CHAPTER 1

Patient Care Documentation Within the Legal Environment

This introductory chapter presents an overview of the law of healthcare malpractice and its relationship to patient care documentation and other forms of professional communication, focusing on the following concepts: the legal bases for imposing healthcare malpractice liability on healthcare providers and organizations, professional negligence and the legal standard of care, depositions, expert witness testimony, patient abandonment, and judicial and legislative tort reform initiatives designed to dampen the incidence of healthcare malpractice claims and lawsuits. This chapter—like the remaining chapters—includes case examples and one or more Focus on Ethics vignettes. The material in this and in succeeding chapters explains in straightforward language how to minimize liability exposure through effective patient care documentation.

THE HEALTHCARE MALPRACTICE CRISIS

In the last four decades, the United States (expanding more recently to other nations) has experienced what has been labeled a healthcare "malpractice crisis," characterized by a public perception of increasing numbers of legal actions and larger civil malpractice verdicts in favor of patient-plaintiffs and against defendant-healthcare providers and organizations. This phenomenon has affected the practice not only of medicine, but of every primary healthcare discipline that provides direct patient care services, including: advanced clinical nurse practitioners and nurse

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anesthetists, physical and occupational therapists, physician assistants, and other primary healthcare professionals.

Primary healthcare providers face a high degree of malpractice exposure, not only because they treat patients when they are most vulnerable and at risk—sick or injured and often in pain—but also because of many other factors. External factors that increase providers' malpractice exposure include a greater sense of consumerism among the patient population, intensified federal and state regulation of healthcare delivery, and a metamorphosis in the healthcare milieu away from informal, time-intensive, personalized care in favor of increasingly competitive, rapid, "business-like" delivery of healthcare services to patients.

Some primary healthcare disciplines, including, for example, physical therapy, have undergone substantive internal professional changes that may increase their members' healthcare malpractice liability risk exposure. Some internal factors that may create greater legal risks for providers within these disciplines specifically include: expanding scope and breadth of professional practice; the increasing importance, utilization, and highly visible presence of these professions within the healthcare delivery system; the trends toward direct-access practice or practice without physician referral in more and more jurisdictions; clinical specialty certification; and the publication of practice guidelines, such as *The Guide to Physical Therapist Practice*. Note that few, if any, other healthcare disciplines have created similar comprehensive practice guides because of justifiable fear, despite any disclaimers to the contrary, that patient-plaintiff attorneys will attempt to use, and courts will allow their use, in healthcare malpractice proceedings to help fact-finders (juries and judges) understand the complex legal standard of care.

Obviously, not all healthcare malpractice claims and legal actions are frivolous. There are a substantial number of medical mistakes annually that result in serious bodily injury to, or the death of, patients. The Institute of Medicine (IOM), a Washington, D.C.-based nongovernmental organization focused on health, reported in 1999 that approximately 100,000 such medical mistakes adversely affect hospitalized patients per year. In 2004, HealthGrades, a Colorado-based private entity that assesses and publicly reports on the quality of healthcare delivery provided by hospitals, long-term care facilities, and physicians, doubled the Institute's previous estimate of annual inpatient medical mistakes to approximately 200,000. The 2005 Harvard Leape study reiterated the findings of the IOM when it concluded

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that there are approximately 100,000 annual inpatient deaths in the United States from preventable medical mistakes. A 2006 IOM report concluded that medication errors account for most of the 1.5 million patient injuries per year attributable to medical mistakes. Although not all medical mistakes constitute healthcare malpractice—some, for instance, may be attributable to non-negligent provider errors in clinical judgment or the patients' own contributory negligence—many do.

Healthcare malpractice plaintiffs do not prevail in their legal cases as often as they lose. On average, patient-plaintiffs prevail in their lawsuits against healthcare providers less than half of the time. A 2001 study conducted by the United States Department of Justice found that in the 75 largest counties in the United States, patient-plaintiffs won healthcare malpractice cases only 27 percent of the time. By 2005, there were only 14,033 healthcare malpractice case payments from settlements or court judgments nationwide, down 15.4 percent from 16,588 in 2001, according to Public Citizen's Congress Watch. The median jury verdict in medical malpractice cases in 2009 was $1,018.86, according to Jury Verdict Research.

Healthcare professionals and clinical managers can do many things in practice to minimize the incidence of claims of healthcare malpractice and malpractice lawsuits. Of paramount importance is excellence in communications between healthcare providers and patients and among healthcare providers who treat patients. In communicating with patients, providers must remember to explain in simple layperson's terms what they are doing during clinical examinations. Providers must similarly explain examination and diagnostic test results to patients (or surrogate decision-makers) in simple layperson's language. Patients not only want information about their health status and care but are entitled to it as a universal ethical and legal principle and fundamental human right. Under the mixed ethical-legal concept of informed consent, healthcare providers must convey to patients sufficient information about their health status to allow patients to make informed choices about whether to accept or decline recommended interventions. (Keep in mind that *all* proposed therapeutic interventions are recommended, not directed.) Effective clinical documentation of primary provider–patient communication processes, especially concerning informed disclosure and consent, is crucial to managing malpractice risk exposure.

In addition to effective communication with patients, healthcare providers must also communicate effectively and systematically with other healthcare

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professionals who are either concurrently treating a given patient or who will treat that patient in the future. The principal means of communicating information among healthcare providers is through patient care documentation. Accurate, timely, thorough, and concise documentation can be the deciding factor for whether a patient lives or dies. Effective documentation also has "professional" life-and-death consequences for healthcare providers charged with malpractice. In a malpractice trial, tried perhaps many years after care was rendered, what is written in the treatment record may constitute the only objective evidence of whether care given to a patient-plaintiff by a malpractice health professional-defendant met or breached minimally acceptable practice standards. While a defense attorney at trial may be able to dispel the inference that if something "wasn't documented, it wasn't done," proof by legal standards that care *was* rendered to a patient, and rendered appropriately and within the legal standard of care, is most easily facilitated through accurate, timely, thorough, and concise patient care documentation by responsible primary healthcare professionals.

Lopopolo reported that effective communication is the most important LAMP (leadership, administration, management, and professionalism) skill that a primary healthcare professional requires in order to be successful in clinical practice. In its 2006 physical therapy malpractice claims study, CNA reported that the failure to timely communicate vital patient information to other primary healthcare providers having a need to know is the most severe (costly) type of physical therapist malpractice claim it processes. CNA reported that the average indemnity (payout) for failure-to-communicate physical therapist malpractice claims was $277,425.

Consider the following hypothetical case example: A is a supervisory physical therapist; B is A's physical therapist assistant, working with patient C, who is postoperative day 6, right knee arthroscopy. C has made little progress in achieving full functional active range of motion of the right knee. In fact, C's active range of motion decreased from 25/75 on day 3 post-op to 27/70 on day 6. A directs B to write an urgent progress note, apprizing D, C's orthopedic surgeon on this fact and seeking guidance on how best to proceed. By the end of the Friday work day (when progress notes are written), B forgets to write the progress note on C. By Monday, C's right

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knee active range of motion has further decreased to 40/60, totally impeding C's gait and necessitating a costly manipulation under anesthesia the same afternoon.

In a malpractice claim for professional negligence, who is liable to C, and why? What documentation strategy would have prevented this adverse event?

A and B are both liable to C for professional negligence, or substandard care delivery. As licensed health professionals, A and B have fiduciary and legal duties to act reasonably and in C's best health interests, which both failed to do. A is legally vicariously (indirectly) responsible as a supervisor for B's patient care documentation.

The optimal approach to meet legal and fiduciary duties in this case would have been for B to write the urgent progress note immediately (assuming that B is privileged under state law and facility policy to do so), and have it checked and countersigned by A. A then should have immediately followed up the urgent notation with a phone call or instant text message to communicate directly with surgeon D.

Besides effective communication and documentation, other strategies can be used to help lessen the risk of malpractice actions. These include simple things such as treating patients with empathy and compassion; practicing only within one's personal scope of clinical competence and within the legal parameters of one's professional state practice act; consulting with other healthcare providers whenever necessary; and establishing within healthcare facilities effective, proactive quality and liability risk management programs to monitor and evaluate patient care activities, including establishing appropriate patient care documentation standards, and to minimize malpractice risk exposure.

Reflective of the expanding domain of primary healthcare practice, legal issues concerning physical therapy and other nonphysician healthcare specialties have received greater attention by legal and healthcare authors in the recent past. Along with private education entities, professional associations, including, among others, the American Health Lawyers Association, the American Medical Association, the American Nurses Association, the American Occupational Therapy Association, and the American Physical Therapy Association, are sponsoring more professional seminars on selected

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legal topics such as liability risk management, expert testimony, the legal standard of care, and HIPAA compliance, among other relevant topics.

Focus on Ethics

A is an orthopedic surgeon who has just completed right knee arthroscopic surgery on patient B. It is a Friday afternoon, past the end of the normal workday, and A does not write a postoperative therapy order or orally communicate with physical therapy about the need to commence intervention for patient B on Saturday morning. As a result, B's care is unnecessarily delayed until Monday late morning. Which of the four biomedical ethical principles (beneficence [acting in patients' best interests], nonmaleficence [do no malicious intentional harm], respect for patient autonomy [self-determination], or justice) was violated by one or more health professionals in this vignette? What systematic processes might prevent such errors in the future?

(See Suggested Answer Framework in Appendix D.)

MALPRACTICE DEFINED

Legal writers and scholars have used two approaches to defining healthcare malpractice. Under the traditional approach, the definition of healthcare malpractice includes only conduct that constitutes professional negligence: the overwhelming basis for imposition of malpractice liability. Under a broader approach, however, every potential legal basis for imposition of healthcare malpractice liability, including professional negligence, breach of a therapeutic contractual promise made by a provider to a patient, patient or client injury from dangerously defective care-related equipment or other products (strict product liability), strict (absolute, nonfault-based) liability for abnormally dangerous care-related activities, and patient or client injury that results from intentional provider misconduct in the course of patient care, may be included in the definition. Defective or incomplete patient care documentation may constitute either professional negligence or intentional misconduct, depending on the circumstances surrounding the case.

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Most of the earlier referenced bases of malpractice liability—negligence, intentional conduct, and product and strict liability—are classified as *torts* (French for "wrongs"), a class of legal actions that encompasses most personal injuries except those caused by breach of contract. Torts are classified as *private actions* because they involve injuries personal to private parties, in contrast to *crimes*, which are public actions, or wrongs against society as a whole.

Two Formulations for the Definition of "Healthcare Malpractice"

Traditional narrow definition: Professional (care-related) negligence only

Broad definition (trend): Any potential legal basis for imposition of liability, including:

- Professional negligence
- Breach of a patient–professional contractual promise
- Liability for defective care-related equipment or products that injure patients or clients
- Strict liability (absolute liability without regard for fault) for abnormally dangerous care-related professional activities
- Intentional care-related provider misconduct

The broad definition of healthcare malpractice is superior to the traditional definition in several respects. From a risk-management perspective, its inclusiveness helps to focus the attention of healthcare system and organizational managers, educators, and clinicians on more parameters than just professional negligence. Also, it serves to make everyone in the healthcare system aware of the fact that the legal system exists to protect the most widely variegated range of rights of patients and clients.

Professional negligence, breach of contract, and intentional misconduct are all fault-based bases for liability. That is, each requires a finding of some degree of culpability on the part of the defendant-healthcare provider for the plaintiff to prevail. On the other hand, product liability and strict liability for abnormally dangerous activities are non-fault-based,

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meaning that no culpability need be established for a finding of liability against a defendant. For these last two bases of liability, like vicarious (indirect) liability discussed later in the chapter, a judge or jury awards a verdict against a defendant as a matter of social policy. The operative question in such cases often is, "Between two innocent parties, who best can bear the burden of financial responsibility?"

PROFESSIONAL NEGLIGENCE

Professional negligence by healthcare providers involves delivery of patient care that falls below the standards expected of ordinary reasonable practitioners of the same profession acting under the same or similar circumstances. By definition, professional negligence involves care that falls below the minimal acceptable standards for practice, or substandard care. To be professionally negligent means that the provider did or failed to do something in the course of patient history-taking, examination, evaluation, intervention, referral, or follow-up that other, similarly situated healthcare professionals would not accept as constituting minimally acceptable care. Put still another way, professional negligence is legally actionable carelessness. Negligent substandard patient care documentation by a provider, when it causes patient injury, constitutes legally actionable professional negligence-based healthcare malpractice.

Whether care is negligent is usually determined at trial by expert testimony by one or more professional peers. To qualify as an expert, such a witness must be familiar with the following: (1) the care-related process or procedure at issue in the case, and (2) the standard of care for the defendant-healthcare provider's discipline in the relevant geographical frame of reference at the time that care and alleged patient injury took place.

Qualifications of an Expert Witness Testifying on the Legal Standard of Care

In-depth knowledge of the following:

- The healthcare examination, evaluative, or intervention-related issue in the case
- The applicable standard of care at the time that care was rendered

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A patient suing a healthcare professional for malpractice must prove the following four elements at trial: (1) The healthcare provider owed the patient a professional duty of care; (2) The provider violated or breached the duty owed; (3) The violation of the standard of care caused physical and/or mental injury to the patient; (4) As a result, the patient is entitled to money "damages" to make the patient as whole again as possible.

The standard (or burden) of proof for proving each of these required elements in civil malpractice trials is "preponderance of the evidence," which equates to "more likely than not" that the trier of fact (jury, or judge acting as fact-finder when there is no jury in the case) believes that the patient-plaintiff 's evidence presented at trial is more credible than that of the health professional-defendant.

The Four Requisite Elements of Proof for a Patient-Plaintiff in a Healthcare Malpractice Trial

1. The provider owed the patient a special duty of care.
2. The provider violated the special duty owed.
3. As a result, the patient was injured.
4. The patient is entitled to legally recognized money damages.

ORDINARY NEGLIGENCE VERSUS PROFESSIONAL NEGLIGENCE

Many clinical situations involving patient injury do not involve professional negligence, but only ordinary or general negligence. Ordinary negligence, even when it occurs in the healthcare clinical setting, does not constitute healthcare malpractice.

A common form of ordinary or general negligence involves what is termed *premises liability*. From falling on a slippery floor surface to being run into by a wheelchair or stretcher to being struck by an ambulance while walking in front of a hospital, ordinary premises negligence involves the kinds of injury-causing events that can occur in any physical setting—from

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a retail store to a college or university to a public street or sidewalk. Ordinary negligence, then, is not healthcare malpractice, as it is not directly care-related. For that reason, with ordinary negligence, an injured patient usually need not introduce expert testimony to attempt to show a breach of the professional standard of care, because everyday situations such as slips and falls are within the common knowledge of lay jurors, who thus do not need experts to explain the mechanism of injury to them.

THE PROFESSIONAL STANDARD OF CARE

When cases do involve allegations of professional negligence, the plaintiff must usually establish the applicable standard of care and its breach by the defendant-healthcare provider. There are three different formulations of the standard of care in effect in various jurisdictions in the United States. Under the traditional view, healthcare professionals are compared with reasonably competent peers practicing only in the exact same community. This standard originally was applied to prevent prejudicing rural healthcare providers who lacked comparable access to the modern technology and resources available to urban-based colleagues. Modernly, this standard is no longer applicable.

The current majority rule is to compare a defendant-healthcare professional with reasonably competent peers practicing in either the same or similar communities. In one reported physical therapy malpractice case, *Novey v. Kishawakee Community Health Services*, the court ruled that an occupational therapist lacked legal competence to testify about whether a physical therapist met or breached the standard of care, because occupational therapy and physical therapy are different "schools of medicine." This case's legal holding potentially has broad implications for healthcare professionals attempting to testify for or against healthcare professional-litigants of different disciplines on the litigant-professional's legal standard of care. (The extent of influence of the *Novey* decision on future cases depends on whether state or federal judges in cases outside of the state choose to adopt the decision as precedent. State court judges hearing cases outside the state in which a case is heard are not bound by law to follow the decision reached.)

The trend regarding the standard of care is to apply a statewide or nationwide standard to all health professionals of a given discipline and compare a defendant charged with healthcare malpractice with reasonably

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competent peers acting under the same or similar circumstances, without regard to geographical limitations. Courts (by case law) and legislatures (by statute) are imposing this standard more and more, because of standardization of education and training and because of advances in communications technology that remove earlier disadvantages of rural or isolated practitioners. The standard of care for board-certified clinical specialists is also a uniform national standard of care.

Three Formulations for the Legal Standard of Care for Healthcare Professionals

The three formulations for the legal standard of healthcare clinical practice all compare the defendant in a healthcare malpractice case with reasonably competent peers and ask whether such a peer would or could reasonably have acted like the defendant under the same or similar circumstances as existed in a pending lawsuit. The three formulations differ only in their geographical frame of reference.

1. *Traditional rule:* Compare defendant with peers in the exact same community.
2. *Modern majority rule:* Compare defendant with peers in the same community or in similar communities, statewide, or nationwide.
3. *Trend:* Compare defendant with any or all peers, statewide or nationwide, acting under the same or similar circumstances.

RES IPSA LOQUITUR: INFERENCES AND PRESUMPTIONS OF HEALTH PROFESSIONAL NEGLIGENCE

Occasionally, a healthcare malpractice plaintiff will be unable, for reasons beyond the plaintiff 's control, to prove that care-related injuries were caused by a breach of the duty of professional care by the defendant. For example, a comatose patient who is injured during surgery cannot testify

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about the cause of the injuries. Under such circumstances, courts may permit negligence to be inferred, or require it to be presumed by a jury, against a healthcare professional-defendant, under a legal principle called *res ipsa loquitur* (Latin for "the thing [i.e., the patient's injury] speaks for itself").

If negligence is merely inferable, a jury is free to infer negligence against the defendant or not, at its will. If, however, negligence must be legally presumed, then the burden shifts to the defendant to produce sufficient evidence to rebut the presumption of negligence in order to avoid the imposition of liability. For example, assume hypothetically that a comatose patient sustained a broken femur during or about the time that a defendant-registered nurse administered passive range of motion. If, under *res ipsa loquitur*, negligence is to be inferred, the jury deciding the case is free to disregard the inference, irrespective of whether the nurse's attorney puts forward evidence in an attempt to rebut or counter the inference of negligence. If, however, negligence is ordered by the judge to be presumed, a formal legal burden shifts from the plaintiff to the nurse's counsel to introduce sufficient evidence to rebut the presumption of negligence. Such evidence might consist of testimony of a radiologist who read the patient's radiographs while the patient was an inpatient (called a fact, or percipient, witness) that the patient suffered from severe osteoporosis, which might have caused the femoral fracture.

For the doctrine of *res ipsa loquitur* to apply and relieve the plaintiff of carrying the sole legal burden of production of evidence in a case, three factors must be present. First, the plaintiff's injuries must be the type that normally do not happen absent negligence (carelessness) on somebody's part. Second, the defendant-healthcare provider must have exercised exclusive control over the instrumentality that caused the plaintiff's injuries. Finally, the plaintiff must not have been contributorily negligent in causing the injury in issue.

One reported physical therapy malpractice case, *Greater Southeast Community Hospital Foundation v. Walker*, concerned a patient burned by a moist heat pack. In that case, the trial court allowed an inference of negligence under *res ipsa loquitur*. On appeal, the court reversed (disallowed) the verdict at the trial level in favor of the patient, because testimony at trial had raised a question as to whether the patient had manipulated the moist heat pack during treatment. With such a question unresolved, it was ruled that it was improper to invoke *res ipsa loquitur*, because the moist heat pack might not have been under the therapist's

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exclusive control, but also under the patient's control, and the patient might have been contributorily negligent for having manipulated the moist heat pack.

Res Ipsa Loquitur: When Negligence Is Inferred or Presumed Without Proof by the Patient

1. The patient's injury was the kind that normally does not occur absent negligence.
2. The defendant-healthcare provider exercised exclusive control over the medication, modality, or treatment that caused injury to the patient.
3. The patient did not contribute in any way to causing his or her own injury.

DEFENSES TO HEALTHCARE MALPRACTICE ACTIONS

Two important defenses available to defendant-healthcare professionals, among many others, are the statute of limitations and comparative fault. The former is a procedural defense (also known as a legal *technicality*), and the latter is a substantive defense.

Statutes of Limitations

Statutes of limitations are legislatively enacted laws in effect in every state that limit the time period within which a private plaintiff in a civil case, or a prosecutor in a criminal case, may commence a lawsuit. There are often special rules applicable to healthcare malpractice, which vary from state to state. Generally, though, the "time clock" begins to run against a patient when the patient discovers or reasonably should have discovered that he or she was injured and knows the source (but not necessarily the cause) of the injury. The running of statutes of limitations may be interrupted or *tolled* by such factors as continuous treatment by a defendant-provider, infancy (where the patient has not reached the

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age of majority), or mental incapacitation of a plaintiff. Many states, however, as part of recent tort reform, have followed the more absolute federal standard, which sets a firm two-year statute of limitations from the date of injury for initiating malpractice legal actions, irrespective of any factors or excuses.

One reported physical therapy case, *Myer v. Woodall*, concerned different statutes of limitations in effect in the state of the lawsuit for professional and ordinary negligence. What resulted was the patient, who was allegedly injured while being transported to physical therapy, was held to have the right to sue the aide who transported the patient to physical therapy but not the physical therapist or the hospital, because the professional statute of limitations had expired. The phenomenon of shortened statutes of limitations for healthcare malpractice actions, like statutes of repose, is a result of tort reform legislation designed to curb the number of healthcare malpractice legal actions.

Comparative Fault

Another major defense in healthcare malpractice legal actions is comparative fault. Comparative fault involves consideration by a judge or jury, not just of a healthcare professional-defendant's conduct, but also that of the patient-plaintiff. Under comparative fault principles, a defendant's liability may be reduced, or eliminated altogether, if the plaintiff violated the expected standard of reasonable care for his or her own safety. There are two formulations for assessing a plaintiffs fault. In contributory negligence jurisdictions, a plaintiff 's case is dismissed and the plaintiff has no legal remedy if he or she was in any way contributorily negligent in causing his or her injuries—even one percent or less at fault. Because this "all-or-nothing" rule is so harsh, it has been subject to many exceptions, such as who had the "last clear chance" to prevent patient-plaintiff injury. It is not currently the law in the overwhelming majority of states.

Most states use comparative negligence as their rule when assessing a plaintiff 's conduct. In most states using comparative negligence, a plaintiff may still prevail in a legal case if he or she was either (depending on the jurisdiction) less than 50 percent at fault or 50 percent or less at fault. A few comparative negligence states allow a plaintiff to recover irrespective of degree of fault. This concept is called *pure* comparative negligence. In a pure comparative negligence state, a patient who was 90 percent at

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fault for his or her own injuries and who sustained $2 million in damages might still recover $200,000 (10 percent of $2 million).

VICARIOUS LIABILITY

Vicarious liability addresses (in addition to partnership liability) circumstances under which an employer, such as a healthcare organization or system, bears indirect legal and financial responsibility for the conduct of a person, such as an employee. The concept of vicarious liability dates back to medieval times and, in legal circles, is often referred to by its Latin name, *respondeat superior* ("let the master answer").

Employer Vicarious Liability

The basic rule of vicarious liability is that an employer is indirectly liable for the job-related conduct of an employee when the wrongdoer (*tortfeasor*) is acting within the scope of his or her employment at the time the negligence occurred. Therefore, when a hospital-based primary healthcare provider is alleged to have committed professional negligence or care-related intentional misconduct (such as sexual battery) while treating a patient, the hospital employing the provider may be required to pay a money judgment if the provider's negligence or intentional misconduct is proven in court.

An employer's indirect responsibility for an employee's negligence does not excuse the individual provider who actually committed the negligence from financial responsibility. The tortfeasor is always personally responsible for the consequences of his or her own conduct. The concept of vicarious liability, however, gives the tort victim another party (usually with more available assets) to make a claim against or to sue. When an employer is required to pay a settlement or judgment for the negligence of an employee, the employer then has the legal right to seek indemnification from the employee for this monetary outlay.

Is it fair to impose liability on an employer who is innocent of any wrongdoing? In balancing the considerations between an innocent patient-victim and an equally innocent employer, the legal system weighs in favor of the patient. There are several good reasons for this. First, it is the employer, not the patient, who is best equipped to control the quality of care rendered by its healthcare providers. Second, the employer earns

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revenue from the official activities of its employees and contractors and should, therefore, bear responsibility for the activities that generate such revenue. Third, the employer is better able to bear the risk of financial loss—through economic loss allocation (e.g., purchasing liability insurance and establishing prices for health professional services) as part of the cost of doing business.

An employer may be held vicariously liable for wrongdoing by others who are not employees. In the relatively few cases addressing the issue, courts also have imposed vicarious liability on hospitals for the negligence of volunteers, equating unpaid volunteers with employees. For this reason, hospitals and clinics using the services of volunteers should carry liability insurance for volunteers' activities and include them in orientation to relevant policies and procedures, including workplace safety measures.

Partnership Vicarious Liability

Another area of vicarious liability involves general partnerships, wherein each partner is considered to be the legal agent of the other partner. Absent an unambiguous express agreement to the contrary, each partner normally is vicariously liable or indirectly financially responsible for the other partners' negligent acts or omissions committed within the scope of activities of the partnership.

Exceptions to Vicarious Liability

Intentional Misconduct

There are several important exceptions to vicarious liability. Although an employer may be liable for employees' negligence, the employer may not be legally responsible for unforeseeable intentional misconduct committed by its employees. An example of such unforeseeable intentional misconduct in the healthcare setting might include the commission of sexual battery on a patient by an emergency room security guard or by another patient. (Such conclusions about vicarious liability are acutely case-specific and involve considerations of whether the employer undertook all available reasonable steps to ensure patient safety.)

Independent Contractors and Their Staffs

Another exception to vicarious liability concerns independent contractors, including contract agency healthcare providers and their employees. The

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legal system distinguishes employees, for whom an employer generally is legally responsible, from contractors, for whom an employer generally is not legally responsible. This distinction is based primarily on the degree of control the employer exercises over the physical details of the professional's work product.

In some cases, courts may hold employers vicariously liable even for contractors' actions under a legal theory called *apparent agency*. When a contract healthcare provider in a clinic is indistinguishable from an employee in the eyes of patients, for example, the law may treat the contract healthcare provider as an employee for purposes of vicarious liability. Therefore, prudent healthcare employers should take appropriate steps to ensure that patients know when they are being treated by contract professionals rather than by employees (e.g., by requiring contractors to wear name tags that identify their status as contract personnel, and/or by posting photographs identifying employees and contract professionals in a clinic reception area).

PRIMARY EMPLOYER LIABILITY FOR ACTIONS OF EMPLOYEES AND CONTRACTORS

A healthcare organization or system may be directly or primarily liable for employees' or contractors' conduct. Such liability exists independent of any vicarious liability that may also apply. An employer is directly liable under the legal concepts of negligent selection and retention, for example, for the wrongful actions of employees or contractors whom the employer reasonably should have: (1) rejected for employment, (2) carried out remediation for deficiencies for, or (3) discharged from employment.

Under law, hospitals and private clinics have certain responsibilities that they may not delegate to employees, professional medical staff, or independent contractors, under a legal concept called *corporate liability*. Such responsibilities are called *nondelegable duties*. Under corporate liability theories, courts have imposed various nondelegable duties on hospitals, including the following, among others: (1) a duty to use due care when selecting, privileging, and recredentialing physicians and surgeons and when evaluating the credentials and privileges (as applicable) of other primary healthcare providers; (2) a duty to ensure that premises

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and medical equipment are safe and adequate for patients, visitors, and staff; (3) a duty to establish patient care quality standards for their organizations and departments and divisions, and to monitor and evaluate the quality of patient care on an ongoing basis; and (4) a duty to continuously monitor the competence of professional and support personnel within the facility.

LIABILITY FOR PATIENT ABANDONMENT

Legally actionable abandonment of a patient occurs when a healthcare provider improperly unilaterally terminates a professional relationship with a patient and may be classified either as professional negligence or intentional misconduct, depending on the circumstances of the abandonment of the patient. Many patient care-related activities can constitute actionable abandonment, from momentarily leaving a patient unattended to refusing to work overtime during an emergency. Although a healthcare provider has almost absolute discretion in electing whether to form a professional relationship with a patient, certain legal rules must be complied with to terminate an existing patient–professional relationship properly. The law imposes a special duty of care on a healthcare provider caring for a patient, similar to the special duty owed by an attorney to a client or a parent or guardian to a child under his or her charge.

Patient abandonment has become a greater issue because of managed care, under which considerations of cost containment may cause third party payers to limit patient care to a set number of visits. Healthcare clinical professionals, not administrators or clerical personnel, are legally charged to determine the duration of patient care. Clinicians must take reasonable steps to appeal, when appropriate, administrative length-of-care decisions adverse to their patients and in contravention to their clinical judgment. Careful and appropriate documentation of justifications and rationale for such appeals (in patient health records and even in memoranda not filed in patient records) are crucial to generate and maintain in order to justify such appeals, and to minimize the likelihood of patient abandonment liability for clinical healthcare professionals.

Termination of the healthcare provider–patient relationship is justified when the patient makes a knowing, voluntary election to end the relationship, either unilaterally or jointly with the provider. The provider may initiate termination of the professional relationship with the patient

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when a medical condition under care has resolved. Unilateral termination of the relationship by the provider also properly may occur when, in a rehabilitation health professional's judgment, the patient has reached the zenith of his or her rehabilitative potential. Such a situation requires careful documentation in the patient's care record that will pass legal scrutiny should a healthcare malpractice action arise. (How to document such a situation and others discussed herein are addressed in later chapters.) Also, a healthcare professional must always communicate the fact that the patient has been discharged to a referring entity any time a patient has received care pursuant to a referral.

Negligent Abandonment

If a patient claims that he or she was discharged prematurely, then the legal action that results may be a professional negligence-based healthcare malpractice action. As with any other health professional negligence case, the plaintiff-patient will have to prove the following four elements by a preponderance, or the greater weight, of evidence: (1) the provider owed a duty of care to the patient; (2) the provider violated the duty by negligently unilaterally terminating the professional relationship prematurely; (3) the provider's improper discharge of the patient caused harm to the patient ("causation"); and (4) the patient suffered legally cognizable damages, such as pain and suffering, additional medical expenses, and lost wages that warrant the award of money damages to attempt to make the patient whole.

Intentional Abandonment

In contrast to negligent abandonment of a patient, a healthcare provider also may be charged with intentional abandonment of a patient, which carries with it more serious adverse consequences. As an intentional tort, intentional abandonment carries with it the possibility of a punitive (exemplary, i.e., "making an example") damages award should the patient prevail at trial. In most cases, the defendant's professional liability insurer will not be obligated (or even permitted) to indemnify the insured if the intentional conduct is adjudged to be sufficiently egregious to justify the imposition of punitive damages against the defendant-healthcare provider.

Intentional abandonment might involve situations in which a patient is discharged for reasons such as failure to pay a bill, a personality conflict with a treating healthcare professional, or an insurance denial of

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reimbursement for further care. Under such circumstances, the provider must, at a minimum, give advance notice to the patient of the provider's intent to terminate the relationship; give the patient a reasonable amount of time to find a suitable substitute healthcare provider, and assist the patient in finding a suitable substitute healthcare provider, if applicable. Any information about the patient—examination findings, diagnosis, or intervention-related data—must be communicated to the substitute care provider expeditiously. The provider transferring the patient must be sure to document in the patient's record the patient's health status at the time of discharge. As a risk-management measure, such a provider transferring a patient should also carefully memorialize in risk management documentation the steps undertaken to assist the patient in finding a substitute care provider. This can be done in the form of an office memorandum, which should be retained for the period of the statute of limitations and then only disposed of under advisement of the provider's or healthcare organization's legal counsel.

Substitute Healthcare Providers

Two special situations bear mentioning. One basis for an abandonment complaint might be that a healthcare provider left a patient in the care of a substitute healthcare provider while the original provider went on vacation, to a conference, or elsewhere for personal or business reasons. In settings in which patients contract for care with specific named clinicians, such as may occur in outpatient private practice settings, such providers must be sure to obtain and document the patients' informed consent before transferring care to substitute healthcare providers. (In hospital and health maintenance organization [HMO] settings, by contrast, patients do not normally contract for care with specific healthcare providers, so that the issue of abandonment during vacations and other periods of coverage does not normally arise involving providers in such settings.)

Abandonment Issues in the Limited Scope Practice Setting

Another problem concerns providers such as medical physicians, psychologists, social workers, physical and occupational therapists, nurse practitioners, dieticians, and other healthcare professionals who operate limited-scope practices. Consider as an example a nurse practitioner specializing exclusively in the care of pediatric and adolescent patients with orthopedic or sports-related injuries. Is such a provider at liberty to

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refuse to treat an unrelated condition involving a current patient? The answer is probably "yes"; however, the clinician must inform the patient before forming the health professional–patient relationship of the limited nature of his or her practice and obtain the patient's informed consent to undergo limited-scope care. Effective documentation of the patient's informed consent to limited-scope care can be crucial in avoiding healthcare malpractice abandonment liability should a claim or lawsuit arise.

When a Healthcare Professional May Be Required to "Abandon" a Patient

Certain circumstances may require a treating healthcare professional to disengage from caring for a patient, such as when the provider terminates his or her employment with a hospital or clinic, or when a patient's third-party reimbursement for care terminates. Depending on the circumstances in each particular case, such a provider may be required to continue necessary care on a *pro bono*, or free-of-charge basis, even when third-party reimbursement terminates. Providers and healthcare organizations should always consult with their attorneys before discharging patients still in need of care under such circumstances.

BASES OF LIABILITY OTHER THAN NEGLIGENCE

The vast majority of reported healthcare malpractice legal cases involve allegations of professional negligence by providers. This is so in large part because courts are reluctant to allow patients to sue for non-negligence-based breach of contract in the healthcare setting, in part because of the special status relationship between primary healthcare professionals and patients. Similarly, courts hesitate to permit patients to sue healthcare providers over injuries from defective products because the delivery of health care is generally viewed as the rendition of a professional service, not the sale of a product. This is changing, however, as more and more healthcare professionals market care-related products in their clinical practices in order to generate necessary revenue in the managed care practice environment. In such cases, courts may permit imposition of strict product liability when dangerous, defectively designed or manufactured healthcare products injure patients, their family members, and other third parties.

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Few healthcare malpractice cases generally are premised exclusively on the issue of a lack of informed consent. Still, this blended ethical-legal area of responsibility is of great importance for all clinicians. Every primary healthcare provider is legally and ethically responsible for obtaining patients' informed consent before treatment. This important area of law and ethics is explored in greater detail in Chapter 4.

OTHER SETTINGS AND CONSEQUENCES OF MALPRACTICE ACTIONS

Criminal Proceedings for Conduct That Also Constitutes Malpractice

Besides a civil malpractice lawsuit, a health professional alleged to engage in gross (substantial) negligence, reckless conduct, or intentional misconduct may face criminal legal proceedings and adverse administrative actions before licensure boards and certification entities. Criminal actions are judicial proceedings but differ from civil malpractice legal actions in that a state or federal prosecutor brings the criminal case against the defendant on behalf of public interests, rather than the interests of an individual victim. Because the prospective penalties and stigma are more severe, the standard of proof—beyond a reasonable doubt—is much higher than the preponderance of evidence (or greater weight of evidence) standard generally in effect in civil court and administrative legal proceedings.

The consequences of a finding of liability in a civil malpractice trial and a finding of guilt in a criminal trial are also different. If a civil defendant is adjudged liable, the patient-plaintiff normally is awarded compensatory money damages for expenses such as lost wages, medical expenses, pain and suffering, loss of enjoyment of life, and property losses. Normally, a civil defendant's insurer indemnifies the insured and pays off such a money judgment. In egregious cases involving reckless or intentional misconduct, a civil jury or judge may award punitive damages to a plaintiff, for which a defendant's insurer might lawfully refuse to indemnify. The penalties for a criminal defendant found guilty of a crime normally are limited to incarceration (or the threat of incarceration, i.e., probation or confinement to one's home) and a monetary fine.

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Administrative and Professional Affiliation Actions

Adverse administrative actions affecting license and/or certification affecting the very ability to practice one's profession may be taken by state administrative licensing agencies and certification entities, and, in the case of a health professional license, typically require a hearing to protect the constitutional due process rights of the respondent (the administrative equivalent of a "defendant"). Private professional association actions affecting professional association membership likewise may result from healthcare malpractice actions that involve professional ethical infractions.

MALPRACTICE TRIAL PRACTICE AND PROCEDURES

Roles of Healthcare Professionals in Malpractice Proceedings

A healthcare provider can take one of three roles in a civil malpractice proceeding: fact witness, expert witness, or defendant. The *fact witness* is probably the most familiar role. Also called an *eyewitness* or *percipient witness*, the fact witness possesses relevant firsthand knowledge about the issues and merits of a legal case important to one or both sides. A percipient witness might include a healthcare clinician or extender, an aide, or a chaperone who observed patient care activities involving a patient-litigant. Like experts and defendants, fact witnesses may be called upon to answer questions in interviews or under oath in depositions by one or both parties in a case during the pretrial, case-building "discovery" phase of the trial process. Fact witnesses normally do not have the discretion to withhold their testimony or admissible opinions, and they normally testify subject to a subpoena or court order. Fact witnesses are normally reimbursed according to fixed (low) statutory fee schedules, rather than being allowed the opportunity that expert witnesses have to negotiate higher fees with the party calling them to testify.

Primary nonphysician healthcare professionals find themselves more frequently in the role of healthcare malpractice defendant, as disciplines other than medicine are increasingly swept up in the malpractice litigation crisis. As a party defendant, a healthcare professional faces serious adverse professional and personal consequences should a verdict be rendered

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against him or her, including monetary losses, loss of reputation and goodwill, and adverse administrative actions at the state and federal levels. This fact is not presented with the intention to frighten healthcare providers into practicing and documenting patient care defensively. Rather, it is to familiarize them with the legal system and its processes, and to make them aware of the need to sequester patient care records and seek out and obtain legal representation expeditiously whenever a potentially compensable event such as a patient injury ripens into a claim or lawsuit. It is vitally important to follow legal counsel's advice and, in particular, to refrain from talking about any potential or actual legal action against you with anyone except counsel or counsel's agents (e.g., paralegal professionals and investigators working for the healthcare provider's attorney). The same admonition applies to written correspondence about a pending case when you are a healthcare malpractice defendant. Do not send any out, without legal counsel's review and concurrence!

Pretrial Proceedings

A healthcare provider must notify his or her facility legal department, personal professional liability insurance representative, and personal attorney immediately upon receipt of any legal papers concerning a patient's care. When a lawsuit is filed, the first papers served normally are the *summons* (notice of an impending lawsuit) and the *complaint* (specifying an incident or events allegedly causing a patient injury as well as the amount of money damages sought against the defendant-healthcare professional or organization). An insurer will expeditiously assign legal counsel to the case to file an *answer* to the patient-plaintiff's initial *pleadings*.

Once the complaint, answer, and other responsive papers have been exchanged and filed with the court having *jurisdiction* (control) over the case, pretrial discovery begins in earnest. The parties to the lawsuit may require each other (but not each other's witnesses) to answer formal questions called *interrogatories*. The defendant-healthcare provider may even be called on by the plaintiff to concede liability in what is called a *request for admission*. Documents, including authenticated or certified copies of patient treatment records, will be requested by the patient's attorney, and other tangible evidence, such as equipment used in the course of treatment, may have to be produced for inspection by the plaintiff's expert(s).

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Depositions: Procedures and Precautions

The deposition is probably the most familiar discovery device, because many healthcare professionals have undergone depositions as expert witnesses or potential or actual malpractice defendants in the past. A deposition consists of sworn testimony of a party or potential party to a lawsuit, or of a fact or expert witness. It is usually taken in the office of the attorney representing the *deponent* (person being deposed) or in another seemingly informal neutral environment. To reduce stress, try to avoid being deposed at your place of work, such as a healthcare organization, where, among other things, interruptions by staff, patients, vendors, and others might affect your necessary concentration on the legal proceedings.

Irrespective of where a deposition takes place, do not as a deponent be lulled into a false sense of security because of the apparent informality of the deposition process. A deposition is a serious legal proceeding, the consequences of which are as important as trial testimony. A court reporter transcribes every word—formal and informal, "on" or "off" record—that every participant in the deposition says. The transcribed deposition may later be introduced at trial, especially to refute trial testimony that may be inconsistent with prior sworn testimony given at the deposition.

If healthcare professionals reading this section take just one piece of advice from it, it is that **they should never undergo a deposition either as a witness or defendant without prior consultation with and preparation by their attorneys**. This does not mean that every deponent needs to have an attorney present to represent him or her at deposition. Bear in mind, though, that a health professional-deponent called on to testify as a witness to an event may be named as a healthcare malpractice defendant the next day as a result of deposition testimony. One of the primary purposes of depositions is for attorneys for both plaintiff(s) and defendant(s) to discover relevant facts that will lead to evidence that will enable them to prevail at trial, or to facilitate a pretrial settlement of the case.

Healthcare Professionals as Expert Witnesses

The overwhelming majority of malpractice (and all other legal) cases are disposed of through means short of resorting to trial, principally through pretrial settlement or outright dismissal of cases. Should a healthcare malpractice case progress to trial, however, the verdict will probably turn on expert testimony. Healthcare professionals may qualify as experts

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for many purposes (e.g., as rehabilitation consultants regarding patient-plaintiffs' rehabilitation or vocational needs or potential). However, the principal area in which they testify as experts in malpractice proceedings is as clinical experts on whether a defendant-healthcare provider's treatment of a patient-plaintiff met or fell below (*breached*) the legal standard of care.

An expert witness on the standard of care may testify for either the patient-plaintiff or for the healthcare provider or organization-defendant. To meet the legal standard of care and avoid being adjudged negligent, a clinical healthcare professional caring for a patient must exercise that special knowledge and skill characteristic of reasonably competent peers acting under the same or similar circumstances. More specifically, a healthcare professional-defendant is expected by law to use examination, evaluative, diagnostic, prognostic, and intervention techniques and procedures that constitute at least minimally acceptable professional practice. Always bear in mind that legally acceptable care equates to minimally acceptable standards of practice, not necessarily what is optimal or even average. "Best care" is not at issue; the legal standard of care focuses on the "floor," not the "ceiling."

Before testifying as an expert on a professional standard of care, a witness must first be qualified as legally *competent*, based on expertise concerning the specific aspect of patient care at issue in the case. Oftentimes, the opponent's attorney will offer to stipulate to the qualifications of an expert witness. In such a case, the judge and jury do not have an opportunity to hear about the expert's academic background, professional publications history, or other individual attributes and achievements. Counsel presenting a witness as an expert may wish, in such situations, to seek the court's permission to enter the witness's qualifications into the record anyway. This exposure to the expert's qualifications will enhance the credibility of the expert in the eyes of the fact-finder and may lead to the fact-finder giving greater weight to the expert's testimony and opinions during deliberations on liability.

Erickson identified three cardinal attributes of an expert witness: (1) consistent superior performance, (2) successful practice outcomes, and (3) measurable, replicable processes and results. Liptak opined that experts selected by the parties instead of by the court are less helpful to juries in deciding cases. (In most other nations, judges appoint what are supposed to be only neutral experts in legal cases.)

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A very important item of documentation in support of healthcare malpractice litigation is the expert witness report. This document is used by plaintiff-patients and defendant-healthcare providers and organizations to bolster their cases. Anyone serving as a consulting expert to a party to litigation should coordinate with the employing legal counsel before reducing an oral report to writing. Written expert witness reports may be legally "discoverable" by opposing counsel, even though they are considered semiprotected "attorney-work product." Ideas generated by an expert working for an attorney, however, enjoy greater protection from involuntary release than expert conclusions under a deliberative processes exemption.

All healthcare professionals should consider it a civic duty to honor a request by an attorney or a court or other public agency to testify as an expert on the standard of care in a case or administrative legal action. If health professionals from within the same discipline as a healthcare professional-defendant under charges do not come forward and assume responsibility for so testifying, members of other disciplines may fill the void and opine on another profession's practice standards, perhaps in an incomplete or incorrect manner. Attorneys and judges in individual cases will normally seek out appropriate expert witnesses from academic and clinical settings, or through referral by litigants and others in the trial process.

Potential and current expert witnesses must maintain and disseminate a fee schedule to prospective clients. The fee schedule for services must be reasonable for the market to be legal and ethical. Components of a fee schedule include charges for consulting, reviewing patient care records and other documents, report writing, travel time, and testifying either at deposition or at trial. Once an expert commits to being a testifying expert, he or she is ethically bound to live up to that commitment.

Some states have enacted tort reform legislation that affects expert witness reports. In Texas, for example, patient-plaintiffs in healthcare malpractice legal actions must serve an expert witness report (including the expert's curricula vitae) on each party within 120 days after filing a healthcare malpractice lawsuit. The expert report must include a summary of the expert's opinion on the legal standard of care; how it was breached by the defendant in the case; and how the defendant's breach of the standard of care caused injury to the patient-plaintiff. Failure to serve this summary expert opinion report automatically results in dismissal of a patient-plaintiff's case, with the added requirement to pay for the

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defendant's legal costs and attorney's fees. These measures help prevent frivolous legal actions from proceeding to depositions and trial, and unnecessarily clogging an already overcrowded legal system.

With tens of millions of civil lawsuits filed or pending in state and federal courts in the United States, far ahead of all other civilized nations combined, there clearly is a serious litigation crisis in the United States. In larger or relatively more litigious states, civil cases, including healthcare malpractice lawsuits, take many years to come to trial.

THE NATIONAL PRACTITIONER DATA BANK

Since September 1990, whenever money (in any sum) is paid to a patient-plaintiff or his or her representative, either in settlement or by way of a court judgment in a healthcare malpractice case, information about the responsible healthcare provider must be forwarded to the Department of Health and Human Services for inclusion in the National Practitioner Data Bank. This Data Bank was established pursuant to the Health Care Quality Improvement Act of 1986.

Another important purpose of the Data Bank is to compile data concerning adverse licensing, credentialing, and other actions, including expulsion from professional associations, involving licensed healthcare providers. Together, malpractice payment reporting and adverse actions reporting are intended to create a record designed to protect the patient-public that follows licensed healthcare professionals included in the Data Bank wherever in the United States they might seek employment.

Employers of licensed healthcare professionals are required under the statute to query the Data Bank regarding new employees and at regular intervals thereafter. The information is deemed strictly confidential and normally is not "discoverable" by patients or their attorneys, nor is it available to the general public. As an exception to the nondisclosure provision, if a healthcare employer fails to query the Data Bank about a provider upon employment, a patient-plaintiff's attorney may petition for, and be granted, access to that provider's Data Bank information. Any licensed healthcare provider may self-query the Data Bank for a nominal fee for his or her own record.

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PATIENT CARE DOCUMENTATION AND TORT REFORM MEASURES

The federal government and most state legislatures have undertaken, since the advent of the litigation and healthcare malpractice crises, reforms focused on patient care documentation. Many of these public entities have also undertaken measures labeled as "tort reform" to decrease the number of civil lawsuits. One of these measures—expeditious filing of expert witness reports—has already been discussed. Some of the other tort reform measures include the following:

1. Enacting and, after substantial delay, implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal statute, focused on patients' protected health information (PHI), is discussed in detail in Chapter 6.
2. Limiting time periods for validity of undated patient health information release authorizations.
3. Requiring that healthcare malpractice plaintiffs undergo administrative hearings on the merits of their cases before proceeding to trial.
4. Capping maximum noneconomic money damages for pain and suffering and loss of enjoyment of life. (Note that this reform has been introduced on a yearly basis in Congress for over a decade without success. Bills introduced typically limit emotional pain and suffering damages to $250,000 as well as limiting attorney contingent fees. The nonpartisan Congressional Budget Office has predicted that such a federal tort reform law would reduce healthcare expenditures attributable to malpractice from 2 to 1.5 percent of aggregate medical costs.)
5. Limiting attorney contingent fees (contingent fees are based on percentages of recovery fees bargained for between attorneys and clients). California was the first state to do this in 1975.
6. Reforming "joint and several liability" to prevent one defendant from being required to pay an entire judgment when that defendant is only partially responsible for a plaintiff's injuries.

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7. Setting absolute time limits—based on the date of manufacture of a product—within which legal action must be commenced (called *statutes of repose*).
8. Relaxing the "collateral source rule," under which juries are prevented from learning of a plaintiff's collateral sources of compensation for injuries, including insurance coverage or partial payments by other defendants.
9. Penalizing attorneys and their clients for initiating lawsuits deemed to be frivolous, especially in the federal courts.
10. Withholding from plaintiffs (and depositing in state treasuries) a percentage of any *punitive* (punishment) damages awarded to them by juries in product liability actions.

CHAPTER SUMMARY

All healthcare professionals, organizations, and systems are affected by the litigation and healthcare malpractice crises, characterized by increasing numbers and severity (cost) of claims and lawsuits, including those brought by patients claiming malpractice-related injuries. The overwhelming majority of healthcare malpractice cases are based on allegations of professional negligence, or substandard delivery of care. Whether a healthcare provider retrospectively met or violated minimally acceptable practice standards is normally determined through testimony of expert witnesses, or reference to relevant professional texts, peer-reviewed journals, and practice standards, guidelines, and protocols.

Employers of healthcare providers may be vicariously or indirectly liable for employees', volunteers', and even independent contractors' commission of healthcare malpractice. Healthcare organizations may also be independently liable for violating nondelegable duties owed to patients and others, including the duty to select and retain only competent healthcare professionals, the duty to maintain safe premises and equipment, and the duty to oversee the quality of patient care provided in their facilities. Clinical managers and practitioners also need to carefully establish procedures delineating the circumstances under which healthcare providers may disengage from further care of patients to minimize allegations of negligent or intentional patient abandonment. This issue is

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particularly important under the current cost containment-focused managed care paradigm.

Healthcare providers must expeditiously notify their facility risk managers, insurers, and personal legal representatives whenever an incident occurs in the clinic that might conceivably ripen into a claim or lawsuit. Such occurrences are called potentially compensable events. A claim of healthcare malpractice ripens into formal legal civil proceedings when a defendant-healthcare provider receives a summons and complaint specifying the basis of the alleged malpractice and a demand for money damages or other relief.

One of the most important pretrial proceedings is the deposition, in which parties and witnesses to malpractice lawsuits undergo examination under oath by the parties' attorneys. Never go into a deposition, either as a witness or defendant, without prior consultation and preparation by legal counsel. The deposition serves several important functions, including locking in sworn testimony weeks, months, or years before trial and discovering facts that might lead to additional relevant evidence in the case.

The consequences of healthcare malpractice legal actions are potentially devastating for both patients affected by substandard care and healthcare professionals whose reputations and personal well-being are affected by such allegations, whether or not the allegations are substantiated as true. Licensed healthcare professionals on whose behalf malpractice judgments or settlements are paid face the additional penalty of having their names included in the National Practitioner Data Bank, maintained by the federal Department of Health and Human Services. For these reasons, and for the protection of patients and healthcare professionals alike, management of healthcare malpractice risk in clinical practice, particularly through creating and maintaining accurate, complete, objective, and timely documentation of patient care activities, is critically important.

The United States is the most litigious nation on earth and in world history. In an effort to stem the numbers of civil lawsuits initiated in state and federal courts, courts and legislatures are taking ongoing actions to dampen the malpractice fervor through procedural and substantive restrictions on plaintiffs' ability to bring civil tort lawsuits. Such measures collectively are called tort reform. Resort to alternative dispute resolution—mediation and arbitration—is an effective and cost-saving means of reducing the number of formal civil lawsuits in the long pipeline.

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REVIEW CASE STUDIES

The following case examples involve hypothetical situations and are not based on actual healthcare malpractice cases, published or unpublished. The characters are fictitious and are not intended to represent or resemble any actual healthcare provider or entity. Any resemblance of any examples in this text to actual cases, situations, individuals, or entities is coincidental and unintended.

1. A is an orthopedic patient with chronic cervical pain, being seen for the first time by B, an outpatient physical therapist. No documentation except the prescription, properly signed by the referring physician, is present with the patient at the initial visit. During the course of examination, B asks A if any x-rays had been taken. A replies "yes," and adds, "I think the doctor said they were OK." Should B proceed with mechanical traction treatment based on the examination findings and A's self-report about her x-rays?

2. X, a hand-care patient of Y, an occupational therapist, admits to Y that he is feigning a work-related hand injury in order to maximize compensation from the workers' compensation system. What documentation steps should Y take?

DISCUSSION: REVIEW CASE STUDIES

1. B probably should not proceed with A's mechanical cervical traction treatment without first reviewing the x-ray report or consulting with A's physician. A might have pathology that could make traction contraindicated. This is a common problem in clinical practice that can readily be resolved through communication between the referring entity and the treating provider, and through

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conversion by healthcare providers and organizations to universally available electronic medical records (EMRs).

2. Y probably does not have a legal privilege to withhold, and may have a legal duty to disclose, X's workers' compensation fraud to authorities. Y should initially document the circumstances of X's disclosure in an incident report and seek immediate further guidance from her supervisor and legal counsel.

For the Suggested Answer Framework to the Focus on Ethics, please refer to Appendix D.

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