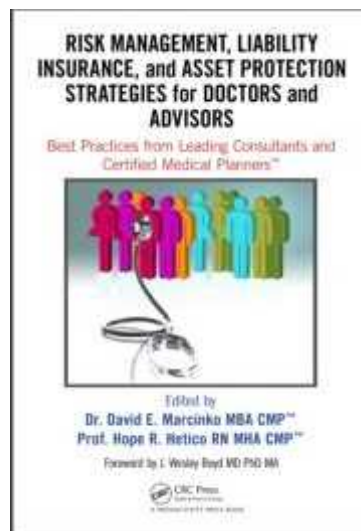


# TOPICAL "A thru "M" LIST OF EMERGING MEDICAL PRACTICE 2.0 RISKS

*[The - Too Numerous to Count - Syndrome]*



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Most traditional books for medical professionals limit their discussion of risk management to life insurance planning, occasionally some property casualty issues, usually asset protection management and perhaps those strategies and methods to avoid medical malpractice claims. Defensive medicine and risk management were often synonymous terms. However, limiting medical risk management concerns to these customary issues is completely misplaced in modernity; for the medical practitioner and his/her financial advisor, attorney, HIT and/or risk management consultant.

## **INTRODUCTION**

In today's medico-legal environment the physician faces risks from many directions; almost *ad naseum* or *too numerous to count [TNTC]*. And so, here is an alphabetized list, "A" thru "M", of some modern perils and emerging risks that may defy formal definition, chapter inclusion or even classification, but are nevertheless important considerations.

**-A-**

### **§ ABUSIVE TREATMENT OR SERVICES**

According to the *Dictionary of Health Insurance and Managed Care*, healthcare abuse is the activity where someone overuses or misuses services. And; the Center for Medicare and Medicaid Services [CMS] states that: "although some of the practices may be initially considered to be abusive, rather than fraudulent activities, they may evolve into fraud." In the case of healthcare abuse, this may occur when a physician sees the patient for treatment more times than deemed medically appropriate. If there are reported issues or actions from other sources, such as the National Practitioner Data Bank [NPDB] or a medical board, a health insurance program can take that opportunity to review healthcare providers' activities. Most insurance or managed care participation agreements allow for this type of scrutiny.

### **§ ACCOUNTABLE CARE ORGANIZATIONS [ACOs]**

Since their four-page introduction in the PP-ACA of 2010, ACOs have been implemented in both the Federal and commercial healthcare markets, with 32 Pioneer ACOs selected (on December 19, 2011), 116 Federal applications accepted (on April 10, 2012 and July 9, 2012), and at least 160 or more Commercial ACOs in existence by 2014. Federal ACO contracts are established between an ACO and CMS, and are regulated under the CMS *Medicare Shared Savings Program (MSSP) Final Rule*, published November 2, 2011. ACOs participating in the MSSP are accountable for the *health outcomes*, represented by 33 quality metrics, and *Medicare beneficiary expenditures* of a prospectively assigned population of Medicare beneficiaries. If a Federal ACO achieves *Medicare beneficiary expenditures* below a *CMS established benchmark* (and meets quality targets), they are eligible to receive a portion of the achieved *Medicare beneficiary expenditure* savings, in the form of a *shared savings payment*.

Yet, by January 2016, three Accountable Care Organizations dropped out of Medicare's Pioneer program, which was designed to test the payment and delivery model with a small group of elite providers deemed best prepared to handle the operational demands and financial risks. The Franciscan Alliance, Genesys PHO, and Renaissance Health Network exited the program, which is now in its third year. A few months earlier Earlier, Sharp HealthCare, San Diego, announced its decision to pull out after determining "the model was financially detrimental", despite the ACO's performance managing quality and healthcare use. Medicare's ACO programs so far have produced inconsistent results, some of which policy experts and ACO executives have blamed on how Medicare calculates how much ACOs potentially saved the program. In December 2014, CMS announced that the initiatives saved Medicare \$817 million through 2013. Dozens of participants shared \$445 million of that amount, but three-quarters of ACOs saw nothing after failing to do sufficiently well against the financial benchmarks.

Commercial ACO contracts, on the other hand, are not *limited* by any specific legislation, only by the contract between the ACO and a commercial payer. In addition to *shared savings models*, Commercial ACOs may incentivize *lower costs* and *improved patient outcomes* through reimbursement models that share risk between the payer and the providers, i.e., *pay for performance compensation* arrangements and/or *partial to full capitation*. Although commercial ACOs experience a greater degree of flexibility in their structure and reimbursement, the principals for success for both Federal ACOs and Commercial ACOs are similar.

Source: Melanie Evans, Modern Healthcare [9/25/14]

## **§ ADVERSE EVENTS**

Aggregated experience from the *Doctors Company* and other malpractice insurers has shown that adverse medical events tend to fall into three categories:

### **A. Medical and/or System Error**

Error is defined by the National Quality Forum Consensus report titled *Standardizing a Patient Safety Taxonomy* as "the failure to perform a task satisfactorily against customary standards and the failure cannot be attributed to causes beyond the patient or provider." When the investigation (including a sentinel event root cause analysis) is complete and the cause is determined to be medical and/or system error, a disclosure meeting should take place with the patient or family.

### **B. Known Risk/Complication or Unforeseeable Event**

The key factor in this category is preventability. Disclosure communications following unpreventable complications or unforeseeable events need to be forthright, open, and compassionate, though they differ qualitatively from apologies after preventable errors.

1. Review the known facts surrounding the adverse outcome.
2. Determine if the event was preventable.
3. Review your process of informed consent to determine if the known risk or complication was discussed.
4. Proceed to the disclosure meeting with the patient or family. Focus on discussing the cause(s) of the known risk or complication. Review the informed consent if appropriate.

### **C. Unexplained Change in Patient Status or New Diagnosis of Late-Stage Disease**

1. The main challenge in communicating after a Category C event is the avoidance of a premature conclusion that a severe and surprising outcome must be due to a negligent error. It is especially important in these circumstances to limit the information conveyed to the confirmed details and to provide ongoing updates as new information becomes available. These cases are particularly vulnerable to retraction and correction cycles that render all subsequent communications with the patient and family questionable.
2. Conduct an internal review of the medical records to determine exactly what happened and to determine if the status change was preventable or if the new diagnosis could have or should have been made earlier.
3. If appropriate, initiate an external expert review. Peer reviews of the medical care with the outcome blinded can lend unique insight into these events.
4. If a sentinel event occurred, a root cause analysis is appropriate.
5. Proceed to the disclosure meeting. Review the findings of your medical record review and investigation. Explain the implications of the change in the patient's health status and how this will affect his or her subsequent disease management. Discuss the prognosis and management of the newly diagnosed late-stage disease.

### **§ ANTI-TRUST RISKS**

) *Monopolistic* risks are reduced when more than a few networks or contracts are available in the local area for excluded providers to join.

) Fee schedule MCO contracts, *per se*, are not generally considered price fixing, provided the providers have not conspired with one another to set those prices. Moreover, network pricing schedule should not spill over into the non-network patients.

) Individual providers may be excluded from a network if there is a rational reason to do so. It is much more difficult to exclude a *class* of providers, than it is to exclude an *individual* provider.

) A *safety zone* can be created if networks or other contractual plans require a substantial amount of financial risk-sharing among plan participants, since Stark II laws have been relaxed. Such zones have been created by the *Department of Justice (DOJ)* and *Federal Trade Commission (FTC)*, in recent policy statements.

) The FTC and DOJ are not likely to challenge an exclusive provider IPA that includes no more than 20-25% of the doctors within the panel, who share financial risk. Such panels are likely to fall within a *Safe Harbor*.

) *Tying arrangements* (e.g.: the requirement to buy one item/service in order to buy another item/service) are suspect if not reasonably justified. For example, a patient should not be required to obtain a brace prescription from a specific provider, in order to purchase the device from a laboratory that the doctor owns.

) *Non-exclusive* provider panels will not usually be challenged if no more than 30% of the providers are included (another *Safe Harbor* provision).

) Physician networks are often analyzed according to *four criteria*: (1) anti-competitive effects, (2) relevant local markets, (3) pro-competitive effects, and (4) collateral agreements.

Further anti-trust considerations consist of analyzing *Market Power*. This consists of two factors: (1) Geographic Power and (2) Product Power.

*Geographic Power* is difficult to define in today's environment. In the past, the geography that was analyzed when medical practices merged was the immediate neighborhood. Currently, the geographical area could consist of an entire metropolitan area. In the past, individual patients would often seek a physician whose office was close to work or home. Now they seek a physician based on inclusion in a health plan. Now, health plans choose physicians based on needs within an entire metropolitan area.

*Product Power* relates to the specific service being performed. There are two products in today's environment: (1) Primary Care and (2) Specialty Care. Since there are so many primary care physicians in practice, it would be difficult for all but the largest group to acquire product power.

It is easier for specialists to develop product power. However, certain specialists may never be able to obtain product power. For example, foot care is provided by many types of physicians. Primary care physicians, emergency physicians, chiropractors, physical therapists, orthopedic surgeons, nurse practitioners, and podiatrists all provide foot care. Therefore, it would be difficult, even for a large group of podiatrists to obtain significant product power.

## **§ APOLOGY PROGRAMS**

To deal with the aftermath of medical errors, an increasing number of providers are encouraging injured patients to participate in "medical apology programs." The idea, proponents say, is for patients to meet with facility representatives to learn what happened and why. It gives the patient a chance to ask questions and it gives providers a chance to apologize, and as appropriate, offer compensation. These programs are promoted as humanitarian, and, at least in terms of providing an emotional outlet for patients, they are. The evidence also suggests that they are about something else: money. Every aspect of how they operate – from who risk managers involve, to what those involved are told to

say – suggests a key goal is to dissuade patients from seeking compensation by creating an emotional connection with them. The data establishes that it works, too. A 2010 study found that at one major facility, apology programs resulted in fewer injured patients making claims and, among those that did, they accepted a fraction of the amount in settlement compared to patients who made claims before the program was instituted. For minor injuries, no real harm is done by this; but the outcome can be cataclysmic for seriously injured patients who accept an apology in lieu of compensation.

Doug Wojcieszak, owner of the advocacy group *Sorry Works*, [<http://sorryworkssite.bondwaresite.com>] often receives requests to teach doctors how to communicate after a problem. He became interested in the topic when his older brother died at age 39 from a medical error. While losing his brother was awful, the experience was compounded by a total lack of communication and accountability afterward.

Curiously, when an attorney suspects that he has committed legal malpractice, he must disclose it to the client and recommend that the client seek outside counsel to get objective legal advice on how to proceed. By contrast, when a doctor suspects that he has committed medical malpractice, at many facilities he is expected to employ a set of protocols that discourage the injured patient from considering the need for compensation. Yet, while an attorney could be disbarred for this sort of behavior, medical apology programs widely receive praise.

Source: Gabriel H. Teninbaum JD: Suffolk University Law School-Chapman Law Review Research Paper 11-30.

## **§ ARTIFICIAL INTELLIGENCE [AI]**

Machines beat humans at chess. Machines can pilot airplanes to land at O'Hare airport in Chicago, or on the planet Mars. There is now a machine that beats the best of us at Jeopardy. Many predict that an Artificial Intelligent [AI] medical clinician is ten years away. And, few will use a biological doctor in twenty five years. Then, the *singularity!* So, if you think *ROBO-MDs* won't impact patients and the industry ... think again!

**-B-**

## **§ BILLING COMPANY RISKS**

Particular attention should be paid to issues of appropriate diagnosis codes, CPT®, DRG and MS-DRG coding, individual Medicare Part A and B claims (including documentation guidelines for evaluation and management services) and the use of patient discharge codes. The billing company should also institute a policy that all rejected claims pertaining to diagnosis and procedure codes be reviewed by the coder or the coding department. This should facilitate a reduction in similar errors. Among the risk areas that some billing companies who provide coding services should address are:

- J Internal coding practices;
- J “Assumption” coding;
- J Up-coding and Down-coding;
- J Alteration of medical records and documentation;
- J Coding without proper documentation of all physician services;
- J Billing for services provided by unqualified or unlicensed clinical personnel;
- J Availability of all necessary documentation at the time of coding; and
- J Employment of sanctioned individuals.

## § BIOLOGICAL AND CHEMICAL ATTACKS

Title X of the USA PATRIOT Act contains several calls for strengthening the public health system. Section 1013(a)(4) calls for “enhanced resources for public health officials to respond to potential bioterrorism attacks.” Section 1013(a)(6) calls for “greater resources to increase the capacity of hospitals and local healthcare workers to respond to public health threats.” Prior to September 11, 2001, the capacity of healthcare entities to respond to biological and chemical attacks by terrorists was quite limited. Strictly speaking, however, healthcare organizational preparedness plans are not as directly encumbered by the USA PATRIOT ACT, or by the Department of Homeland Security’s (DHS’s) Chemicals of Concern [COC] List, or the various steps of its Section 550 Program as some other industries. Nevertheless, healthcare organizations may have their sources of contaminants, such as: *Mercury*, *Dioxin*: *DEHP* (2-ethylhexyl), *Volatile Organic Compounds* and *Glutaraldehyde*, etc. For some time now, the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) has also required hospitals to have a disaster preparedness plan mimicking the USA PATRIOT Act [personal communication, Kenneth A. Powers, *Media Relations Manager*, TJC]

After September 11, 2001, “disaster preparedness” evolved into something that could more accurately be described as “emergency preparedness.” Experience in New York and Virginia has shown that there will be spillover outside the immediate geographic areas affected by a terrorist attack, which will affect suburban and rural hospitals. Thus, the emphasis in emergency preparedness is on the coordination and integration of organizations throughout the local system. Hospitals and healthcare entities therefore need to revise existing plans for disaster preparedness to reflect the realities of potential terrorist threats. Mitigation against risk is essential to safeguard the financial position of an entity. Medical practices and healthcare entities can mitigate risks by developing an emergency preparedness plan. The entity should start by identifying possible disaster situations, such as earthquakes and biological or chemical attacks that could affect the facility. Next, the entity should identify the potential damages that could occur to structures, utilities, computer technology, and supplies. After that, the entity should use resources currently available to safeguard assets, and then budget to acquire any additional materials or alterations required to secure the facility. Practices can take several steps to mitigate even in the absence of significant funding:

) First, establish links with ‘first responders’ such as local law enforcement, fire departments, state and local government, other healthcare organizations, emergency medical services, and local public health departments.

) Second, establish training programs to educate staff on how to deal with chemical and biological threats.

) Third, make changes in their information technology to facilitate disease surveillance that might give warning that an attack has occurred. Information technology may be useful in identifying the occurrence syndromes such as headache or fevers that might not be noticed individually but in the aggregate would signal that a biological or chemical agent had been released.

) Fourth, acquire access to staff and equipment to respond to biological and chemical attack through resource sharing arrangements in lieu of outright purchases.”

In addition to preparedness for an attack within its catchment area, a healthcare organization must be prepared for an attack on its own facility or office. They should assess the vulnerability of the heating, ventilation, and air conditioning (HVAC) systems to biological or chemical attack. The positioning of the air intake vents is especially important because intakes on roofs are fairly secure as compared to intakes on ground level. One way to increase security is to restrict access to the facility. Some facilities are using biometric screening to restrict access to their facilities. Biometric screening identifies people based on measurements of some body part such as a fingerprint, handprint, or retina. The advantage of this approach is that there are no problems with forgotten badges, and biometric features cannot be shared or lost like cards with personal identification numbers (PINs). In preparing for a possible attack, healthcare entities should also examine the federal, state, and local laws that might affect their response to a biological or chemical attack. Unfortunately, there is no central source of legislation, and an extensive search of many sources might be required to determine the legal constraints.

## **§ BLOGGING DOCTORS**

According to [www.NPR.org](http://www.NPR.org), there are more than 120,000 health care forums on the Internet with opinions ranging from pharmaceuticals, to sexual dysfunction, to acne. The same goes for commercial doctor blogs that promote lotions, balms and potions, diets and vitamins, minerals, herbs, drinks and elixirs, or various other ingest-ants, digest-ants or pharmaceuticals, etc. And, to other doctors, the blogging craze is a new novelty where there are no rules, protocols, standards or precise figures on how many “medical-doctor” or related physician-blogs are “out there.” Unfortunately, too many recount gory ER scenes, or pictorially illustrate horrific medical conditions, or serious and traumatic injuries. Of course, others simply are medical practice websites, or those that entice patients into more lucrative plastic surgery or concierge medical practices. Some are from self-serving/credible plaintiff-seeking attorneys wishing to assist patients.

Not all physician blogs are geared toward practice information, marketing or medical sensationalism. In fact, just the opposite seems to be the case in extremely candid blogs, like “Ranting Docs”, “White Coat Rants,” “Grunt Docs”, “Cancer Doc,” “The Happy



Hospitalist,” “Mom MD”, “Cross-Over Health”, “Angry Docs” and “M.D.O.D.,” which bills itself as “Random Thoughts from a Few Cantankerous American Physicians.” Link: [www.thehappyhospitalist.blogspot.com](http://www.thehappyhospitalist.blogspot.com) According to some of these, they are more like personal journals, or public diaries, where doctors vent about reimbursement rates, difficult cases, medical mistakes, declining medical prestige and control, and/or what a “bummer” it is to have so many patients die; not pay, or who are indigent, noncompliant. We call these the “disgruntled doctor sites.” Some even talk about their own patients, coding issues, or various doctor-patient shenanigans.

But, according to psychiatrist and blogger Dr. Deborah Peel and others, the problem with blogging about patients is the danger that one will be able to identify themselves – the doctor – or that others who know them will be able to identify them.” Her affiliation, *Patient Privacy Rights*, rightly worries that patients might tracked back to the individual, and adversely affect their employment, health insurance or other aspects of life. Link: [www.patientprivacyrights.org](http://www.patientprivacyrights.org) And, according to Dr. Jay S. Grife; MA Esq., it is certainly true that if a doctor violates a patient’s privacy there could be legal consequences. Under HIPAA, physicians could face fines or even jail time. In some states, patients can file a civil lawsuit if they believe a doctor has violated their privacy. Still, internet privacy issues are an evolving gray-area that if not wrong, may still be morally and ethically questionable [personal communication].

Our colleague Robert Wachter MD, author of the blog called “Wachter’s World,” says it’s important for doctors to be able to share cases, as long as they change the facts substantially. On the other hand, the author of “Wachter’s World” and a leading expert on patient safety alternately suggests “You might say we as doctors should never be talking about experiences with our patients online or in books or in articles.” But, he says that “patients shouldn’t take all the information on blogs at face value. Taken for what they are — unedited opinions, and in some cases entertainment — blogs can give readers some useful insight into the good, the bad and the ugly of the medical profession”. Link: <http://www.the-hospitalist.org/blogs> Well, fair enough! But, doctors unhappy with their current medical career choice, or its modern evolution, should probably consider counseling or even career change guidance, re-education and re-engineering. It is very inappropriate to vent career frustrations in a public venue. It’s far better for the blog to be private and/or by invitation only; if at all [Personal communication].

We believe that a hybrid mash-up of both views can be wholly appropriate, or grossly inappropriate in some cases. Of course the devil is in the details; linguistics and semantics aside. Nevertheless; what is not addressed in electronic physician “mea-culpas” are the professional liability risks and concerns that are evolving in this quasi-professional, quasi-lay, communication forum. For example, we have seen medical mistakes, and liability admissions of all sorts, freely and glibly presented. In fact,

*“Some physicians find that the act of liability blogging as a professional confession that is useful in moving past their malpractice mistakes. And, it is also a useful way to begin a commitment to a better professional life of caring in*

*the future. It helps eliminate the toxic residue and angst of professional liability and guilt. Moreover, as they are unburdened of past acts of omission or commission, doctors should remember to also forgive those who have wronged them. This helps greatly with the process and brings additional peace.”*

However, although some may say that this electronic confession is good for the soul, it may not be good for your professional liability carrier, or you, when plaintiff’s attorneys release a legion of IT focused interns, or automated bots, searching online for your self-admissions and scouring for your self-incriminations. Of course, a direct connection to a specific patient may still not be made and no HIPAA violation is involved. But, a vivid imagination is not need needed to envision this type of blind medical malpractice discovery deposition query even now.

**Q:** *“Doctor Smith, I noted all the medical errors admitted on your blog. What other mistakes did you make in the care and treatment of my client?”*

And so, the question of plausible deniability, or culpability, is easily raised. If you must journalize your thoughts for sanity or stress release; do it in print. And, don’t tell anyone about it so the diary won’t be subpoenaed. Then tear it up and throw it away. Remember, with risk management, “It is all about credibility.” Don’t trash yours! These thoughts may be especially important if you covet a medical career as a researcher, editor, educator, medical expert or something other than a working-class or employed physician.

## **§ BULLIES**

Every workplace has “micro-aggressors” or/or bullies that exhibit disruptive behavior. But, when the workplace is a hospital, it’s not just an employee problem. In one reported case, the worker, felt threatened: His superior came at him “with clenched fists, piercing eyes, beet-red face, popping veins, and screaming and swearing.” He thought he was about to be hit. Instead, his angry co-worker stormed out of the room. But, it wasn’t just any room: It was in a hospital, adjacent to a surgical area. The screamer was a cardiac surgeon, and the threatened employee was a perfusionist, a person who operates a heart/lung machine during open heart surgery. In 2008, the Indiana Supreme Court ruling in Raess v. Doescherupheld a \$325,000 settlement for the perfusionist, who said he was traumatized.

Source: Kim Painter: When doctors are bullies, patient safety may suffer. USA TODAY. April 20, 2013.

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## **OVER HEARD IN THE DOCTOR’S LOUNGE** [Fighting Physician Burn-Out]

Lisa Chu MD is a physician, life coach, sound healer, musician, body-worker, and artist, based in Half Moon Bay, California. She is the creator of *The Music Within Us*. She inspires, educates, and empowers adults to live more creatively, and more courageously. She just launched her new offering, *Live Your Medicine*, for physicians facing burnout. Lisa is considered an evolutionary leader being called to create a new definition of medicine for our world.

**Ann Miller RN MHA**  
[[www.TheMusicWithinUs.com](http://www.TheMusicWithinUs.com)]

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## **§ BUSINESS PRACTICE LITIGATION RISKS**

A recent Federal Record [FR] report stated that 25% of all suits filed in *Federal District Court* relate to a growing field of law loosely called “Business Practices Litigation.” That percentage is only likely to grow in the coming years. Business Practices Litigation encompasses a wide variety of issues, but they mostly resolve around the relationship between a business and its employees and customers. The issues include, for example, racial and sexual discrimination, sexual harassment, wrongful termination, and violations of the *Americans with Disabilities Act*. These claims are not confined to big corporations, but can affect the sole proprietor physician.

For example, a Georgia physician recently paid \$5,000 in settlement of an employment claim. Apparently, the physician would have won the claim, but only after paying over \$20,000.00 in legal fees. That \$5,000.00 settlement was not paid by the malpractice insurance carrier, but was paid by the individual physician himself.

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## **§ CAPTIVE INSURANCE COMPANIES [CICs]**

Medical practices face multiple risks in their daily operations including loss of a medical license or professional certification, legal defense reimbursement, medical/Medicare collections risk, HIPAA violations, and reputational risk. Small-to-medium-sized practices can benefit from risk-management tools that can help them handle such risks more effectively and reduce their overall insurance costs. To that end, the practice may want to consider the establishment of a Captive Insurance Company (CIC) to protect themselves from risks not typically covered by traditional insurance companies.

Captive insurance planning is a strategy for physicians to manage risk through the purchase of a property-casualty insurance policy. Premiums paid by the practice to a properly structured CIC should be tax-deductible to the practice under section 162(a) of the IRS code just like their workers’ compensation or malpractice coverage. When the

practice forms a CIC, it receives premium income tax-free up to \$1,200,000 per year, per captive. Profits that come out of the CIC come out as a distribution from a C-corp. as qualifying dividends or long-term capital gains, which are currently 15%. Furthermore, the CIC may retain surplus from underwriting profits within reserve accounts, free from income tax. Profits that accumulate within the CIC can be used as a tax-deductible sinking fund in order to save money on malpractice premiums by shifting to a high deductible policy and/or insuring that deductible through the CIC.

There are no hard-and-fast rules regarding the minimum amount of gross revenue from a practice or the minimum amount of insurance premiums paid by a practice before considering the establishment of a CIC. The establishment of a CIC creates immense planning opportunities for physicians because of the flexible ownership of the CIC. The CIC is set up as a C-Corp and someone or some entity owns the shares of the C-Corp While it's important to keep in mind the primary business purpose of the CIC is for risk management, some potential financial planning opportunities include the following, according to Guy P. Jones CFP® [personal communication]:

- J) Wealth Accumulation/Surplus Retirement Income: Physicians own the CIC outside the practice for surplus dollars in retirement.
- J) Asset Protection Planning: Most physicians have the CIC owned inside an asset protection trust to potentially shield pre-tax dollars and assets from judgment creditors or litigation.
- J) Estate Planning/Wealth Transfer: Physicians who don't need access to this money may be interested in having the CIC owned outside of their estate to also bypass gift and estate taxes with each premium payment.
- J) Practice-Owner Benefits: By the CIC not being an employee benefit plan, it is not subject to the non-discrimination rules of ERISA, and therefore only benefits the owners of the practice.
- J) Non-Mandatory Participation for Practice Doctors: Doctors at smaller levels can join together to create a CIC for economies of scale.

## **§ CAREER SELECTION RISKS**

Even as doctors enter a medical field with more paying patients under the Affordable Care Act and unprecedented numbers of job opportunities, 25 percent of “newly trained physicians” would still choose another field if they could, according to one analysis. More than 60 percent of doctors-in-training who were in the final year of their medical residency last year received at least 50 job solicitations during their training, according to a survey by physician staffing firm *MerrittHawkins*. Another 46 percent received at least 100 job solicitations. The 2015 survey of residents in their final year of medical residency, which tallied more than 1,200 responses from a sampling of 24,000, indicates that young doctors are ready to enter a world of “9 to 5” employment rather than launching their own private practice. More than 90 percent said they preferred employment with a salary rather than an “independent practice income guarantee.

Source: Bruce Japsen, *Forbes* [1/11/15]

## § CELEBRITY PATIENT RISKS

In the wake of Michael Jackson's death more than five years ago, as well as Joan Rivers on September 4, 2014, a recent essay in *American Medical News* summarizes some of the dangers physicians face by taking on celebrities. The piece cites a study which concluded that "celebrities were an average 17% more narcissistic than the general public," and perhaps because of this, some "are extremely manipulative, and there is a lot of drug-seeking behavior." When treating a celebrity, the standard doctor-patient relationship doesn't apply, with the patient's fame upsetting the dynamic: "It is a power issue," said Dr. Turton, a Sarasota, Fla., internist. "In a normal doctor-patient relationship, there is a well-defined power relationship. The doctor has the power to prescribe, and he follows his professional tenets to do that appropriately, and we depend on him for that. But, if the patient has power over the doctor, then it short-circuits those professional guidelines and safeguards. ... That is the conflict of interest — who are you really taking care of here, yourself or your patient?" [personal communication]. And, to compound that difficulty, if the doctor takes a stand against a celebrity, he or she can be easily replaced by another who will eagerly fill the role. So, beware when taking on high-profile patients. No doubt Michael Jackson's personal physician, Dr. Conrad Murray, is having some serious second thoughts right about now.

Source: <http://www.amednews.com/article/20090713/profession/307139981/2/>

## § CERTIFICATE OF NEED (CON) LAWS

Certificate of Need (CON) was a federal requirement enacted as part of the Health Planning Resources Development Act of 1974. Though the federal law was repealed in 1987, state CON programs still restrict and govern the development and licensure of medical services in approximately 36 states. The original intent of these laws was to prevent any tendency to create overutilization of healthcare services by limiting the supply of healthcare provider facilities. Nursing homes are the most commonly controlled healthcare service under state CON laws. Additionally, over one dozen states have enacted moratoriums (freezes) on the total number of nursing home beds in their respective state. In some states, nursing home bed licenses are regularly bought and sold between facilities as transferable assets. Here are the latest counts of state CON programs for various services:

- Nursing home/LTC beds: 36 states/DC
- Hospitals: 28 states
- ASCs: 27 states
- Cardiac Cath: 26 states
- Open Heart Surgery: 25 states
- Rehabilitation: 25 states
- Neonatal Intensive Care: 23 states
- Radiation Therapy: 23 states
- PETs: 20 states
- Substance/drug abuse: 19 states
- MRI: 18 states and DC
- Home Health, Hospice: 18 states
- Computed Tomography (CT): 13 states

## **§ CIVIL ASSET FORFEITURE**

Civil asset forfeiture is a “seize now, ask questions later” activity. This appears on the surface to constitute punishment without due process. However, in civil asset forfeiture there is due process, it just comes AFTER the seizure. Civil asset forfeiture is to property like an arrest is to the person. A warrant is issued stating in essence that the property did something wrong. The property is "arrested" (i.e., seized) and then a hearing or trial will follow at some later date to determine the facts. But, in February 2015, Attorney General Eric Holder reduced a related national policy called *equitable sharing*—a policy that for decades allowed law enforcement to seize billions of dollars from criminal activities.

## **§ COLLATERAL CONSEQUENCES RISKS**

Many risks inherent in medical practice also have collateral consequences. For example, making a payment in response to a medical malpractice claim requires reporting to the *National Practitioner Data Bank*. Often such a report instigates an investigation by state boards and hospital staffs. The result is that the medical license of staff privileges can be placed in jeopardy.

## **§ CONCIERGE MEDICAL PRACTICE**

Concierge medicine firm found liable for doctor’s negligence. MDVIP is the nation’s largest concierge medicine practice promising “exceptional care” and quick access to doctors in exchange for a \$1,500 annual membership fee. But, it took a big hit in 2015 when a Palm Beach County, FL jury returned an \$8.5 million malpractice verdict against the company, which has nearly 800 affiliated physicians in 41 states. It was the first malpractice verdict against MDVIP and is believed to be the first against any concierge management firm. The companies offer such perks as same-day appointments and more personalized care with contracted doctors in return for a retainer. The jury found that MDVIP was liable for the negligence of one of its physicians, who was sued for misdiagnosing the cause of a patient’s leg pain, leading to its amputation. The jury also found the firm had falsely advertised its exceptional doctors and patient care. Industry experts say the ruling is significant because it shows concierge companies can be held liable for the care provided by their contracted doctors.

Source: Phil Galewitz Kaiser Health News [2/13/15]

## **§ CONTRACT COHORT PITFALLS**

There are several key pitfalls to watch out for when evaluating an ACO, HMO, managed care organization or related cohort contract or book-of-business, as medicine migrates from a retail model; to a wholesale cohort contract business model:

- J **Profitability** — Less than 52% of all senior physician executives know whether their managed care contracts are profitable. “Many simply sign up and hope for the best.”
- J **Financial Data** — 90% of all executives said the ability to obtain financial information was valuable, yet only 50% could obtain the needed data.
- J **Information Technology** — IT hardware and sophisticated software is needed to gather, evaluate and interpret clinical and financial data; yet it is typically “unavailable to the solo or small group practice.”
- J **Underpayments** — The rate is typically between 3 – 10% and is usually “left on the table.”
- J **Cash Flow Forecasting** — MCO contracting will soon begin yearly (or longer) compensation disbursements, “causing significant cash flow problems to many physicians.”
- J **Stop-Loss Minimums** — SLMs are one-time up-front premium charges for stop-loss insurance. However, if the contract is prematurely terminated, you may not receive a pro rata refund unless you ask for it!
- J **Automatic Contract Renewals** — ACRs or “evergreen” contracts automatically renew unless one party objects. This is convenient for both the payor and payee, but may result in overlapping renewal and re-negotiation deadlines. Hence, a contract may be continued on a sub-optimal basis, to the detriment of the providers.
- Ñ **Eliminate Retroactive Denials** — Eliminate the rejection of claims that were either directly or indirectly approved, initially. Sample: “*MCO reserves the right to perform utilization review [prospective, retrospective and/or concurrent] and to adjust or deny payments for medically inappropriate services.*”
- Ñ **Define “Clean” and “Dirty Claims”** — Eliminates the rejection of standard medical claim formats like newer or updated CMS-1450, CMS-1500 or UB-92 for non-material reasons. Make payment of appropriate clean claims within some specific time period, like 30 days, in order to enhance free cash flows.
- Ñ **Reject Silent or Faux HMO or PPs, etc** — Eliminate leased medical networks or affiliates and reject further payment discounts to larger subscriber cohorts than originally anticipated.
- Ñ **Include Terms for Health Information Technology** — Eliminate the economic risk of leading edge electronic advancements like EMRs, PHRs, CPOEs, and so on.
- Ñ **Establish ability to recover payments after contract termination** — Eliminate financial carry forward for an excessive period of time.
- J **Preserve Payment Ability** — Provide medical services if requested by patients, who are then billed directly.
- Ñ **Minimize Differentials** — Establish a standardized rate structure [fee schedule] for all plans and then grant discounts for administrative or other efficiencies; rather than have different schedules for each individual plan.

## **§ CONTRACT CAPITULATION DILEMMA**

The dilemma that a medical provider will have to consider when facing the adverse effects of an *Hold Harmless Clause* is the prospective detriment to his/her practice if he/she does not capitulate to the managed care company's demand to provide indemnification for a settled case. The provider has the option to fight the issue in court. In some cases, the provider may prevail, but it is likely to be a futile and expensive effort in most scenarios. In any event, if the provider does not indemnify the managed care company, most likely, he/she will find himself/herself de-selected from the panel. Such a de-selection is likely to create a domino effect of de-selection from other panels. Such events could destroy the provider's practice.

## **§ CONTROLLED SUBSTANCES RISKS**

The Drug Enforcement Agency (DEA) controls the issuance of DEA numbers that permit the physician to prescribe controlled substances to their patients. The use of controlled substances is important to almost all medical specialties. Family practitioners use codeine to treat coughs and surgeons use narcotics to manage pain. The spectrum-of-use is wide. Unfortunately, there will always be a rogue physician willing to sell narcotic prescriptions. These physicians cause the DEA to cast a jaundiced eye towards all physicians. However, the dilemma may be that there are simply too many stories of physicians who "over-use" controlled substances in a practice designed to ease the suffering of their patients; or not? And, how do we differentiate among them all? The physician never knows when a patient coming into the office complaining of pain and asking for pain medication – whether that patient is truly in pain or not – is an undercover agent for the DEA. Has it come to *prescriber beware*? This peril and paranoia (combined with the risk of a malpractice claim of "hooking" the patient) causes some physicians to actually under prescribe pain medication. The U.S. Department of Veterans Affairs may be at particular risk [Chicago Tribune, January 9th, 2015].

## **§ CORPORATE PRACTICE OF MEDICINE (CPM) LAWS**

Approximately half of states in the U.S. have made it unlawful for practicing physicians to be employees of corporations. This ban on the *corporate practice of medicine* (CPM) is intended to keep medical professionals independent and free from financial pressures and influence. Most states have made exceptions allowing physicians to become employees of not-for-profit organizations and sometimes hospitals. States such as California, Iowa, and Texas, have declined to allow hospitals to employ physicians, although even those states have special exceptions. Iowa hospitals may employ pathologists and radiologists, and Texas public hospitals and California teaching hospitals may employ physicians. Ohio has no ban on the corporate practice of medicine. Anyone can own a physician practice in Ohio.





## § CORRECTIONAL CARE RISKS

Most primary care doctors, psychologists and psychiatrists who work in corrections long enough will end up being named in a lawsuit or having a complaint filed against them with their licensing board. It is a fact that physicians who treat inmates are at greater risk of litigation. According to the 2011-12 National Inmate Survey conducted by the Bureau of Justice Statistics:

- J Half of state and federal prisoners and jail inmates reported a history of a chronic medical condition.
- J About 2/3 of females in prisons (63%) and jails (67%) reported ever having a chronic condition
- J An estimated 40% of prisoners and inmates reported having a current chronic medical condition.
- J About 1 in 5 (21%) of prisoners and 14% of jail inmates reported ever having an infectious disease.
- J Approximately 1% of prisoners and jail inmates reported being HIV positive.
- J High blood pressure was the most common condition reported by prisoners (30%) and inmates (26%).
- J Nearly a quarter (24%) of prisoners and jail inmates reported ever having at least 2 chronic conditions.
- J 66% of prisoners and 40% of jail inmates with a chronic condition reported taking prescription medication.

And, although specific figures are not available, malpractice carriers are quite aware of this risk. Yet, according to colleague Eric A. Dover MD and Jeffrey Knuppel MD, a psychiatrist who blogs at *The Positive Medical Blog*, the risk of litigation should not be a deterrent to working as a health care professional in correction facilities if:

1. You truly like working in the correctional setting. This work is not for everyone. If you don't really like it anyway, then the thought of getting sued is just likely to decrease your career satisfaction further.
2. You have ability to be assertive yet get along well with most people. If you frequently find yourself in power struggles with people or cannot politely set limits, then do not work in corrections. If you let your ego get involved in you interpersonal interactions very

often, then you're likely to irritate many inmates, and you probably will become a target for lawsuits and complaints [personal communication].

## **§ CREDENTIALING DELAYS**

“Delegated Credentialing” is the process by which a health plan (or any other entity responsible for credentialing) agrees to turn over a portion of their credentialing review process to a qualified entity and must provide oversight over the delegate for ongoing adherence to program requirements. Delegated credentialing involves three key components. The delegation agreement outlines the responsibilities of both the plan and the delegated entity, the assessment and evaluation of the credentialing program provides the plan all information required to determine whether the proposed entity meets plan standards and ongoing oversight insures that the delegated entity continues to operate in a compliant manner. The delegation process is repeated with each plan.

## **§ CROWD SOURCED FUNDING ETHICS FOR MEDICAL CARE**

*“If we use crowd-sourcing for healthcare costs as a way to replace what a good insurance policy or healthcare system might do, then are we really creating a new health disparity?”*

So, is it fair to ask the blog-o-sphere to help pay medical and hospital bills? Is the internet a moral hazard in this case?

Source: Cari Romm, The Atlanta, March 15, 2015

## **§ CROWD SOURCED MEDICINE**

Do-it-yourself healthcare, in the guise of CrowdMed.com, harnesses the wisdom of crowds to collaboratively solve even the world's most difficult medical cases quickly and accurately online. The company offers individuals, insurance providers, and self-insured corporate customers the ability to more quickly diagnose medical conditions and reduce healthcare costs without compromising care. Founded by veteran technology entrepreneur Jared Heyman and based in San Francisco, CA, CrowdMed has received more than \$2.4 million in funding from some of Silicon Valley's top venture capital firms including NEA, Andreessen Horowitz, Greylock Partners, SV Angel, Khosla Ventures and Y Combinator. The company's advisors have founded and run some of the world's most successful online healthcare companies including WebMD. CrowdMed graduated from Y Combinator's Winter 2013 class, and was officially launched during the TEDMED 2013 conference in Washington DC. So, US physicians and consumers may be ready to embrace a dramatic expansion of the high-tech, personal medical kit. And, wearable technology, smartphone-linked devices and mobile apps will become increasingly valuable in care delivery. And, other firms like 23andMe, Navigenics, DeCodeMe, CollabRx and Cure Together, hope that genomics and aggregated patient experiences will advance fast enough so the current epidemic of “more diagnosis with less ability to

change outcomes” will morph into one where knowing your future averts adverse medical consequences.

**-D-**

## **§ DATA-BASE BREACHES**

While not a new risk, the higher prevalence is new. The risks of a being fined by OCR due to the privacy rules of HIPAA because a practice had a data-breach with their EHR are becoming more common and very expensive. The three classic components of information security and data integrity are confidentiality, integrity, and availability. iMBA Inc., colleague Richard J. Mata MD MS-CIS CMP™ [Hon], and Donna B. Parker, a pioneer in the field of computer information protection added possession, authenticity, and utility to the original three. These six attributes of information that need to be protected by information security measures is defined as follows:

1. *Confidentiality*: The protection and ethics of guarding personal information — for example, being cognizant of verbal communication leaks beyond conversation with associated healthcare colleagues.
2. *Possession*: The ownership or control of information, as distinct from confidentiality — a database of protected health information (PHI) belongs to the patients.
3. *Data integrity*: The process of retaining the original intention of the definition of the data by an authorized user — this is achieved by preventing accidental or deliberate but unauthorized insertion, modification or destruction of data in a database. Make frequent backups of data to compare with other versions for changes made.
4. *Authenticity*: The correct attribution of origin — such as the authorship of an e-mail message or the correct description of information such as a data field that is properly named. Authenticity may require encryption.
5. *Availability*: The accessibility of a system resource in a timely manner — for example, the measurement of a system’s uptime. Is the intranet available?
6. *Utility*: Usefulness; fitness for a particular use — for example, if data are encrypted and the decryption key is unavailable, the breach of security is in the lack of utility of the data (they are still confidential, possessed, integral, authentic and available).

## **§ DEBT COLLECTION AGENCIES**

According to the U.S. Department of Health & Human Services, "The Privacy Rule permits covered entities to continue to use the services of debt collection agencies; like doctordefender.com; for example. Debt collection is recognized as a payment activity within the “payment” definition (See the definition of “payment” at 45 CFR 164.501). Through a business associate arrangement, the covered entity may engage a debt collection agency to perform this function on its behalf. Disclosures to collection agencies

are governed by other provisions of the Privacy Rule, such as the business associate and minimum necessary requirements. The Department is not aware of any conflict between the Privacy Rule and the Fair Debt Collection Practices Act. Where a use or disclosure of protected health information is necessary for the covered entity to fulfill a legal duty, the Privacy Rule would permit such use or disclosure as required by law."

## **§ DE-SELECTION CONTRACT RISKS**

In the current medical environment a physician's practice does not consist of a collection of individual patients or of the "charts." A physician's practice consists of a number of managed care contracts, cohorts, or "book-of-business", that allows the physician to be a member of a panel and listed in the individual subscriber's insurance book. The patients merely flow from these contracts. Without the contracts, there will be no patient flow. Therefore, the physician faces the risk of being de-selected from an individual, or several, managed care panels. Each de-selection will have an adverse effect on the physician's practice. In actuality, the revenue lost from de-selection will come disproportionately from the net revenue of the practice. Often one de-selection will snowball into several de-selections, until the physician barely has a practice remaining. Therefore, in order for you to appeal the decision, the following guidelines are suggested in any request for a reconsideration process.

- ) Obtain a letter of explanation from the medical or clinical executive director.
- ) Ensure your initial application went through the proper channels of consideration.
- ) Contact your local plan representative, in person, if possible.
- ) Make sure your state and national medical affiliations are current; as well as hospital and surgical center staffing applications and credentials.
- ) Write a letter to the medical director and send it return receipt (U.S. mail) or by private carrier.

Inform the director of the actions you are taking [in writing] to become more attractive to the plan or what you have done to correct the deficiencies that caused your non-inclusion initially.

## **§ DIGITAL ASSET PROTECTION**

### **Facebook**

In Facebook's settings since 2015, people can now appoint a friend or family member to be in charge of their legacy. The person gets to make one last public post, download all the loved one's photos, and respond to friend requests. The decision was applauded by asset protection attorneys and estate planners—especially because it gets around the issue of needing a password to get into people's accounts.

### **Apple**

If you die, you can't designate anybody else to get into your account. "Any rights to your Apple ID or content within your account terminate upon your death," Apple's iCloud terms in the US say. "Upon receipt of a copy of a death certificate your account may be terminated and all content within your account deleted."

### **Yahoo!**

Cancelling bills, many of which are now auto-paid online or arranged through e-mail, may be difficult. Some cable or Internet providers that don't have the right pass-codes or account information can require mailing a death certificate and a legal cover letter. E-mail accounts may also give clues or avenues to other revenue streams, such as blogs with regular advertising revenue or Bitcoins, which may not otherwise be discovered.

### **Google**

Like Facebook, Google allows someone to decide whether his or her profile should be deleted after death or to create an "inactive account manager." Once that person has died, the account manager can complete a questionnaire to request data or shut it down, among other options.

Source: Sarah Frier, Bloomberg, February 2015

## **§ DIRECT PATIENT ACCESS TO LABORATORY RESULTS**

According to Patricia Salber MD [personal communication], there are a number of reasons why direct patient access to laboratory results is a good idea:

- J Between 8 and 26% of abnormal test results, including those suspicious for cancer, are not followed up in a timely manner. Direct access could help reduce the number of times this occurs
- J Self-management, particularly of chronic illness has known benefits. Just like the QS people, many folks with chronic illness obtain and manage to self-acquired lab results every day via gluco-meters, home pulmonary function tests, blood pressure measurements, and so forth. Direct access to laboratory-acquired data, one could argue is a continuation of that personal responsibility
- J Patients want to be notified about their results in what they perceive as a timely fashion. In one study, patients who received direct notification of their bone density tests results were more likely to perceive they had timely notification compared to usual care even though there was no measurable effect on actual treatment received after three months
- J Being more responsible for test results could encourage consumers to try to learn more about the meaning of the test results, conceivably increasing their health literacy.

But, the arguments against direct access discussed include the following:

- J Patients prefer their physicians contact them directly when they have abnormal test results, although the major studies published in 2005 and 2009, preceded the extraordinary use of the internet to access health information that exists today.
- J There is concern over whether patients will know what to do when they receive the results – will they make erroneous interpretations or fail to contact their docs? This could be, but the intent of the proposed rule is shared access to the results. We suspect if the rule become law, docs will develop better notification mechanisms so that they reach the patient before the patient directly accesses the results *or* lab companies will design better lab test notifications with easy-to-understand interpretations *or* a whole new industry will appear that can provide instantly available individualized lab interpretation...*or* maybe all three of these would happen and that would be a very good thing.
- J Unknown impact of dual notification (doctors and patients) of lab test results on physician behavior...would docs simply shift responsibility for initiating follow-up care from themselves to their patients?
- J Would direct access of life-changing lab tests, such as HIV or malignancy, lead to unnecessary patient anxiety – or worse? (Conversely, is there less anxiety, desperation, or suicidal ideation if the bad news is delivered face to face?)
- J Individuals likely may contact their physicians immediately after getting the lab results asking for a telephonic or face-to-face interpretation ... it is not known how this would impact physician workload and/or potential for reimbursement [personal communication, Richard Hudson DO, Atlanta, GA].

## **§ DIRECT PAY MEDICAL PROVIDER RISKS**

A cash-based medical practice or direct care provider has these basic duties:

- \* to comply with statutory duties such as the drug laws
- \* to obtain proper consent for medical care
- \* to render care that is not substantially inferior to that offered by like providers

A breach of any of these duties that causes harm to a patient can result in a malpractice suit. While the first two duties are important, it is the duty to render good quality medical care that is the basis for most malpractice lawsuits. The breach of this duty is most likely to result in a serious patient injury. The prevention of such negligent injuries is the responsibility of the individual provider, but it also basic to the institution's quality control program. From the individual provider's point of view, quality control involves continuing education, attention to detail, and retrospective review of the course of the provider's patients. The process is only loosely structured and is usually poorly documented. This lack of formal structure is less important for the individual provider because the provider's actions are judged only within the context of the injured patient in question (although previous actions may be used to negate claims of accidental injury). The legal questions is whether the care rendered the injured patient was negligent. It is

not relevant to the case if the provider carried out an effective personal quality control program.

## **§ DUTY TO TREAT RISKS**

The simplest example of a duty to render care is the duty owed to a patient already under the health care provider's care. If a patient is under the care of a physician for an acute illness, the physician cannot quit treating that patient (unless released by the patient) if it would compromise the patient's recovery. The physician may arrange to transfer the patient to the care of another physician, but this cannot be done without the patient's permission. If the transfer is done without the patient's permission, the referring physician must ensure that the new physician is equally skilled, will accept the patient, and will be equally accessible to the patient. The patient cannot be referred to a physician 100 miles away, nor can the duty to continue treating the patient be obviated by referring the patient to a physician who refuses to treat the patient. The physician has a responsibility to transfer the patient if the patient needs special care that the physician is unable to render. And, the doctor must still ensure that the patient will receive proper care as a result of the transfer. If the patient's only choice is limited care from the original physician or no care because the receiving physician will not accept the patient, it would be legally risky to force the patient to accept the no-care alternative.

The continuing duty to treat is fairly limited in chronic conditions. If the patient has a chronic condition, such as diabetes, the physician may terminate the physician-patient relationship during a stable period of the patient's illness. The patient must be given notice of the provider's intention to end the relationship so that the patient may seek care elsewhere. This notice should be in writing, and there should be a receipt indicating that the patient received the notice. If the patient is not due for an appointment or has ceased coming to the physician, the most effective way to give notice is to send a letter by certified mail. A return receipt should be requested, with delivery restricted to the addressee. When the return receipt is received, it should be clipped to a copy of the letter and placed in the patient's medical record. If the letter is returned as undeliverable, it should be placed, unopened, in the patient's record as evidence of a good faith effort to contact the patient. The physician does not owe the patient a legal duty to recommend alternative sources of care; but it is good practice to do so, and it may defuse potential disputes with the patient.

No matter how effective the notice is, it would be questionable, from a quality control point of view, if the physician should ever knowingly refuse care to a former patient who presents to the physician needing emergency care. If the patient is injured because of a delay caused by the physician refusing to render care, the physician may be sued and may have to defend the decision to refuse care. The law may be on the physician's side, but this will not prevent the expense and trauma of litigation.

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### **§ EMERGENCY ROOM [DEPARTMENT] RISKS**

In the emergency room, or department setting, indemnification means that some third person, either the physician or the emergency room service company, contracts with the hospital to pay the hospital for any losses the hospital incurs due to the negligent actions of the emergency room physician. The two requisites for indemnification are (1) that the third party be legally obligated to pay the losses, and (2) that the third party have sufficient assets to cover the potential losses. The third party is usually required to carry insurance to cover any expected losses, although this is not essential if the third party has sufficient liquid (and nonexempt) assets. Indemnification is widely used in business contracts, but it is seldom found in medical services agreements.

### **§ EMPLOYEE OFFICE RISKS**

Medical practice employees have *inside information* concerning the practice and the physician's patterns of practice. In most cases the staff is trained by the doctor. The staff's frame of reference is thereby limited to what they have been taught. However, more credit should be given to the office staff. Staff members deal everyday with insurance companies (including Medicare) and they field a wide array of patient questions and complaints. An astute staff member will soon realize if the physician is mis-coding insurance submission.

An informed, irate employee can be your biggest risk. Many medical malpractice lawsuits have been brought by patients because terminated employees have informed the patient that "something was wrong" with their treatment. Likewise, OSHA investigations have been instituted by disgruntled employees. In these cases the employee had nothing to gain but revenge against real or perceived injustices from their former employer. Now, an employee also has a financial incentive to bring health care fraud charges against their former physician employer.

### **§ EMPLOYMENT CRISIS MANAGEMENT**

Soon or later the employed medical professional, or hospitalist, will be terminated or reduced in force due to the current health reform care crisis. In the future, it will not be unusual to have a career with several different companies throughout a lifetime. This form of employment crisis management encompasses two different perspectives. If you become aware that you may lose your, job the following proactive steps will be helpful to your financial condition:

- ) Decrease retirement contributions to the minimum required to get the company match. Place the difference in your after tax emergency fund.
- ) Eliminate unnecessary payroll deductions and deposit the difference to cash.



- ) Replace group term life insurance with personal term, or universal life insurance. Take your old group term policy with you, if possible.
- ) Establish a home equity line of credit to verify employment.
- ) Borrow against your pension plan only as a last resort.

After you have lost your job, negotiate your departure and get an attorney if you believe you lost your position through breach of contract or discrimination. Then, the following retroactive steps will be helpful to your financial condition:

- ) Prioritize fixed monthly bills in the following order: rent/mortgage; utility bills; minimum credit card payments; and restructured long-term debt.
- ) Consider liquidating assets to pay off debts, in this order: emergency fund, checking accounts, investment accounts, or asset held in your children's names.
- ) Review insurance coverage. Increase deductibles on homeowner's and automobile insurance for needed cash.
- ) Then, sell stocks or mutual funds; personal valuables, such as furnishings, jewelry and real estate; and finally assets not in pension or annuities; if needed.
- ) Keep or roll over any lump sum pension or savings plan distribution directly to your new company, if possible, when you get rehired. Pay taxes, penalties and use the money only as a last resort.
- ) Apply for unemployment insurance
- ) Review your medical insurance, COBRA coverage and the PP-ACA.
- ) Eliminate un-necessary variable, charitable and/or discretionary expenses
- ) Become very frugal.

## § EMR RISKS

EMRs can increase malpractice risk in documentation of clinical findings; copying and pasting. This was first noted more than 30 years ago by Dr. Williams P. Scherer MS, of the Department of Radiology at Barry University, in Boca Raton, FL [personal communication]. As a pioneer of digital health records, he noted that previously entered information can perpetuate any mistakes that may have been made earlier. Incorrect information is the most common user-related contributing factor in malpractice cases involving EMRs, according to a study by *The Doctors Company* of EMR-related closed claims from 2007 to 2013 [personal communication]. In the study, 15 percent of cases involved pre-populating/copy-and-paste as a contributing factor. Copy-and-paste is a necessary evil to save time during documentation of daily notes, but whatever is pasted must also be edited to reflect the current situation. Too often, the note makes reference to something that happened "yesterday." For example, the sentence "Patient presented to ED with chest pain yesterday..." is pasted over the next two weeks in the daily progress note. An even more telling example is a sentence like "Patient's admitting lab is normal ..." being perpetuated while the actual creatinine levels rise every day. In one case, the judge commented about copy-and-paste issues: "I cannot trust any of the physician notes in which this occurred and the only conclusion I can reach is that there was no

examination of the patient ... it means to me that no true thought was given to the content that was going into ‘the note.’”

Checkboxes, particularly those that pre-populate, can be a physician’s nemesis. It’s easy to click on checkboxes, and often they are pre-checked in templates. EMRs have been presented in court that show, through checkboxes, daily breast exams on comatose patients in the ICU, detailed daily neurological exams done by cardiologists, and a complete review of systems done by multiple treating physicians on comatose patients. Questioning in court as to how long it takes to do a review of systems and a physical examination, the patient load of the physician for that day, and how many hours the physician was at work cast doubt on the truthfulness of the testifying physician. A time analysis showed that there was no way the physician could have accomplished all that was charted that day. The fundamental mantra when writing a note in an EMR is to show that you put thought into the record. Discrete data, though strongly favored by IT professionals and insurance companies, does not accomplish this. Free-text entry of three or four sentences can convey far more information than several pages of template-driven notes and will reflect that you saw the patient and put thought into the note.

All these common EMR issues — incorrect information, copy-and-paste, and poor note-taking — cast doubt on the integrity of the doctor and the medical record. While the doctor may not have committed a clear-cut act of malpractice, these types of issues in the medical record cast the doctor in an unfavorable light in front of a judge or jury.

Source: Keith L. Klein MD, clinical professor of medicine, David Geffen School of Medicine, University of California, Los Angeles.

## **§ ENVIRONMENTAL PROTECTION AGENCY [EPA] RISKS**

The practitioner may not think about the *Environmental Protection Agency (EPA)* when thinking about the possible risks of practicing. But, that agency could be a nightmare for the unsuspecting physician. For example, a doctor who improperly disposes of developing fluid, silver wastes, bodily fluids or bio-hazardous materials, and/or other wastes, may become a target of the EPA.

## **§ EVIDENCE BASED MEDICINE [EBM]**

A disconcerting component of the health care reform debate in 2010 was the opposition by many to research into and use of “evidence-based” practices as a means to reduce the cost of care while improving its effectiveness. Numerous studies have shown wide variability in treatment methodologies and associated costs, often on a regional basis, and have called on adoption of those practices that have show to have positive outcomes at lower costs. Opponents have condemned such proposals as “cookbook medicine” that strips away professional judgment and discretion; while supporters argue that physicians should be advocates for widespread application of such “best practices” when proven to provide more effective outcomes. This debate will continue so long as organized

medicine fails to acknowledge that widespread variation in treatments increases the cost of care without contributing to optimal outcomes.

### **§ EXCLUSION FROM MEDICARE [CMS] PROGRAM RISKS**

Medicare rules provide for a mandatory exclusion of a provider who has been convicted of certain crimes. For example, a physician who is convicted of insurance fraud (unrelated to the Medicare program) could also be excluded from Medicare participation during a five-year period.

### **§ EXIT FEE-FOR SERVICE MEDICINE**

Continuing the health insurance industry's march further away from fee-for-service medicine, UnitedHealth Group UNH +0.81% (UNH) will increase value-based payments to doctors and hospitals by 20 percent in 2015 to "north of \$43 billion." UnitedHealth, considered a barometer for the health insurance industry given its size, is rapidly departing from the traditional fee-for-service approach that can lead to overtreatment and unnecessary medical tests and procedures. Value-based pay is tied to health outcomes, performance and quality of care provided. UnitedHealth's pronouncements are in keeping with its previously stated commitment to increase payments that are tied to value-based arrangements to \$65 billion by the end of 2018. Value-based payments come in a variety of forms. They include: pay-for-performance programs, patient-centered medical homes and accountable care organizations [ACOs], a rapidly emerging care delivery system that rewards doctors and hospitals for working together to improve quality and rein in costs.

Source: Bruce Japsen, *Forbes*

### **§ EXPERIMENTAL MEDICAL TREATMENT RISKS**

What is a medical experiment? Physicians conduct experiments when they try a treatment that is different from the accepted practice in their specialty. Are experimental treatments always more dangerous than conventional treatments? No. In many cases the experimental treatment is being tried because it is believed to be safer or less painful than the conventional treatment. As a patient, can one be experimented on without any consent? No. There are very strict ethical requirements that the doctor must fulfill to obtain consent for experimental treatment. Additionally, there are legal standards that the physician must meet to ensure that your consent is informed. So, here are some of these requirements:

- J Patients must be told the details of the proposed treatment, its risks, its' possible benefits, and how it differs from the conventional treatment.
- J Patients are entitled to know how the experimental treatment was developed and the basis for any claims that are made about its safety or effectiveness.
- J Patients have the right to end the experimental treatment at any time and to be given conventional treatment.

- ) All possible efforts must be made to protect patients from any unnecessary mental or physical suffering or injury.

And, as a charity patient, may one be required to participate in medical experiments? No. A patient cannot be required to participate in medical experiments to get medical care, charitable or otherwise.

## **§ EXPERT WITNESS RISKS**

In the past, a physician expert witness for the plaintiff was merely an opposing opinion by a learned and/or like colleague. But today, it is becoming a risk management minefield; but why? Allen Frances MD, a psychiatrist and professor emeritus of Duke University suggests that many factors contribute to experts generating heat, not necessarily light [personal communication].

- ) First, some alleged experts are simply not really all that expert and say things that are just dead wrong. The filters meant to eliminate errant opinion and junk 'science' don't work.
- ) Second, the adversarial system cultivates expert allegiance bias. Consciously or unconsciously, expert opinions are strongly influenced by who is paying the bill.
- ) Third, juries often have to decide questions that are far beyond their competence. And, which dueling expert to believe is more often determined by presentation skills and likability than the technical accuracy of medical testimony?
- ) Finally, the adversarial quality of the legal system demands that experts give black-and-white, yes-or-no answers to questions that often require a shades-of-gray, nuanced response. Even wise and unbiased experts mislead when they are forced to choose a yes or no when the best answer would be maybe or a little bit of both. As it stands now, the expert testimony in some trials is pretty worthless. Each side presents an extreme set of opinions that in opposite ways distort the complex reality. The jury cancels them out or makes a pretty blind choice between them.

The AMA and other groups are urging state medical licensing boards to police expert witnesses, which might require expert testimony be considered the practice of medicine. This seems especially true with the Illinois based American Association of Neurological Surgeons (AANS). Currently, a member of the AANS can file a complaint against any fellow member for testimony as either an expert witness for the plaintiff, or defense witness for the doctor. A committee then reviews the court records and requires the accuser to face the accused in a formal review. Sanctions range from three months to a year, to complete expulsion from the association. Since 2001, the courts are beginning to take the AANS process seriously. So always remember, if you testify falsely, or too far from the norm, you may be at risk.

**-F-**

## § FACILITY FEES

Increasingly, it seems that patients are being caught off guard by new “medical facility fees” for visiting doctors who are based in a hospital-owned building. The issue is not exactly new, but it is expected to become more contentious as patients use the PP-ACA’s high deductibles, and/or those insurance plans imposed by consumer directed health care plans [HD-HCPs]. Those facilities, like Milwaukee’s Froedtert & Community Health that charge the fees, usually post warning signs although their patients often end up arguing with insurance companies over payment. Making the financial sting even worse, some insurance companies treat the facilities fee at the doctor’s office as the first dollar of what can be a high hospital deductible, rather than applying it to a physician deductible. And, the fees vary widely, from a relatively small \$20 or \$30 to a few hundred dollars. What’s even more insidious is that some hospitals are already charging patients not only for professional medical services, but also a facilities fee for physical use of the building.

## § “FASTER MEDICINE” RISKS

Our colleagues Darrell K. Pruitt DDS and blogger Kent Bottles MD are opining and posting about the emerging philosophy of “slow medicine”. Of course, health economists realize how complex and difficult it is to transform American health care so that we will enjoy lower per-capita costs along with increased medical care quality in our lives. Unfortunately, grass root practitioners have done just the opposite these last two decades or so. In other words, practicing “faster medicine” with assembly line efficiency and relegating office visits to 15, 10 or even 7 minute increments etc, in order to compensate for diminishing MCO/HMO reimbursement. And, this may have been a financially acute perspective for modernity, until now! The risks and need for speed are great [personal communication].

## § “FATIGUED MEDICINE” RISKS

Fatigue matters; even when it comes to doctors. Especially when it comes to doctors! Clinicians make many patient care decisions each day. The cumulative cognitive demand of these decisions may erode clinicians’ abilities to resist making potentially inappropriate choices. Psychologists, who refer to the erosion of self-control after making repeated decisions as *decision fatigue*, and have found evidence that it affects medical, as well as nonmedical professionals, alike.

Source: Time of Day and the Decision to Prescribe Antibiotics: Jeffrey A. Linder, MD, MPH; Jason N. Doctor, PhD; Mark W. Friedberg, MD, MPP Harry Reyes Nieva, BA; Caroline Birks, MD; Daniella Meeker, PhD; Craig R. Fox, PhD

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-H-

## § HIERARCHY OF NEEDS\*

Everyone, it seems, aspires at some point in their lives to become a doctor. It's somewhat of a dream job to most people: High pay, respect, prestige, authority. Nevertheless, for those who never made the dream come true, there's some comforting news.

*Doctor* is the most overrated profession there is, according to a website that analyzes careers. On a list of 12 most overrated jobs compiled by Career Cast, doctors — specifically surgeons, physicians and psychiatrists — occupy three of the top five spots. Only a corporate executive is more overrated. Career Cast analyzed pay, stress, physical demands and the current and future employment outlook in compiling its list. And, Wall Street's stockbrokers, vilified on Main Street, average a little over \$67,000 a year, less than some teachers.

\*NOTE: Maslow's hierarchy of needs is a theory proposed by Abraham Maslow in his 1943 paper "A Theory of Human Motivation". Maslow subsequently extended the idea to include his observations of humans' innate curiosity. His theories parallel many other theories of human developmental psychology, some of which focus on describing the stages of growth in humans. Maslow used the terms "physiological", "safety", "belongingness" and "love", "esteem", "self-actualization", and "self-transcendence" to describe the pattern that human motivations generally move through.

Source: <http://www.careercast.com/jobs-rated/most-overrated-jobs-2011>

## § HEAD-HUNTER RISKS

Any time an executive search firm makes the following claims you should push back and try to get more information before assuming it's the truth. While some can deliver, others can't - and it's up to you to figure out which ones are sincere. So, here some potential misleading statements and/or lies told to physician-executives in the hiring process:

1. There's great opportunity for advancement
2. Our bonus structure will double your income
3. Your job and schedule is protected and won't change it.
4. You'll get extensive on-boardig and training.
5. We'll hire you some help when it gets busy.
6. Once you fix this problem/department/project, etc., you'll get to work on something new and exciting.

## § HEALTH ECONOMICS OUTCOME RESEACH [HEOR]

New draft guidelines recently issued by the federal Office for Human Research Protections (OHRP) regarding the evaluation and disclosure of risks in comparative-effectiveness research (CER) fail to clarify current federal policy. If adopted, the result of

this approach will be consent forms that make research seem riskier than it truly is and make existing practices seem safer than they truly are.

Source: The New England Journal of Medicine, 11/19/14.

## **§ HEALTHCARE LICENSING LAWS**

Every state has its own licensing laws and standards for healthcare facilities, services, and professionals. State departments of health usually have a licensing division that processes new applications and renewals, performs site survey inspections, and revokes licenses when deemed appropriate. State licensure, accreditation, and Medicare certification are separate credentials, yet they are sometimes related by state law. Some states require businesses to achieve accreditation (e.g., The Joint Commission, AAAHC) as a requirement for state licensure. Some states perform Medicare surveys on behalf of the federal government. To further complicate things, different versions of healthcare building life safety codes and AIA building guidelines may be required for different state licensures, and those versions of the standards may differ from those required by accreditation organizations. In one unique example, California has no state licensure requirement for ASCs that have partial or total physician ownership. So in California, all non-physician-owned ASCs pursue state licensure, while physician-owned ASCs must instead become accredited through an accreditation organization or become certified by Medicare to satisfy California's requirements.

## **§ HISTORIC BARS TO MANAGED CARE RISKS AND LAWSUITS**

Historically, managed care companies have been afforded immunity from negligence and malpractice lawsuits. Several state and federal bars, including *ERISA (Employee Retirement Income Security Act of 1974)*, have insulated managed care companies from liability relating to the treatment of patients. Likewise, managed care companies have historically been immune from malpractice committed by a health care member of its panel of providers. On a state laws basis, the *Corporate Practice of Law* often insulated managed care companies from such liability. The theory underlying this protection was essentially uncomplicated; since corporations are prohibited under the Corporate Practice of Law Doctrine from practicing medicine, they should not be held liable for medical negligence and malpractice. However, in recent years, it has become apparent that managed care companies do in fact "practice medicine." These companies tell their panel of providers how to practice, whether it is in a generalized or specific field of medicine. They establish a formulary of approved drugs, limiting those medications available to their subscribers. They review and then approve or deny needed medical care. They create economic incentives for patients to be under treated or treated in a predetermined manner. They effectively minimize referrals to specialists, often at the peril of the patient subscriber and the health care provider seeking that consultation.

In the Federal arena, ERISA has been the primary deterrent to suits against managed care companies. Under the theory of Federal preemption, even the lowest Federal regulation

takes precedence over any and all state laws. ERISA has however been described as possessing “*Super-preemption.*” That term was coined to evince the special deference that courts have displayed to potential defendants who allege defensive protection based upon ERISA. In the past, most providers ran into the ERISA preemption when a health plan governed by ERISA was contrary to a state law, such as state anti-discrimination law (i.e., a state law prohibiting insurance payment discrimination based on degree). In the context of this chapter, the reader should understand that liability claims, such as medical malpractice claims, are a State cause of action. Since the Federal ERISA law trumps state laws, bringing a medical malpractice action against an ERISA entity is almost impossible.

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### **§ IDENTITY THEFT CONCERN**

Along with a rise in health care breaches, medical identity theft remains a top concern among patients and consumers as cyber-criminals look to capitalize on the bigger payout for PHI on the black market. Industry reports reveal medical identity theft has now claimed more than 1.8 million U.S. victims, granting hackers the ability to gain medical services, procure drugs and defraud private insurers and government benefit programs. Health care organizations face the challenge of securing a significant amount of sensitive information stored on their networks, which combined with the value of a medical identity string makes them an attractive target for cyber-criminals.

### **§ IMPROPER MEDICAL SUPERVISION**

A major class of risks involving nursing and medical students are involves injuries resulting from improper supervision. These injuries may occur because of improper delegation of authority by the staff physicians, or they may occur because of unauthorized care rendered at the initiative of the student. In the first situation, the staff would be legally liable because they authorized the medical student's overreaching behavior. The student would also be liable if it could be shown that the student knew or should have known that the actions were improper. In the second situation, the staff would be liable for failing to supervise the student properly, and the student would be liable for failing to supervise the student properly, and the student would be liable for taking unauthorized initiatives. In both situations, the student's actions would precipitate the lawsuit, but students are seldom named as defendants. The hospital and the supervising physicians are the usual defendants in these lawsuits.

Most medical malpractice suits are pieced together from the medical records after the charts have been "completed." At this point, all the student's orders will have been cosigned, and the entries will be legally attributed to the supervising physician. The supervising physician will be *estopped* from denying the validity of these orders because the countersignature legally shifts the liability from the student (and the nursing personnel who take the orders) to the staff member. The countersignature process is routine and



often lags the execution of the student's orders by the nursing staff. This puts the hospital in the legal position of depending upon after-the-fact ratification of the student's orders. This can be very risky if the order causes immediate harm and the supervising staff member refuses to countersign it. The liability for the injury will then lie with the nurse for carrying out the unauthorized order and with the hospital for failing to supervise the nurse properly.

All non-physician medical personnel - whether in a hospital, clinic, or individual practice - must be cautioned never to accept orders from a medical student without specific authorization by a licensed physician. If the authorization is verbal, it should be entered into the medical record as a voice order, that, "1 grain codeine by mouth, [verbal] voice order Mr. Smith, confirmed by Dr. Jones." Dr. Jones will then cosign the order as required by the applicable hospital or practice protocol. All members of the medical and nursing staffs should be apprised of the legal problems associated with the exercise of medical judgments by medical students. The students themselves should be warned that although the hospital and supervising physicians will usually be the defendants, plaintiffs' attorneys are beginning to name students as parties to lawsuits. This is especially true when the injury occurs because of an unauthorized action initiated by the student.

### **§ INFORMATION DISTRUSTING PATIENTS**

With the ubiquity of medical information on the internet, the risks incurred by a medical practice in properly dealing with the newly informed patients with medical degrees from the "University of Google or "Bing Medical School" are on the rise. Physicians must refine their "bed side manner" and improve their communication skills in order to deal with a more questioning patient population. Clinicians should actively discuss what patients have read on the internet when patients refer to their internet diagnoses

Source: Lam-Po-Tang, John, and Diana McKay. "Dr Google, MD: A Survey of Mental Health-Related Internet Use In A Private Practice Sample." *Australasian Psychiatry* 18.2 (2010): 130-133. *Academic Search Complete*, Web. 27 Apr. 2012.

### **§ INFORMED CONSENT IN MALPRACTICE CASES**

Evidence that a patient affirmatively consented to treatment after being informed of the risks of that treatment generally is irrelevant to a claim of medical negligence, a state high court said (Brady v. Urbas, 2015 BL 82413, Pa., No. 74 MAP 2014, 3/25/15). The Pennsylvania Supreme Court affirmed an appeals court decision that vacated a judgment for podiatrist Dr. William Urbas in a medical malpractice action brought by Maria Brady. The two higher courts held that the trial court erred by allowing the jury at trial to see a consent form Brady signed prior to her treatment by Dr. Urbas. The State Supreme court however, didn't go as far as the intermediate appeals court, which had adopted a bright-line rule that informed-consent evidence is never admissible in a medical negligence case. Such evidence might be relevant, the Supreme Court said, if the standard of care required a physician to discuss certain risks with a patient and might be relevant to establish the

standard of care itself. The consent to treatment doesn't amount to a consent to negligence - regardless of the risks - of which the patient was made aware of, it said.

Source: BNA's Health Care Daily Report [3/20/15]

## **§ INFORMED CONSENT RISKS**

According to the *Dictionary of Health Insurance and Managed Care*, informed consent is the oral and written communication process between a patient and physician that results in the agreement to undergo a particular procedure, surgical intervention or medical treatment. Unfortunately, a lack of standardization surrounding this process represents a major risk for patients and surgeons, and may lead to inaccurate patient expectations, lost or incomplete consent forms, missing encounter documentation and delays in critical surgeries and procedures.

Render S. Davis MHA CHE of Emory University [2008 recipient of the *Health Care Ethics Consortium's Heroes in Healthcare Ethics Award*] writes in the *Business of Medical Practice* [third edition], that the concept of informed consent is rooted in medical ethics and codified as a legal principle [personal communication]. It is based on the assertion that a competent person has the right to determine what is done to him or her [self-regulated autonomy]. And, The American Medical Association [AMA] recommends that its members disclose and discuss the following with their patients:

- ) The patient's diagnosis, if known,
- ) The nature and purpose of a proposed treatment or procedure,
- ) The risks and benefits of a proposed treatment or procedure,
- ) Alternatives (regardless of cost or health insurance coverage),
- ) The risks and benefits of the alternative treatments, and the
- ) The risks and benefits of not the procedure.

The requirements for informed consent are spelled out in statutes and case law in all 50 states. It is a necessary protocol for all hospitals, medical clinics, dental, chiropractic, podiatry and related healthcare practices and ASCs. Now; as a patient, may you decline to be informed about my condition, or the risks of treatment? Yes, but you should put this in writing because your physician is legally required to inform you and needs proof that you decline this information. May an adult refuse treatment, even if this means certain death? Yes. You may refuse any treatment, although the physician or hospital may ask the court to intervene. The courts have shown a strong tendency in favor of taking all steps necessary to preserve human life and will often direct treatment when a patient refuses. The right to refuse treatment is very important for certain religious groups. If you plan to refuse some or all medical care, you should fill out an explanation form before you need care, preferably with the advice of an attorney.

May a minor refuse care? Only when the minor falls into one of the categories (described above) allowing consent by a minor. However, an older minor may have the ability to

veto some care that could have a severe impact, such as a therapeutic hysterectomy for a 16-year-old minor. What if a minor and the minor's parent, or guardian, disagree over nonemergency care? If the minor falls into one of the exempt categories, the minor may refuse care even if a parent or guardian requests the care. If the health care provider has any doubts about the minor's capacity to consent, a court ruling should be obtained.

Finally, may medical care be rendered without a valid consent? Medical care may be rendered without a valid consent only in emergency situations, or when a child is apparently the victim of neglect or abuse. What recourse is there if I am being treated without proper consent? You should bring this to the attention of your physician with a written complaint, stating clearly that you do not consent to such treatment. You should keep a copy of this complaint for yourself.

### *Emergency Treatment Informed Consent*

What is an emergency? An emergency exists when treatment is needed at once to preserve the patient's health or life. Although this may be self-evident, in some situations an "emergency" can be determined only by a physician.

Is consent needed in an emergency? In an emergency, consent to necessary treatment is implied; it does not need to be given expressly. What must be done if an adult patient is unconscious but there is no emergency? Unless someone has already been legally authorized to consent for the patient, a guardian must be appointed to give consent to treatment. As indicated before, although doctors and hospitals often furnish treatment to such patients, they should insist upon the appointment of a guardian if a dispute arises as to the proper care.

### **Inadequacy of Traditional Consent Forms-to-Date**

The typical informed consent process, particularly one that relies solely on traditional generic consent forms, is often inadequate, incomplete or offers the potential for not fully explaining and documenting a particular procedure to a given patient. Traditional consent forms are subject to errors and omissions, such as missing signatures (patient, provider or witness), missing procedure(s), and missing dates that place the validity of consent at risk. Lost or misplaced forms may result in delayed or postponed procedures often at the expense of costly operating room time. Moreover, far too many forms are generic in nature and wholly unsuited for a specific patient or increasingly sophisticated podiatric procedure.

According to the Institute of Medicine's [IOM] report, *To Err is Human*, more than 1 million injuries and nearly 100,000 deaths occur annually in the United States due to mistakes in medical care. Wrong patient, wrong-side, wrong-procedure and wrong-toe surgery are particularly egregious. In fact, these are among several other "never-events" that Medicare, and an increasing number of private insurance companies are refusing to reimburse. Based on the need to make healthcare safer, the Agency for Healthcare

Research and Quality (AHRQ) undertook a study to identify patient safety issues and develop recommendations for “best practices”. The AHRQ report identified the challenge of addressing shortcomings such as missed, incomplete or not fully comprehended informed consent, as a significant patient safety opportunity for improvement. The authors of the AHRQ report hypothesized that better informed patients “are less likely to experience errors by acting as another layer of protection.” And, the AHRQ study ranked a more interactive informed consent process among the top 11 practices supporting more widespread implementation. General Accounting Office report found that malpractice insurance premiums were relatively flat for most of the 1990’s, but projections began to increase dramatically by 2016.

Failure to obtain adequate informed consent, depending on state law, may place surgeons, resident, fellows, ambulatory and office surgery centers, medical clinics and hospitals at risk for litigation ranging from medical negligence to assault and battery. And, allegations of a lack of informed consent are often a secondary factor in medical malpractice litigation. Some attorneys note that physicians are liable, and that plaintiffs may be able to recover damages, in cases involving improper informed consent, even if the procedure is successful.

The AMA advises its membership of the following regarding informed consent and liability reduction:

*“To protect yourself in litigation, in addition to carrying adequate liability insurance, it is important that the communications process itself be documented. Good documentation can serve as evidence in a court of the law that the process indeed took place. A timely and thorough documentation in the patient’s chart by the physician providing the treatment and/or performing the procedure can be a strong piece of evidence that the physician engaged the patient in an appropriate discussion.”*

### **Impact of Comprehensive Informed Consent Forms**

One iMBA, Inc., study found that providing informed consent information to patients in written form increased comprehension of the procedure [personal communication]. It was also hypothesized that:

- ) Better informed patients are more compliant with medical advice and recover faster.
- ) Informed consent discussions strengthen physician-patient relationships and increase patients’ confidence in their doctor.
- ) Well informed patients are more engaged in their own care, and are thus less likely to experience surgical errors than more passive, or less informed patients.

As a result, a particularly innovative new firm for lower extremity surgeons, podiatrists and orthopedists, offering a possible solution to the informed consent dilemma is

[www.ePodiatryConsentForms.com](http://www.ePodiatryConsentForms.com). The firm offers a suite of software programs that seem to help solve informed consent problems and enhance the education, discussion and documentation of the informed consent process for any doctor performing foot, ankle and leg reconstructive surgical procedures.

### **TV Drama and Realty Shows**

Patients caught up in emergencies are now also vulnerable to informed consent problems, posing special issues for reality TV shows. They may not be conscious or be able to speak for themselves; they may be quite literally exposed, as caregivers work to help them. So, the American College of Emergency Physicians opposes “the filming for public viewing of emergency department patients or staff members except when they can give full informed consent prior to their participation,” yet show after show returns to the emergency room, drawn by the life-or-death stakes. In an example, The New York Times Co. was sued for invasion of privacy in the early 2000s, by a group of patients in New Jersey who appeared in “Trauma: Life in the E.R.,” a series produced for Discovery’s Learning Channel. One appeals court ruled that the show qualified as news and deserved the same protections under the law. Medical ethicists and groups like the American Medical Association worry that these shows exploit patients’ pain for public consumption, but their makers argue that they educate viewers and inspire people to choose careers in medicine.

Source: Marcinko, DE: Emerging Medical Informed Consent Dilemma, Medical Executive Post, October 14, 2008

### **§ INFRASTRUCTURE RISKS**

Title X of the USA PATRIOT Act contains section 1016, entitled “The Critical Infrastructures Protection Act of 2001.” It acknowledges that the defense of the United States is based upon the functioning of many networks and that these networks must be defended against attacks of both a physical and a virtual nature. Section 1016 specifies that actions necessary to carry out policies designed to protect the infrastructure will be based upon public and private partnerships between the government and corporate and non-governmental agencies. Further, it specifies that these actions are designed to ensure the continuity of essential government functions under all circumstances. Toward this end, the act establishes a National Infrastructure Simulation and Analysis Center (NISAC) to support counter-terrorism, threat assessment, and risk mitigation. NISAC will acquire data from governments and the private sector to model, simulate, and analyze critical infrastructures including cyber, telecommunications, and physical infrastructures. Attacks on the Internet and attacks on the information systems of hospitals have already occurred in significant numbers and are likely to continue. As a result of the USA PATRIOT Act, agencies to combat information technology (IT) terrorism have been created, such as the Critical Infrastructure Protection Board and the Critical Infrastructure Assurance Office. An Information Sharing and Analysis Center (ISAC) has been created to gather, analyze, and distribute information on cyber threats and vulnerabilities, provide alerts, and develop response plans. An ISAC for healthcare that will compile industry best

practices, develop security systems, and establish a governance structure to which health systems can turn is under development.

The increasingly complex relationships among layers of hardware and software mean that new avenues for exploitation appear on almost a daily basis. Also, increased connectivity among computers means that the effects of attacks can be far reaching. One interesting consequence of the USA PATRIOT Act is that some cyber attacks can now be defined as acts of terrorism. As a practical matter, legal recourse against most attacks is of no use since laws tend to apply only locally and cyber attacks can come from anywhere in the world. As a result, most organizations concentrate on technical defenses to protect their infrastructure. However, efforts to protect computer systems may not be entirely defensive. One mode of defense is to monitor for intrusions, trace the source of intrusions, and aggressively attack and shut down the server of an intruder.

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### **§ JUSTICE FOR STUDENT LOANS**

Studentloanjustice.Org is a grassroots, citizen organization dedicated to returning standard consumer protections to student loans. The group was started in March, 2005, and has focused primarily on research, media outreach, and grassroots lobbying initiatives. The group and its members have been featured on 60 Minutes, 20/20, The News Hour, CNBC, and many other television programs, print media including the New York Times, Wall Street Journal, Washington Post, Fortune Magazine, The Chronicle of Higher Education, and many others as well as numerous radio and internet broadcasts. The group is also featured in two documentaries airing and screening in the Fall of 2010. It was credited as the inspiration for The Student Borrower Bill of Rights, and has broken numerous news items in the press with its research findings regarding conflicts of interest in the student loan system, student debt levels, default rates, corporate lobbying, and other areas. Group Founder Alan Collinge has written numerous articles and editorials on the topic, and also published The Student Loan Scam, in 2009. He was selected as one of seven "Financial Heroes" by CNN/Money Magazine in December 2008. The group is funded entirely by its members [personal communication]. Contemporary tips for managing medical school debt in 2016 can be found at: <http://www.enttoday.org/article/tips-managing-medical-school-student-loans/>

**-K-**

**-L-**

### **§ LEAVING A JOB**

With the tighter financial medical market and pressures from managed care mounting, hospitals, medical clinics and private practice employers are less likely to tolerate a non-productive employee. Inter-office or personality conflicts may become intolerable for an

unhappy or stressed physician. Leaving a hospitalist system or medical practice is never an easy decision, whether it is made voluntarily or not. A physician terminating a relationship with an employer may face emotionally charged conversations, difficult financial considerations and long-term legal consequences. Physician turnover is a common occurrence, and if not handled properly, it can be disruptive for all parties involved. So, be aware of these issues and address them proactively with your employer. This can minimize hard feelings and surprises down the road for you, your former employer and your colleagues.

### *The Employment Agreement*

Ideally, physician separation matters are addressed preemptively when the physician enters the employer-employee relationship and executes an employment agreement. Before contemplating a move, you should always start by reviewing the terms of your current employment agreement. A well-drafted employment agreement should specify the grounds for termination, both for cause (i.e., a specific set of reasons for immediate termination) and without cause (i.e., either party may terminate voluntarily, usually after providing notice). The agreement should also specify the parties' rights and obligations following a termination, which will likely vary depending on the basis for termination. Typically, an employer will provide malpractice insurance for its physicians during their term of employment. However, upon termination of employment, physicians may be responsible for the cost of "tail coverage," insurance that is designed to protect the departing physician's professional acts after leaving the employ of a practice with claims-made coverage. Because this coverage can be quite costly, a good employment agreement will often set forth terms determining whether the employer or employee-physician is responsible for the procurement and payment of tail coverage. You should also review the employment agreement in order to determine the proper method to provide notice of termination, such as first class mail, overnight courier or hand delivery. Employment agreements will often include a clause titled "Notice" that outlines the proper delivery method.

### *Termination / Separation*

Entering into a termination agreement, sometimes referred to as a separation agreement, may address and resolve many of the outstanding issues that are not otherwise addressed in the employment agreement. A termination agreement may avoid unnecessary problems down the road, including potentially acrimonious and costly litigation. The key elements of a termination agreement often include the following:

- ) The effective date of the separation, as well as what exactly is ending (e.g., employment, co-ownership, board membership, medical staff privileges);
- ) Payment terms and any buyout terms;
- ) If the physician is an owner of the practice, a requirement that he or she be removed from the board, any officer position and any retirement plan positions. Deferred compensation payments or severance pay may need to be calculated and distributed;

- ) The employer's obligations, if any, to provide the departing physician's fringe benefits and business expenses, including retirement plan contributions, health insurance, life insurance and medical dues;
- ) Explanation of any post-departure compensation, unused vacation days, bonuses or expenses due to the leaving physician;
- ) If previously addressed in the employment agreement, a reaffirmation of obligations regarding medical records, confidential information, non-competition and non-solicitation provisions. Otherwise, the termination agreement should define the physician's competitive and solicitation activities post-termination;
- ) A non-competition provision that defines the geographic territory in which, and the time period during which, the departing physician cannot compete with the former employer. Courts will render these provisions unenforceable and invalid if improperly drafted or overly broad;
- ) Non-disparagement provisions, whereby each party agrees to refrain from making any disparaging or false statements regarding the other. Non-disclosure provisions, detailing what may be disclosed to third parties, are common as well;
- ) A separation agreement that addresses the return of company property, including office key, credit card, computer, cell phone and beeper. Patient records and charts should be returned to the practice. Typically, the departing physician will still be allowed reasonable access to patient records post-termination for certain authorized purposes, often at his or her personal expense. The termination agreement may also outline how patients will be notified about the changes in the practice and the circumstances of the physician's departure. If a patient wishes to continue treatment with the departing physician, the medical practice must be ready to transition the patient; and
- ) Mutual releases, as well as any exclusions from the mutual releases, such as pre-termination date liabilities, medical malpractice claims resulting from the physician's misconduct, or taxes, interests and penalties covering the pre-termination date.

### *Severance Pay*

Depending on the circumstances surrounding the termination and the employment agreement terms, you may be entitled to severance payments on the date of termination or for a period of time post-termination. You should determine whether severance is appropriate or whether you're willing to forego severance payments in exchange for other benefits. Depending on the dollar amount and your career objectives, it may be worthwhile to sacrifice severance payments for a less onerous non-competition provision, as an example.

Source: Dr. Jay Grife Esq MA, personal communication; and Steven M. Harris, Esq., ENT Today, March 6, 2012

### **§ LICENSING DOCTORS?**



Dr. Shirley Svorny is chair of the economics department at California State University, Northridge, and holds a PhD in economics from UCLA. About a decade ago, Dr. Svorny wondered if a medical degree is a barrier – rather than enabler – of affordable healthcare. As an expert on the regulation of health care professionals, including medical professional licensing, she participated in health policy summits organized by Cato and the Texas Public Policy Foundation. She argues that licensure not only fails to protect consumers from incompetent physicians, but, by raising barriers to entry, makes health care more expensive and less accessible. Institutional oversight and a sophisticated network of private accrediting and certification organizations, all motivated by the need to protect reputations and avoid legal liability, offer whatever consumer protections exist today. Malpractice attorneys and monetary gain potential - motives, too!

Want an example of the growing wave? On February 25th 2015, the US Supreme Court ruled that the North Carolina state dental board did not have the authority to regulate the teeth-whitening businesses. In a 6-3 decision, the justices found the North Carolina Board of Dental Examiners, which is comprised mostly of dentists, illegally quashed competition from non-dentists who sought to open teeth-whitening shops in the state. And, momentum grows nationally to establish dental therapists as advocates push hard to get states to enact laws that would open the way for dental therapists to get care to people who might otherwise go without it.

Experienced nurse practitioners in New York also took a step toward greater independence on New Year's Day 2015 when new rules under the *Nurse Practitioner Modernization Act* went into effect. The rules stipulate that nurse practitioners with more than 3,600 hours of clinical practice no longer need to work under a written collaborative agreement with a physician. The required clinical experience equates to about two years in clinical practice. Nurse practitioners with less than the required amount of experience will still be required to work under a physician, according to the legislation. In addition to rescinding the collaboration requirement, the NPMA frees experienced nurse practitioners from submitting patient charts to a physician for review. The only requirement that remains that will tie experienced nurse practitioners to physicians or hospitals is that they must maintain an established relationship for referral or consultation.

These decisions have the potential to impact other professional licensing boards, across the country. And, economists who have examined the market for physician services in the United States generally view state licensing as a means by which to enforce cartel-like restrictions on entry that benefit physicians at the expense of consumers. Medical licensing is seen as a constraint on the efficient combination of inputs, a drag on innovations in health care and medical education, and a significant barrier to effective, cost efficient health care.

Source: <http://journaltalk.net/articles/5473>

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## **§ MAINTENCE OF CERTIFICATION [MOC]**

Doctors complain about onerous rules to get recertified, warning the demands will force some out of practice at a time when the nation faces a shortage. New requirements have made maintaining certifications a process that never ends. Younger doctors already retake arduous certification exams every 7-10 years to keep their credential, long considered the gold standard of expertise. But, physicians of all ages must now complete a complex new set of requirements every 2-3 years, or risk losing their certification. Supporters contend the process will ensure doctors incorporate the latest medical advances into their practices, but critics dismiss it as meaningless, costly and a waste of time.

To date, the highest-profile pushback to the new rules has come from the Association of American Physicians and Surgeons, which last year sued the American Board of Medical Specialties, and accused the organization of restraint of trade. Several other medical specialty societies (which are separate entities from the certifying boards) have also criticized the requirements. The American Association of Clinical Endocrinologists wrote that they have “no proven benefit to physician or patient,” and proposed its own alternative certificate for endocrinologists who engage in ongoing education.

Source: Roni Caryn Rabin - Kaiser Health News July 24, 2014

## **§ MALPRACTICE ATTORNEYS LIKE EHRs**

*“Lawyers smell blood in electronic medical records – as electronic medical records (EMRs) proliferate under federal regulations; as kludgy workflow processes and patient data entry quality can be problematic! The inherent issues with EMRs — and for the healthcare professionals required to learn them — hasn’t been lost on lawyers, who see the potential for millions of dollars in judgments for plaintiffs suing for medical negligence.”*

Source: Lucas Mearian ComputerWorld.com [April 13, 2015]

## **§ MANAGED CARE CONTRACT RISKS**

Attorneys are becoming more aggressive in suing MCOs, ACOs, HMOs and other managed care companies. Historical bars to such suits are declining simultaneously with recent Federal ERISA protection erosion. The upshot is that more litigation against managed care companies, their affiliates, and their health care providers are likely. The health care provider needs to be aware of these trends, needs to evaluate his/her own situation, and may need to take certain steps to limit these new evolving risks and potential liabilities. For example, the usual method of protection for the practicing physician, the use of the corporate form of business, is usually no benefit when signing managed care contracts. Most managed care companies credential the individual physician and hence require that the individual physician and not the professional corporation sign the contract. *This puts all of the physician’s personal assets at risk.*

## § MEDICAL CARE CONTRACT RISKS

The conversion to managed healthcare and capitation financing is a significant marketing force and not merely a temporary business trend. More than 60% of all physicians in the country are now employees of a MCO. Those that embrace these forces will thrive, while those opposed will not. After you have evaluated the HMOs in your geographic area, you must then make your practice more attractive to them, since there are far too many physicians in most regions today. The following issues are considered by most MCO financial managers and business experts, as they decide whether or not to include you in their network:

### General Standards

- ) Is there a local or community need for your practice, with a sound patient base that is not too small or large? Remember, practices that already have a significant number of patients have some form of leverage since MCOs know that patients do not like switching their primary care doctors or pediatricians, and women do not want to be forced to change their OB/GYN specialist. If the group leaves the plan, members may complain to their employers and give a negative impression of the plan.
- ) A positive return on investment (ROI) from your economically sound practice is important to MCOs because they wish to continue their relationship with you. Often, this means it is difficult for younger practitioners to enter a plan, since plan actuaries realize that there is a high attrition rate among new practitioners. They also realize that more established practices have high overhead costs and may tend to enter into less lucrative contract offerings just to pay the bills.
- ) A merger or acquisition is a strategy for the MCO internal business plan that affords a seamless union should a practice decide to sell out or consolidate at a later date. Therefore, a strategy should include things such as: strong managerial and cost accounting principles, a group identity rather than individual mindset, profitability, transferable systems and processes, a corporate form of business, and a vertically integrated organization if the practice is a multi-specialty group.
- ) Human resources, capital, and IT service should complement the existing management information system (MIS) framework. This is often difficult for the solo or small group practice and may indicate the need to consolidate with similar groups to achieve needed economies of scale and capital, especially in areas of high MCO penetration.
- ) Consolidated financial statements should conform to Generally Accepted Accounting Principles (GAAP), Internal Revenue Code (IRC), Office of the Inspector General (OIG), and other appraisal standards.
- ) Strong and respected MD leadership in the medical and business community is an asset. MCOs prefer to deal with physician executives

with advanced degrees. You may not need a MBA or CPA, but you should be familiar with basic business, managerial, and financial principles. This includes a conceptual understanding of horizontal and vertical integration, cost principles, cost volume analysis, financial ratio analysis, and cost behavior.

- ) The doctors on staff should be willing to treat all conditions and types of patients. The adage “more risk equates to more reward” is still applicable and most groups should take all the full risk contracting they can handle, providing they are not pooled contracts.
- ) Are you a team player or solo act? The former personality type might do better in a group or MCO-driven practice, while a fee-for-service market is still possible and may be better suited to the latter personality type.
- ) Each member of a physician group, or a solo doctor, should have a valid license, DEA narcotics license, continuing medical education, adequate malpractice insurance, board qualification or certification, hospital privileges, agree with the managed care philosophy, and have partners in a group practice that meet all the same participation criteria. Be available for periodic MCO review by a company representative.

### **Specific Medical Office Standards**

ACOs, HMOs and MCOs may require that the following standards are maintained in the medical office setting:

- ) It is clean and presentable with a professional appearance.
- ) It is readily accessible and has a barrier-free design (see OSHA requirements).
- ) There is appropriate medical emergency and resuscitation equipment.
- ) The waiting room can accommodate 5 – 7 patients with private changing areas.
- ) There is an adequate capacity (e.g., 5,000 – 10,000 member minimum), business plan, and office assistants for the plan.
- ) There is an office hour minimum (e.g., 20 hours/week).
- ) 24/7 on-call coverage is available, with electronic tracking and eMRs.
- ) There are MCO-approved sub-contractors.

### **§ MEDICAL FRAUD & ABUSE STATISTICAL BILLING RISKS**

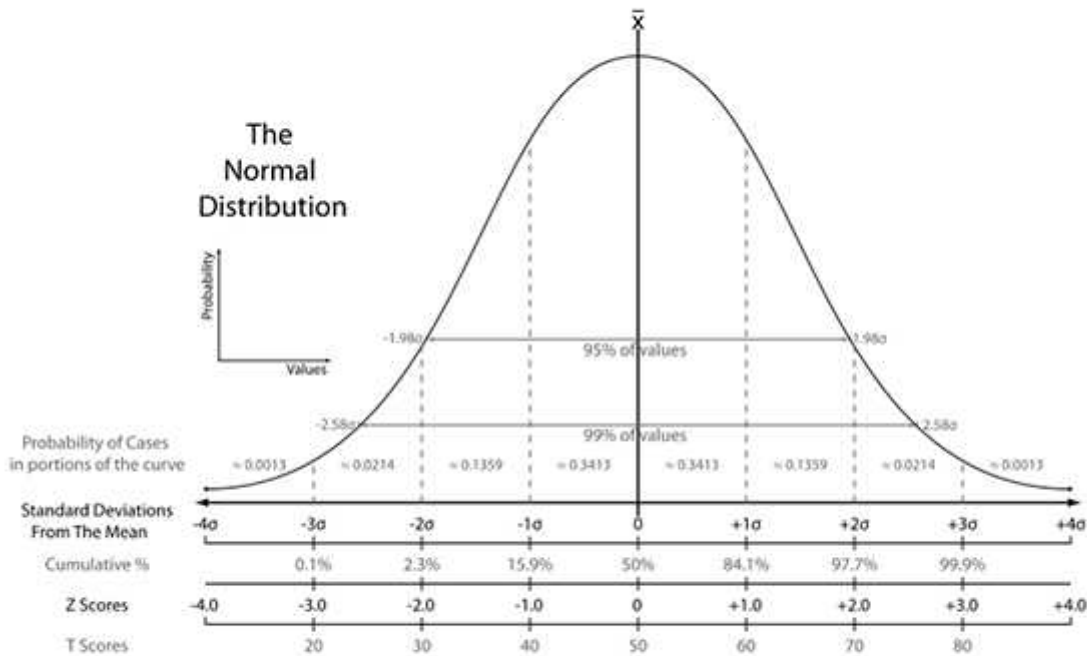
The following actions can be taken by the practitioner in an attempt to limit charges of fraud.

a. **Statistical Analysis and Fraud Investigations:** The CMS compiles data concerning fee charges and payments by all physicians. This data is broken down into various categories, such as by CPT® code, physician specialty, and state. Each and every physician should obtain a copy of this report and review it thoroughly. This data is available through CMS or can be downloaded from its internet web site. The report contains valuable yearly statistical information concerning the rendering of services to

Medicare beneficiaries. By comparing the statistics of this report with the statistics of your office, you can determine your risk of an audit. Since the likelihood of an audit is dependent upon "where the money is," then the nationwide average and the placement of your state in the table can indicate the likelihood of your being audited. Therefore the risks are that many physicians in high reimbursement states will be audited and few physicians in low reimbursement states will be audited. This is not as arbitrary as it may seem. There must be a reason why the average physician's Medicare charge in one state is higher than that of the national average. Unfortunately only an audit will determine the reason why, whether the reason is due to valid treatments or health care fraud. These statistics are available to Medicare. Since "knowledge is power," you should familiarize yourself with the data that Medicare will use in targeting audit candidates. By knowing where a likely audit will take place, the practitioner can alter procedures and documentation to ensure that such has the ability to withstand an audit.

**b. Bell Shaped Normalization Curve:** Although a bell shaped normalization curve will not ensure that you will not be audited, it can go a long way to disprove any intent to de-fraud a third party payer. Understanding your options is the first step in visualizing the bell curve.

For example, take these five traditional patient E/M codes (99201, 99202, 99203, 99204, and 99205) and five established patient E/M codes (99211, 99212, 99213, 99214, and 99215). A normal bell curve for most physicians would probably see most of the visits spread fairly evenly over the different levels of codes of each group, with a smaller amount in the level one and five codes. You can use your computer to evaluate whether your CPT® codes, especially the E/M codes and the other codes all fall within a bell curve. If these codes do not fall within a bell curve, then you should consider whether to adjust your coding patterns to bring them into a bell curve. Staying within the Bell Curve is a prudent defensive step.



**c. Contracts:** The provider should read every managed care contract. Most providers simply sign and return every contract that comes across their desk. In recent years, with so much of the population participating in some form of managed care, many providers feel that they have no choice but to sign the contract. Remember that even if the terms are not negotiable, you still have a choice of not signing the contract. If you do sign the contract, you should fully understand the risks that you are undertaking. It is okay to assume a risk, BUT, only if you understand the risk you are assuming and are willing to assume that risk. It is often not reasonable to expect that the provider will fully understand the import of many of the clauses in current managed care contract. For that reason, it is prudent to have an attorney review every contract that you intend to sign. Although it costs more initially to pay legal fees to review the contract, it could potentially save a lot of problems and money at a later date. Once you become aware of a risk or a clause in the managed care contract that is contrary to your interests, your first defensive step is to attempt to negotiate the clause out of the contract. Unfortunately, the individual provider has very little leverage in negotiating such contracts and the clause is likely to remain.

The next defensive step to take is to “Just Say NO!” Many readers will balk at that statement and will declare: “I don’t have a choice. If I don’t sign the contract, I will not have any patients!” The point is that you do have a choice. If you choose to sign the contract, then what becomes important is what you do after you sign the contract. If you

choose to sign the contract, then you should sign the contract in the name of your Professional Corporation and as agent of your Professional Corporation (*i.e., do not sign the contract in your personal capacity*). By signing the contract on behalf of your corporation, your liability (in most cases) becomes limited to your equity in the corporation.

Unfortunately, the usual method of protection for the practicing physician, the use of the corporate form of business, is usually no benefit when signing managed care contracts. That is because most managed care companies credential the individual physician and hence require that the individual physician and not the professional corporation sign the contract. This puts all of the physician's personal assets at risk. Nonetheless, the provider should attempt to sign all such contracts in the name of the corporation. Some contracts are likely to be accepted by the managed care company. When the company requires the provider to sign in his individual capacity, then the provider can make the decision at that time.

So, it is important to realize that the risks delineated above apply not only to affluent physicians, but to any physician who signs a managed care contract. A typical example resonates when the provider requests legal analysis of the contract and is quoted a fee for this professional service. More often than not, the health care provider will reject this as costing too much, yet in reality, the fee, when juxtaposed to the fees charged for medical services is generally fair and equitable. A young physician with unpaid student debt load that finds herself on the wrong end of a *Hold Harmless Agreement* with a managed care company may find herself forced into bankruptcy.

**d. Practicing Bare:** Many providers in practice would not think of "practicing bare." In the past, the term practicing bare meant that the provider did not have malpractice insurance. Current managed care contracts often require that the provider not only have certain limits of malpractice, but also that the provider shows evidence of such insurance. Therefore, many providers are under the impression that they are not practicing bare. As can be seen from the example clauses above, most providers are in effect practicing bare. Most providers have no protection from adverse results arising out of a Hold Harmless Clause in an agreement. Most malpractice insurance companies do not provide such coverage. If your malpractice insurance company does not provide coverage for such events, it is incumbent upon you and your associations to lobby the malpractice insurance carriers to provide such coverage. An additional rider, at an additional premium, for Hold Harmless coverage would help the practitioner sleep better at night.

The first question that the provider should ask is: *Would I consider practicing without malpractice insurance?* If the answer to that question is "no", then the next question that the provider should ask is: "*Why am I assuming the risk under the Hold Harmless Clause?*" If the provider cannot provide a lucid answer to that question (stating: "I have no choice," is not a lucid answer!), then the provider should not sign the managed care contract. Nonetheless, if the provider has signed managed care contracts, then the provider should understand that he is practicing bare and should take steps to reduce his

exposure. In effect, the provider should attempt to become “judgment-proof.” Such a step does present its own risks. Ultimately, the first step for every physician who signs a managed care contract, with hold harmless agreement, is to read the contract and then consult an attorney or other professional. Plaintiff attorneys are beginning to make inroads in suing managed care companies. The managed care attorneys foresaw such events and provided protection for the company in the contracts most providers have signed.

As plaintiffs become successful in suing and recovering from managed care companies, those companies are going to seek indemnity from the provider. Unless the provider protects himself, the provider is likely to become a collateral casualty of events. The current practice of medicine presents risks to the provider. The provider may not be able to insure against these risks and therefore should take defensive steps to avoid future problems.

**e. Risky Treatments Elimination:** One of the methods most often overlooked in malpractice risk management is an evaluation of the risk-reward ratio of treating certain patients or performing certain surgical procedures. Managed care has effectively reduced the reimbursement of treatments and surgeries across the board. In the past, the physician could demand a reasonable fee for the risk involved. Now, that fee is determined by someone other than the physician. Although the resource based view [RBV] values include a malpractice component, sometimes that component does not adequately reflect the risk of certain procedures or the increased risk of certain patients. Therefore, the physician should evaluate their own practice and identify those procedures and those patient types that carry a high risk of malpractice and for which the physician is not adequately reimbursed for that risk. The physician then should tailor his or her practice so that he no longer provides those services. The revenue lost will be worth the risk of the malpractice suit and the collateral consequences. This is simply the unintended consequence of insurance company and other managers reducing the physicians’ reimbursement. If the reward is high enough, people will take the risk. If the reward is reduced and the risk remains the same, fewer people will be willing to engage in that behavior, simple free market economics. A physician need not feel bad for turning away patients or dropping certain procedures from ones practice. That is simply part of risk management.

**f. Staff Education and Training:** The medical staff is an extension of the physician. Furthermore, several federal regulations, including HIPAA and OSHA have specific staff training requirements. Failure to provide the required training not only subjects the physician to the risk of employee transgression, but also to the risk of administrative discipline for failure to conduct proper training of staff.

## **§ MEDICAL SCHOOL HEALTHCARE SERVICES RISKS**

One area where indemnification may be useful is in the relationship between medical schools and non-university hospitals that are used as teaching hospitals. Past court



decisions have usually held the medical school liable for the actions of its students and staff. These decisions usually turned on the close relationship between the students, staff, and the medical school. Since the medical school staff members are also members of the hospital medical staff, the hospital could be held liable if it failed to monitor properly the competence of these medical staff members.

The problem is that the hospital is seldom able to evaluate independently the credentials of the members of the teaching staff. The usual agreement between the medical school and the hospital allows the medical school to decide who will be on the teaching staff, and it allows all members of the teaching staff to oversee the teaching in the hospital. In this type of situation, it would be in the hospital's interest to require the medical school to indemnify it against any judgments arising from the negligence of medical school personnel. Since the assets of the medical school would be large enough to pay any judgment, the indemnity would not even require the medical school to carry additional insurance. The benefits to the medical school of having the hospital accept its' students is sufficiently important that the potential risk of the agreement would be offset. This balance of interests is basic to the negotiation of indemnification agreements. The hospital can exact indemnification agreements only if the use of the hospital's resources is sufficiently valuable to offset the potential costs of the agreement to the third party.

In a teaching hospital, there are two factors that mitigate the risk to the medical school of indemnifying the hospital. First, hospitals are seldom held liable for the actions of medical students or residents. Second, in the usual malpractice suit involving a teaching hospital, the plaintiff will sue the student, the medical school, and the hospital. Unless the hospital was in actual control of the student, the hospital will be liable only if it breached its duty to monitor the overall quality of medical care. The hospital can escape liability if it can prove that it did not breach its duty to the patient. The best way to do this is to put all of the blame on the medical school. However, this will seriously compromise the ability of the medical school to defend its actions. It is better for the medical school to risk the potential losses of an indemnification agreement than to force the hospital to aid in making the plaintiff's case. In general, it is the potential infighting between defendants that provides the strongest rationale for indemnification agreements.

#### **§ MEDICAL STUDENT DEBT AND SUICIDE?**

Every year 300 to 400 physicians commit suicide. More than 10 percent of doctors are thought to have depression, a frequent precursor to suicide. Rates of depression and suicide among physicians are higher than in the general population. Many reasons including stress, heavy workload, sleep deprivation, lack of autonomy, and lack of outlets for personal care may contribute to higher vulnerability in doctors. Despite the importance of debt and financial worry, few studies have investigated their effect on physician depression and suicide. A number of studies show that higher debt leads to more burnout, a negative reaction to work-related or interpersonal stress. A Study of over 260 radiology residents found that a resident's subjective financial strain was a stronger predictor of burnout than amount of debt. Another study of over 4,000 internal medicine

residents found that more educational debt was associated with more depressive symptoms and cynicism about medicine. Burnout itself is a risk factor for depression and suicidal behaviors. Concerns about finances likely begin during medical school. Medical students worry most about finances even more than academics. Despite an increase in financial worries during course of medical school, students with financial worries are less likely to seek counseling.

Source: <http://www.kevinmd.com/blog/2015/03/medical-student-debt-lead-suicide.html>

### **§ MID-LEVEL PROVIDER RISKS**

While the use of physician extenders can bring added legal risks to a practice, they can also help prevent incidents of malpractice by providing more individualized care for patients. There are several legal theories that may be applied to attach liability to a physician for a Physician Extender's negligence. First, the physician may be directly responsible for negligent hiring of a PE. Another legal theory is a failure to supervise properly. And, the responsibility for quality assurance, including review and cosigning of charts is also a common statutory provision. Failure to perform this function may be deemed negligence *per se* such that the supervising physician may be held liable even without proof of negligence by the PE. A physician may also be held vicariously liable for the acts of a PE on the grounds that the PE is acting as an agent of the physician. In some states, statutes create a conclusive presumption of agency so that a physician will always be responsible for the negligence of a PE. In other states, liability will depend on whether the physician has a right to control the work done by the PE. It is also important to be aware, to the extent possible, of the applicable standard of care for PEs. In some states, the PE is held to the standard of care of the supervising physician, on the theory that the PE is carrying out the function of the doctor and the patient is entitled to an equivalent level of treatment regardless of the provider. In other states the PE is held to the lesser standard of a similarly trained and certified PE, while in still other states the standard of care has not yet been determined by the courts. In this latter circumstance it is best to err on the side of caution and assume that the PE will be held to the higher standard of care.

Source: Christopher D. Bernard JD Medical Economics February 18, 2015

### **§ MISTAKEN SURGERY RISKS**

While the consent of an individual patient to medical treatment is the responsibility of the treating physician, the monitoring of consent is an important part of the quality control program. Consent should be checked before surgery to ensure that there has been no confusion of patients. Performing the wrong surgery on a patient, or wrong limb, is not easily justifiable, and checking the consent form is good insurance against this type of mistake. The importance of preventing mistaken surgery mitigates against the use of oral consent for surgical procedures. The hospital will share liability for mistaken surgery because it is the hospital's employees (nurses and orderlies) who prepare the patient for surgery and actually deliver the patient to surgery. Because of this shared liability, the

hospital must demand written consent to surgery. This consent should at least describe the intended surgery so that the hospital personnel can determine if the patient is being prepared for the proper operation.

### **§ MONEY LAUNDERING RISKS**

Charges of money laundering may seem foreign to the practice of medicine. The term "money laundering" evokes visions of a suitcase of drug cash being brought into a legitimate business and being transformed into that business's receipts and later tunneled through legal channels. In medicine the route beings with receipt of a claim payment check (i.e., a check as opposed to the drug dealer's cash). The check is then deposited into the professional corporation's checking account. The funds are then paid to the physician in the form of wages. Those wages are then deposited into the physician's personal checking account. Those funds and other similarly situated funds are then accumulated until a check is written to pay for a sports utility vehicle. The money received from the alleged fraudulent insurance claim has successful been "laundered" into a hard asset (e.g., a new SUV).

### **‘§ MYSTERY PATIENT SHOPPER’ RISKS**

In 2014, the Department of Health and Human Services proposed a “mystery shopper” program to gauge primary-care physicians’ timeliness in accepting new patients, according to a notice in the Federal Register. The plan calls for contacting 4,185 primary-care physicians—465 in each of nine as-yet-unnamed states—twice, once by someone pretending to be a new patient who has private insurance and once by someone pretending to be a publicly insured patient. Scenarios will involve patients with both urgent medical concerns and those requesting a routine medical exam. The purpose of this program is to assess the timeliness with which primary-care services could be provided, gain insight into reasons why availability is lacking, and provide current information on primary-care availability and accessibility.

### **CONCLUSION**

*Medical Risk Management is no longer just about medical malpractice anymore – it has not been for some time now, despite the recent resurgence of liability fears.* In fact, since most practicing physicians have malpractice insurance, then a malpractice suit should be viewed as a mere inconvenience and the practitioner and his financial advisors should realize that the lawsuit is mainly about someone else’s money.

A shift in thought paradigm is needed. The medico-legal landscape has changed. The physician in practice today is faced with many legal challenges that have the potential to destroy the medical practice and the individual’s personal assets. These have been briefly reviewed in this chapter.

Therefore, every practice, medical clinic or healthcare entity should consider having a qualified attorney, crisis manager and/or risk management consultant on retainer. Be aware, the risks are only going to increase, going forward!

## **COLLABORATE**

Discuss this chapter online with others at: [www.MedicalExecutivePost.com](http://www.MedicalExecutivePost.com)

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## **REFERENCES**

- ) Bode, GL: Internal Medical Practice Controls. In, Marcinko, DE [editor] Business of Medical Practice Springer Publishing, New York, NY 2010
- ) Informed Consent, Comparative Effectiveness, and Learning Health Care
- ) Ruth R. Faden, Ph.D., M.P.H., Tom L. Beauchamp, Ph.D., and Nancy E. Kass, Sc.D. N Engl J Med 2014; 370:766-768 February 20, 2014 DOI: 10.1056/NEJMhle1313674
- ) Fenton, CF and Marcinko, DE: Modern Risk Management Issues for Physicians. Comprehensive Financial Planning Strategies for Doctors and Advisors. Productivity Press, Boca Raton FLA, 2015
- ) Fenton, CF: Medical Practice Sales Contract. In Marcinko, DE, Business of Medical Practice Springer Publishing, New York, NY 2010
- ) Fenton, CF: Medical Risk Management Issues. In, Marcinko DE, Insurance Planning and Risk Management for Physicians. Jones and Bartlett Publishing, Sudbury, MA 2005
- ) Marcinko, DE and Hetico, HR: Dictionary of Health Insurance and Managed Care. Springer Publishing, New York, NY 2008
- ) Marcinko, DE and Hetico, HR. Healthcare Workplace Violence Prevention. In, Hospitals and Healthcare Organizations. Productivity Press, Boca Raton, 2013
- ) Pho, Kevin: Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices. Greenbranch Publishing, 2013



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**THE END**