and more satisfied patients."

She notes that physicians were all taught the "teach back" method in medical school. "This is a really good way to ensure you have communicated with the patient," she says. "Audio recordings are the no. 1 best way for patients to remember instructions. And it doesn't take a minute, as a rule."

Oliver compares the current resistance to allowing patients to record instructions, to fear of lawsuits when family members first started to be present in labor and delivery rooms in the 1970s. "Doctors thought, 'the family members will all sue us,' but people started stepping out of the box because it was the right thing to do," and those legal concerns subsided over time, she says.

"The best way not to get sued is to develop a good relationship with your patient," says Oliver. "This is one of the ways to do it." *(See related story on a pilot program involving patients recording instructions, below.)*

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SOURCES/RESOURCE

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- The **Your Doctors Advice** program allows users to register a cell phone number to record and play back advice given to them by a physician. A "record advice" phone number is dialed for the recording, and a "play back advice" phone number is dialed to play back the recording, which can be done from any cell phone. After a six-month free trial, the cost of the program is $15 for one year. For more information, go to www.YourDoctorsAdvice.org. ✦

No added legal risks seen with recordings

When physicians in the departments of hematology, oncology, and family medicine at the University of Texas Medical Branch in Galveston were given the chance to participate in a pilot project involving patients using "YourDoctorsAdvice," a website allowing them to record instructions given by their doctor, it was understood that some might be wary of legal risks.

"We are careful to consider risk with any new program," says **Steve Q. Quach**, MD, chief medical officer of the University of Texas Medical Branch (UTMB) Health System and director of the Oliver Center for Patient Safety and Quality Healthcare, both in Galveston.

Because the tool helps the patient remember and understand the treatment advice of their doctor, Quach says he expects to see increased patient compliance with the plan of care and ultimately, better health outcomes. "Bad outcomes are one of the drivers of liability and risk," he adds. "As such, it stands to reason that this tool could reduce risk as opposed to increasing it."

In previous years, healthcare providers nationally were concerned that disclosure of medical errors to patients would expose them to increased litigation, notes Quach. "However, it appears that studies have not shown that to be the case, and it is a practice that is spreading," he says. "That is an example of another initiate where liability was an initial concern, but studies did not show that to be the case."

Meredith Masel, PhD, MSW, the Oliver center's program manager, says that when physicians express concerns about liability risks, she informs them that the program has been vetted by the institution's compliance and privacy experts. Five providers have participated to date by offering their patients the chance to record instructions with a handheld recorder or "YourDoctorsAdvice."

"Of course, liability is always a concern. But at this point, we do not have objections to our providers participating," says Masel.

Positive feedback

The pilot identified that providers and patients in oncology, the acute care for the elderly unit, and family medicine practitioners all thought the tool was valuable.

"One unexpected result is that family members involved in elder care are particularly interested," says Masel. "I have not received resistance from physicians, except regarding concerns about this taking extra time. There are ways to work around that, so those concerns can be eased." Masel says that to save time, patients can record themselves at the same time the physician is docu-

menting in the medical record, when the physician is reviewing the visit with the patient, or when the patient is asked to repeat instructions back to the physician as part of the "teach back" method.

Several departments have opted to use handheld digital tape recorders instead of the patient's cell phone. "This is not a new concept in oncology," says Masel. "Previous research at UTMB has shown that patients like this technology."

During phase two of the pilot, patients will be given the choice of using "YourDoctorsAdvice" or a handheld recording device, and patient adherence with follow-up care and treatment plans will be tracked.

"We want to know if the recordings are being used, shared, or enhance the perception of care," adds Masel. ✦

You can't legally share some info on children

Certain exceptions may apply: treatment of STIs, reproductive health, mental health, and substance abuse

Adolescents often seek care for various conditions in which obtaining informed consent from a parent or legal guardian might be "awkward, inconvenient, detrimental, or even impossible," says **William M. McDonnell**, MD, JD, associate professor of pediatrics in the Division of Pediatric Emergency Medicine at University of Utah in Salt Lake City and adjunct professor of law at the university's S.J. Quinney College of Law.

Parents who provide consent for care of their children are entitled to full disclosure about the child's medical care, and adolescent minors lack the legal ability possessed by adult patients to provide informed consent, says McDonnell. However, specific areas may be legally "carved out" from the general rule of parental consent and parental disclosure, he explains, and physicians generally are not permitted to disclose information to parents in those areas.

"Although these rules are determined by state law, and therefore vary from state to state, there are some common patterns," he says. To encourage adolescents to seek treatment for certain conditions, states may "carve out" the need for parental consent prior to treatment of sexually transmitted infections (STIs), reproductive health, mental health, and substance abuse, he explains.

"Nevertheless, the ability of adolescents to consent for such care does not always prohibit disclosure to the parents," says McDonnell. Some state-specific rules direct that physicians must breach confidentiality in certain circumstances, such as when necessary to protect the life or safety of third parties, he says.

Balancing act needed

State law might allow adolescents to provide informed consent for reproductive health, mental health, or substance abuse, but that same state also might have a law compelling disclosure to parents Ð most commonly for abortion or contraception.

"These are probably the trickiest cases in which to balance informed consent and confidentiality rules," says McDonnell, adding that physicians can best reduce their liability risks by knowing the following:

• their state laws regarding the legal age of majority;

• the specific areas of care for which adolescent minors can consent;

• any state rules for mandatory disclosure to parents of adolescent health care. *(See related story on mandatory reporting requirements, p. 10.)*

"They should also know when and to whom they must report suspicions of child abuse and promptly follow through on such reporting," he says.

When classified as emancipated, minors are adults according to laws relating to confidentiality and consent, adds McDonnell. "The emancipated minor's parents have no legal control over the adolescent's healthcare and no right to his health information," he says.

Executive Summary

Parents are entitled to full disclosure about their child's medical care, except in specific "carve-out" areas for which physicians aren't generally permitted to disclose information.

✦ "Carve out" areas vary by state and include treatment for sexually transmitted infections, reproductive health, mental health, and substance abuse.

✦ Physicians might need to breach confidentiality to protect the life or safety of third parties.

✦ Parents have no right to the health information of emancipated minors.

SOURCE

For more information on confidentiality of care given to adolescent patients, contact:

• William M. McDonnell, MD, JD, Associate Professor of Pediatrics, Division of Pediatric Emergency Medicine, University of Utah, Salt Lake City. Phone: (801) 587-7450. Fax: (801) 587-7455. Email: william.mcdonnell@hsc.utah.edu. ✦

Know legal rules for mandatory reporting

Warning! Physicians might face criminal charges

When it comes to disclosure of medical information about an adolescent to law enforcement or other third parties, as opposed to parents, "an entirely different set of legal rules apply," says **William M. McDonnel**l, MD, JD, associate professor of pediatrics in the Division of Pediatric Emergency Medicine at University of Utah in Salt Lake City.

The federal Health Insurance Portability and Accessibility Act (HIPAA) and state confidentiality laws generally do not prohibit the disclosure of minors' health information to parents, but they do protect their health information from disclosure to other people, he explains.

However, specific mandatory reporting laws overrule HIPAA and other confidentiality laws, such as the mandatory reporting requirements related to child abuse and neglect adopted by all states, adds McDonnell.

When a physician has a reasonable suspicion of child abuse or neglect, this information must be provided to law enforcement or child protective services, regardless of other confidentiality concerns, he explains. "Consensual sexual activity between unmarried adolescents and noncustodial adults may present physicians with troubling confidentiality and reporting issues," says McDonnell.

While all states have criminalized such activity via statutory rape laws, there is wide variety among states regarding whether physician reporting of such activity is mandatory or even permissible, he says. "Because of the complexities of state-specific laws in this area, physicians who treat adolescent patients should familiarize themselves with child protection laws in their state related to adolescent-adult sexual behavior," he says.

Successful lawsuits?

Minors who are specifically permitted by state law to provide consent and receive confidentiality protection in the "carve-out" areas might be successful in suing physicians for breaches of confidentiality, says McDonnell. However, McDonnell says that when physicians are specifically directed by state law to disclose to law enforcement or parents, the physicians are protected from liability.

"The law starts with the presumption that adolescents cannot provide informed consent and that parents are entitled to full disclosure," says McDonnell.

Unless it fits into one of the "carve-out" exceptions, or unless related to a medical emergency, care provided without disclosure and consent from the parents might violate informed consent rules, which might support a legal claim against the physician, he explains.

"The state can bring criminal Ð usually misdemeanor Ð charges against the physician who fails to report to law enforcement authorities when he or she is aware of child abuse," adds McDonnell. ✦

Blaming colleague? It may increase legal woes

(Editor's Note: This is the first part of a two-part series on actions physicians should take after being named in a lawsuit. This month, we cover why physicians should avoid placing blame on colleagues. Next month, we'll give recommendations on what information physicians should review.)

If a nurse practitioner claims a physician made a mistake that harmed a patient, and the physician in turn blames the nurse, the plaintiff "just has to sit back and wait for them to prove the case against each other," says **Roger L. Hillman**, JD, an attorney with Garvey Schubert Barer in Seattle.

Plaintiffs typically name all of the practitioners involved in their care, and all are presumably eager to be dismissed. "But the last thing they should start doing is proving the plaintiff's case for them," says Hillman. "The plaintiff has the burden of proof." To avoid placing blame on colleagues:

• Don't offer opinions on the care of others.

"If Doctor A is being deposed and is asked for his opinion of care rendered by Doctor B, the answer is, 'I wasn't hired as an expert witness. That is not for me to say. I can't offer an opinion on someone else's care,'" Hillman advises.

A fact witness is not obligated to have an opinion, explains **Norm**

Executive Summary

Physician defendants should avoid placing blame on colleagues if possible, as this situation can make it easier for plaintiffs to prove their case.

- ✦ Avoid offering opinions on the care of colleagues.
- ✦ If a colleague criticizes your care, don't automatically respond in kind.
- ✦ Work with lawyer: Be truthful without causing problems for others in the suit..

Jeddeloh, JD, an attorney with Arnstein & Lehr in Chicago. If the plaintiff's attorney asks, "Didn't Dr. Smith err in the way he did the coronary bypass?" he advises that the physician being deposed state, "I don't have an opinion about that," or "I wasn't there, and I haven't reviewed it."

• If a colleague criticizes your care, don't automatically respond in kind.

David S. Waxman, JD, an attorney with Arnstein & Lehr, says, "When somebody throws a bomb in your direction, you have to decide how to respond. Sometimes you can absorb the blow and move on constructively."

• Remember that you may be able to get out of a case without harming your colleagues.

"There are times when it is somebody else's fault," says Waxman. "If you are not responsible, your desire is to get out of it. Nobody wants to be a defendant for an hour longer than they have to be."

If you can avoid causing problems for other individuals named in the suit, however, "it's usually the better path," says Waxman. "That is where you work with your lawyer about how to be truthful without necessarily making the situation worse."

Is there an expert?

If the plaintiff has an expert witness to testify about a physician's care, "you are going much deeper in the process than you would otherwise. That means you will either settle or go to trial," says Waxman.

If the plaintiff has not identified an expert witness against a particular physician, the defendant might move for summary judgment, which would put the plaintiff in the position of revealing the expert witness sooner than he or she had planned on doing or risk having the motion granted, says Hillman. "If the expert opinion says that Dr. A was wrong for this reason and Dr. B was wrong for that reason, and says nothing at all about Dr. Z, then Dr. Z can file for summary judgment," Jeddeloh explains.

It is "extremely rare" for a case to proceed if the plaintiff does not have an expert witness, according to Waxman. "There are exceptions, but if the plaintiff doesn't have an expert who will pull the trigger against a defendant physician, it would be quite unusual if that physician was not dropped from the case," he says.

Even if the plaintiff does have an expert witness against you, it might be strategically advantageous for them not to make a case against you if they have a stronger case against your colleague, notes Waxman.

"You may be able to get out without necessarily hurting any of your colleagues," he says. "This is where litigators occasionally have to be diplomats."

SOURCES

For more information on avoiding finger-pointing during litigation:

• **Roger L. Hillman**, JD, Garvey Schubert Barer, Seattle. Phone (206) 816-1402. Fax: (206) 464-0125. Email: rhillman@gsblaw.com.

• **Norm Jeddeloh**, JD. Arnstein & Lehr, Chicago. Email: npjeddeloh@arnstein.com.

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COMING IN future MONths

✦ How EMR charting can make a case indefensible

✦ Your personal texts can become evidence during suit

✦ Why incidental findings pose major legal risks

✦ Take immediate action if you suspect patient will sue

CME OBJECTIVES

After reading *Physican Risk Management*, the participant will be able to:

- describe the legal, clinical, financial, and managerial issues pertinent to physician risk management;
- explain the impact of risk management issues on patients, physicians, legal counsel, and management;
- identify solutions to risk management problems for physicians, administrators, risk managers, and insurers to use in overcoming the challenges they face in daily practice.

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.

2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CME Questions

1. **Which is true regarding reports filed with the NPDB, according to Elise Dunitz Brennan, JD?**
   A. A plaintiff's attorney can typically access information in the NPDB, even without evidence that a hospital failed to conduct a query that it should have as part of its credentialing process.
   B. NPDB reports involving medical malpractice payments and those involving denial of privileges generally are equally damaging to a physician's ability to practice.
   C. If a physician withdraws an application for privileges while under investigation as defined by hospital bylaws, that is a reportable event.

2. **Which is true regarding auditing of charting in EMRs during medical malpractice litigation, according to Michele Luckie, a senior risk management specialist at Texas Medical Liability Trust?**
   A. Audits of EMRs can't be used as evidence to show how long it took a physician to act after an abnormal lab result came in.
   B. Evidence as to whether the physician checked an online reference before making a clinical decision would not be admissible.
   C. Plaintiff attorneys can't use information obtained through EMR audits to claim that a doctor took too long to respond to a lab test result.
   D. If a physician makes a late entry to the EMR, an addendum to the original note should be made.

3. **Which is true regarding legal requirements for physicians involving disclosure of health information of minors, according to William M. McDonnell, MD, JD?**
   A. If a state "carves out" specific areas from the general rule of parental consent and parental disclosure, physicians generally are not permitted to disclose information to parents involving those areas.
   B. If treatment for reproductive health is "carved out" by a state, the ability of adolescents to consent for such care always prohibits disclosure to the parents.
   C. An emancipated minor's parents maintain a right to certain types of health information involving their child.

4. **Which is recommended regarding physicians named in a lawsuit, according to David S. Waxman, JD, an attorney with Arnstein & Lehr?**
   A. When being deposed, physicians should not hesitate to offer opinions on the care rendered by their colleagues.
   B. Physicians should keep in mind that they are obligated to offer opinions on whatever they are being deposed about.
   C. It is generally advisable for physicians to place blame on the other individuals named in the suit.
   D. Physicians should avoid offering opinions on the care of others during depositions.

Physician Legal Review & Commentary

A Monthly Supplement to PHYSICAN RISK MANAGEMENT

Neonatal necrotizing enterocolitis case leads to $7.05 million verdict

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News: A female infant was transferred to the hospital's neonatal intensive care unit for airway management and prematurity after her birth on June 13, 2004. The infant was diagnosed with uncompensated metabolic acidosis. On June 21, 2004, the female infant was diagnosed with a perforated bowel. She was taken to surgery, but died during the operation on June 21, 2004, due to complications of severe necrotizing enterocolitis. A lawsuit was filed against the physician and the nurse practitioner, by the child's mother and father on her behalf. Following trial, the jury returned a verdict of $7.05 million.

Background: A female infant was transferred to the hospital's neonatal intensive care unit for airway management and prematurity after her birth on June 13, 2004. The supervising physician diagnosed her with uncompensated metabolic acidosis. The supervising physician and the neonatologist agreed to start feeding the infant.

The feeding was advanced per an order from the nurse practitioner. A nursing assessment was conducted, and the nurse practitioner and supervising physician were informed that the infant appeared pale. It was noted that the infant had symptoms of metabolic acidosis on June 20, 2004, at 11:20 a.m. The supervising physician and nurse practitioner ordered continued observations and additional workups for sepsis if symptoms occurred. The female infant's abdomen was continuously documented due to increase of her abdominal girth.

Had there been a process to voice nursing concerns up this chain of command, would the outcome have been di˜erent?

The infant was diagnosed with a severe combination of acidosis, respiratory failure, and shock. The infant was transferred to a children's hospital on June 21, 2004, for medical treatment. Decompressing of the infant's distended abdomen was conducted. The infant died due to complications of severe necrotizing enterocolitis.

A lawsuit was filed against the medical physician and the nurse practitioner, by the child's mother and father on her behalf. Plaintiff argued that the supervising physician and the nurse practitioner breached the standard of care when the failed to adequately diagnose and timely treat the infant's condition, failed to reduce the risk of developing necrotizing enterocolitis, failed to appropriately monitor the infant's condition, failed to report her condition, and failed to obtain informed consent.

The defense argued that there were no signs of infection of necrotizing enterocolitis until the evening of June 20, 2004, and that it was properly treated. The defense also argued that the infant's abdominal examinations revealed that the infant's abdomen were not consistent with a finding of necrotizing enterocolitis.

Financial Disclosure: Co-Authors **Jonathan D. Rubin**, Esq. **Sandra L. Brown**, Esq., **Ericka Saint-Hilaire**, JD, RN, MPH, and **Leilani Kicklighter**, RN, ARM, MBA, CHSP, CPHRM, LHRM, and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

The case proceeded to trial, and the jury returned a verdict of $7.05 million. About $50,000 of the amount represented past pain and suffering. The remainder of the award represents past and future loss of consortium. The defense has indicated it will appeal the verdict.

What this means to you: The loss of a child for any reason at any age is a devastating tragedy.

Necrotizing enterocolitis is a devastating condition that often leads to the ultimate untoward outcome suffered by this newborn and her family. If the signs and symptoms were recognized and addressed on a timely basis, would the outcome have been different? That question remains unanswered in this matter. The eight days from birth to death shows how quickly this condition can progress.

This infant was born prematurely, showed respiratory problems requiring airway management, and was diagnosed with uncompensated metabolic acidosis, which necessitated transfer to the neonatal intensive care unit (NICU) on her birth day. These two conditions are symptoms of necrotizing enterocolitis that should have raised the flag to conduct more tests and evaluations to rule out or confirm the diagnosis. Timeliness of proper diagnosis and intervention is important in this situation. As time went by, this infant began to exhibit all the signs and symptoms of necrotizing enterocolitis. Why was it not at least picked up as a differential diagnosis? Several questions arise such as why it took seven days to recognize this infant needed a higher level of care and to transfer the infant to the children's hospital.

This case should be referred to peer review to determine why there was a delay in diagnosis and the implementation of the proper medical intervention. According to the facts, it is unclear if the physician and nurse practitioner were employees of the hospital or specialized in the applicable area of medicine (i.e., neonatology, pediatrics, and neonatology). Was the physician board-certified? Was the nurse practitioner certified? Is there a process to assess the competency of physicians and nurse practitioners as there is for employees on an annual basis? If not, should there be? Are the physician and the nurse practitioner provided through a contracted service? Was the risk manager involved in the review of this contract to assess the risk exposures and risk assumptions created by the contract? Are the contract insurance requirement and other liability protection language adequate to protect the hospital?

Depending on the parties to the contract, the insurance limits are normally $1 million per claim/$3 million in the aggregate, or less. In most claims, these limits would be adequate; however, in this case, these limits would not be sufficient. In this case, the physician and nurse practitioner were named as defendants and not the hospital.

In addition to the peer review, the risk manager should conduct a root cause analysis to determine the answers to some of these questions and others with the intent to prevent a recurrence of such an unfortunate outcome. Collaborating with the department of pediatrics, an inservice on necrotizing enterocoloitis should be developed and presented as mandatory for the pediatricians, neonatologists and neonatology intensivists, nurse practitioners, and newborn nursery and NICU nursing staff.

Working with the nursing leadership, the chain of command process should be readdressed with the nursing staff. Nurses are educated to recognize signs and symptoms of certain conditions to bring to the attention of physicians or covering allied health professionals such as physician assistants and nurse practitioners. When it appears the response is delayed or non-responsive, such a situation should be reported to the nursing supervisor and, if necessary, up the medical and administrative chain of command to the CEO and medical staff president, if necessary, to intervene to invoke the bylaws to secure appropriate care. It is shared that the nursing staff reported changes in this infant's condition. Had there been a process to voice nursing concerns up this chain of command, would the outcome have been different? Again, this issue should be addressed as a part of the peer review and the root cause analysis as a consideration for prevention of recurrence of this situation or similar ones.

Of course, as difficult as it will be, a disclosure discussion with the parents of this infant also should be conducted. While there may be hesitancy on having such a meeting for fear of it generating a lawsuit, such meetings should be corrdinated by risk management with input from legal counsel, if it is thought to be necessary. Many states have passed statues requiring such disclosures, and many states also have passed statutes that address the admissibility of apologies should a lawsuit be initiated. Risk managers should be familiar with these statutes in their state and follow those guiding principles in these meetings. In addition, it is an eithical issue that should be considered in dealing with patients and families who have suffered an untoward outcome as a result of a possible or confirmed preventable medical error. In addition, a standard from The Joint Commission governs disclosure of unanticipated untoward outcomes.

This case raises many questions that cannot be answered, according to the facts provided herein. However, the answers to these questions can assist in developing risk control activities and interventions to prevent such situations in the future.

Reference

Bellrose v. Janet S. Lloyd MD, et al. Superior Court of Massachusetts, Suffolk County. Case No. SUCV2006-02412. ✦

Failure to diagnose fracture of the cervical spine

$9 million verdict awarded in case of 51-year-old who presented to the emergency department

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News: A 51-year-old man presented to the hospital emergency department (ED) after a vehicular rollover accident with the chief complaint of neck pain. The ED physician failed to order X-rays of the patient's neck, failed to examine the patient, and failed to provide a cervical collar at the time of discharge. Four days later, the patient returned to the hospital after losing the use of his left arm and shoulder. He was diagnosed with multiple unstable cervical spine fractures and underwent emergency neck fusion surgery. The patient and his wife sued and claimed that had the physician properly diagnosed his condition in a timely manner during his initial visit to the ED, it would have prevented further injury. The jury returned a verdict of $9 million, including $2 million for spousal claims of loss of consortium. Post-trial, the loss of consortium award was reduced to $500,000 for a net award of $7.5 million.

Background: On Dec. 9, 2008, a 51-year-old oil field worker was on the job and driving a company truck when he was involved in a rollover accident. At the scene of the accident, he was immobilized on a backboard, and a neck brace was placed by emergency response workers before he was rushed to the hospital. The triage nurse noted the patient's chief complaint was neck pain, and the nursing notes stated the patient had been restrained and driving when the rollover vehicle rolled approximately five times. While the emergency physician ordered X-rays of the patient's head and back, he discharged the patient the same day without examining the patient, without taking X-rays of his neck, and without providing him with a cervical collar (C-collar).

The patient returned to the hospital four days later after losing the use of left arm and shoulder. Upon presentation to the hospital, he was immediately placed in a C-collar. A CT was ordered that showed a C5 articular pillar fracture with mild anterolisthesis at C4-5 and severe disc narrowing at C4-5; possible flexion teardrop fracture of C5; and a small bone garment within the left C4-5 nerve root canal laterally from the articular pillar fracture. Emergency neck fusion surgery was performed the same day. In follow up on Dec. 30, 2008, the surgeon found that while he was able to avert further damage with the surgery, the surgery could not undo the damage that already had been done. Since the initial emergency neck fusion surgery, the patient has had a second neck fusion operation as well as several procedures aimed at reducing his pain. The patient has been unable to work since the accident.

The patient and his wife filed suit in federal court against the ED physician and hospital asserting negligence and medical malpractice claims. Plaintiffs claimed the defendants negligently failed to diagnose a fracture or dislocation of the cervical spine that was unstable and which led to the development of neurological injury with dysfunction of his left arm and shoulder. Plaintiffs co-ntended that had the physician properly diagnosed his condition in a timely manner during his initial visit to the hospital ED, it would have prevented further injury. The patient's wife also filed a claim for loss of consortium.

The jury determined that the defendants' negligence caused the patient's damages and awarded the amount of $7 million, including $217,904 for past medical expenses, $557,337 for future medical expenses, $175,552 for past wages, and $683,058 for future wages. The jury also awarded the patient's wife $2 million in loss of consortium damages, giving a total award of $9 million, the highest medical malpractice award in Wyoming's history.

In post-trial motions, the defendants asserted that the award of damages to both the plaintiff and his spouse were unreasonable and unsupported by the evidence adduced at trial. Defendants requested a remitter, or in the alternative, a new trial. The court denied the defendants' motion related to the plaintiff's award. The motion to reduce the loss of services award for the spouse was granted, and the award was reduced to $500,000, for a net award of $7.5 million.

What this means for you: This is a disability that might have been prevented with appropriate diagnosis and medical management. The first responder rescue team appropriately stabilized this patient's head and neck for transport from the accident scene to the hospital. The chief complaint on admission was

neck pain. A motor vehicle accident (MVA), especially one that involves a rollover, five times no less, would warrant a thorough medical physical evaluation upon arrival at the hospital. However, the facts we are given states the physician did not examine the patient before discharge. This omission would be a deviation from the accepted standard of care. We are not provided with information regarding the ED physician's documentation of his assessment and medical decisions of this patient before discharging him home.

The emergency physician was board certified in emergency medicine and, according to the facts above, was an employee of the hospital. Being board certified is the gold standard of qualifications of physician/surgeons' credentialing and a standard to give the public confidence of physician competence. In this case, the question is what, if any, further competency evaluations of employed physicians are conducted annually. It would be of interest to know why X-rays of the neck and cervical spine were not taken, especially since the patient was complaining of neck pain. One would think it would be prudent to take such X-rays when it is known that individuals who are using their seat belts and are involved in a MVA frequently suffer injuries from the seat belt, especially those who are involved in rollover accidents. Air bags, while they save lives, also can cause injuries. Only the documentation would indicate if this neck area was evaluated and why X-rays were not taken. Was this an oversight or determined by the ED physician to be unnecessary? Why was no physical examination of the patient conducted by the ED physician? Why was a neurologist not called in to evaluate the patient before discharging, or in the alternative referred for follow-up post-discharge? Many questions that are important to know for prevention of repeat such situations remain unanswered.

This situation should be referred to the medical staff peer review for evaluation of the physician's actions or lack of action and medical care. In addition, the risk manager should conduct a root cause analysis (RCA) to determine the causes of why the sequence of events occurred in this initial ED visit. In collaboration with the departments of emergency medicine, neurology and neurosurgery, the risk manager might explore development of critical pathways or a checklist to be used when certain types of injuries present to the ED. Furthermore, a mandatory educational session on evaluation and treatment of these types of injuries should be given to all ED physicians and ED nurses. It appears the care was appropriate and timely when the patient presented to the ED four days later, although it is unclear whether the defendant ED physician was on duty on this second visit or if the patient was seen by a different ED physician. This situation also calls for a disclosure meeting and discussion with the patient and his family.

The fact that the ED physician was an employee brings into play the legal theory of respondeat superior: the employer is responsible for the acts of its employees. This theory raises the liability exposure for the hospital. From the risk management aspect, the liability insurance/risk financing program for the employed physicians and surgeons is an issue in such instances. Is coverage adequate? Are the limits of coverage per physician or shared limits? Is the physicians' coverage provided from a carrier different than that providing coverage to the hospital? If so, is there an agreement for cooperative defense? Will the hospital's excess coverage respond to the physician's primary coverage?

This patient was driving a company truck on company business when the accident occurred. The lawsuit against the hospital and its employed ED physician was filed in federal court. This could be a workers' compensation (WC) claim against the employer as well as a professional liability case against the hospital and doctor. Risk managers should be knowledgeable about WC laws in their states. In some states, WC claims are exclusive remedies, meaning the employee must choose whether to file a WC claim or a liability claim against their employer. That situation doesn't seem to apply in this case. Some states have no such rules, and other legal aspects may factor into these issues. Risk managers also should be familiar with federal claims issues. There are several factors that can be the basis for filing a claim in federal court. (This filing does not mean the claim is filed against the federal government.) While these are legal issues for the most part, again the risk manager should have a familiarity with the issues as it might influence claims management and insurance issues. Legal counsel can be helpful in sharing this information in most instances.

This case surrounds a tragic untoward outcome related to medical care, a missed or mis-diagnosis. Often these types of situations go unrecognized until the patient returns because they have deteriorated or their symptoms haven't gotten better. Readmissions to the hospital within 30 days of discharge are getting much more attention and will influence the reimbursement to hospitals. Hopefully, the tracking and analysis of these readmissions will include risk management evaluations and analysis as a part of the process and prevention or avoidance activities.

Reference

1. Prager v. Campbell County Memorial Hospital, et al, United States District Court, Wyoming, 2011 WL 7664679. ✦