CLAIMS RX

CLINICAL & RISK MANAGEMENT PERSPECTIVES

JUNE/JULY 2017

INSIDE

MANAGING RISK ON THE BUSINESS SIDE OF MEDICINE

NORCAL MUTUAL®
MEDICUS Insurance Company
FD INSURANCE First for Doctors.

MANAGING RISK ON THE BUSINESS SIDE OF MEDICINE

CME INFORMATION

Sponsored by:
NORCAL Mutual Insurance Company,
a member of the NORCAL Group.
The NORCAL Group of companies includes NORCAL Mutual Insurance Company, Medicus Insurance Company and FD Insurance Company.

NORCAL Mutual Insurance Company is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

METHOD AND MEDIUM

To obtain CME credit, read the enduring material article then log in to your online account to take the CME quiz, or download the free MyNORCAL® app, to get your certificate. The MyNORCAL app is available now for iOS and Android and has all of the same CME materials available in MyACCOUNT and automatically syncs your CME activity with your other devices.

Access your account online:

- NORCAL Mutual Insurance Company
  norcalmutual.com
- Medicus Insurance Company
  medicusins.com
- FD Insurance
  fd.norcalmutual.com

Create an account

MyACCOUNT and the MyNORCAL app require a NORCAL Mutual or Medicus login. Call Risk Management Department for an activation code/Client ID **855.882.3412**.

Please complete and submit the online quiz by the expiration date indicated below:

Original Release Date: May 15, 2017
Expiration Date: July 1, 2019

LEARNING OBJECTIVES

By reviewing medical professional liability claims and/or emerging topics in healthcare risk management, this enduring material series will support your ability to:

- Assess your practice for risk exposures.
- Apply risk management best practices that increase patient safety and reduce medical professional liability claims.

TARGET AUDIENCE

All physicians, healthcare staff and administrators.

CREDIT DESIGNATION STATEMENT

NORCAL Mutual Insurance Company designates this enduring material for a maximum of *2 AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

DISCLOSURE POLICY

As an ACCME accredited provider, NORCAL Mutual Insurance Company requires planners, reviewers or authors who influence or control the content of a CME activity to disclose financial relationships (of any amount) they have had with commercial interests associated with this CME activity during the year preceding publication of the content. Any identified conflicts of interest are resolved prior to the commencement of the activity.

DISCLOSURES

Individuals involved in the planning, reviewing or execution of this activity have indicated they have no relevant financial relationships to disclose.

EDITOR

Mary-Lynn Ryan
Risk Management Specialist,
NORCAL Mutual

CONTENT ADVISORS

Jaan E. Sidorov, MD
Chair, NORCAL Mutual,
FD Insurance and Medicus

Patricia A. Dailey, MD
Director, NORCAL Mutual,
FD Insurance and Medicus

Rebecca J. Patchin, MD
Director, NORCAL Mutual,
FD Insurance and Medicus

William G. Hoffman, MD
Family Practice Content Advisor

Dustin Shaver
Vice President, Risk Management,
NORCAL Mutual

Neil Simons
Vice President, Product Development,
NORCAL Mutual

Paula Snyder, RN, CPHRM
Regional Manager, Risk Management,
NORCAL Mutual

John Resetar
Claims Specialist, NORCAL Mutual

Andrea Koehler, JD
Counsel, NORCAL Mutual

PLANNER

Shirley Armenta
CME Program Lead,
NORCAL Mutual

Introduction

Common business decisions can contribute to patient injuries and complicate the defense of liability claims.

Running a medical practice involves making business decisions that can increase the risk of adverse patient outcomes, professional liability and regulatory violations. These risk-laden business decisions that contribute to NORCAL claims are frequently associated with improving the bottom line and/or saving time. Other business decisions do not necessarily affect patient safety, but can increase liability or regulatory risk (e.g., entering into a contract without understanding the terms, using misleading marketing materials or responding to negative online comments). The skills and training that support conscientious, excellent medical care do not always facilitate skilled business decision-making.[1,2]

Physicians are additionally constrained in business decision-making by ethical and professional expectations.[3] The aim of this article is to highlight the more common business decisions that have contributed to patient injuries or complicated the defense in NORCAL claims. Risk management strategies are not meant to replace legal advice, but instead to prompt consideration of practice policy and protocol-making to avoid the triggers that can result in lawsuits and regulatory actions, and to facilitate satisfactory and effective claims resolution.

Over-Utilized Externs

In the following case, the group's medical director over-utilized medical assistant (MA) externs for cost-saving purposes. Because he did not understand how his plan was putting patients at risk, he was resistant to negative input from his colleague. The physician conflict exacerbated the inherent risks of the externship program.

Case One

Allegation:

The group did not have proper oversight of MA externs, which resulted in an adverse event.

Practice Structure
A busy family practice group was composed of two physicians, their two MAs, a billing manager, an office manager and a part-time human resources (HR) person. Physician 1 was the medical director of the group. Neither of the physicians reported to the other or to any other person.

MA Externship Program
The practice had a robust MA externship training program. During office hours there were four to five externs working on administrative or clinical tasks. Externships generally lasted two months; consequently, there was a constant flow of individuals with varying degrees of competency cycling in and out of the office. The HR person had complete control over the externship program and received no direction or input from the medical director. She recruited, oriented and trained the externs. When the HR person determined an extern had been adequately trained to do a medical task, an MA could then delegate the task to the extern when one of the physicians ordered it. Neither MAs nor physicians supervised the externs when they were completing tasks for which they had been deemed competent by the HR manager.

Physician 2's Opinion
According to Physician 2, the practice had more externs than it could handle, the program was not appropriately administered and many of the externs were incompetent. She avoided using externs whenever possible and denied any responsibility for supervision or training. She assumed the externs were overseen by Physician 1. She had complained to Physician 1 about the externs, but Physician 1 refused to discontinue or reduce the use of externs. The extern situation was driving Physician 2 to seek a position elsewhere.

Physician 1's Opinion
Physician 1 believed the externs provided an economical workforce for the group, and they obtained valuable training in return – a "win-win" situation. He felt Physician 2 was overreacting to small issues with a couple of externs who had made regrettable, although minor mistakes with no lasting consequences to patients.

Adverse Event
A long-term patient of Physician 2 came in for ear irrigation. Physician 2's MA was not available. Unbeknownst to Physician 2, the irrigation was delegated to an extern. The extern punctured the patient's ear drum. The patient sued both physicians and the group.

Discussion

Although both physicians denied involvement in the training or supervision of the MA, according to defense experts, the physicians were ultimately responsible for what their MAs – or the MA externs to whom a task has been delegated by their MAs – did or didn't do with their patients. The experts believed both physicians should have been more involved. For example, the experts believed unsupervised ear irrigation could be within the appropriate scope of practice for an MA extern, but the physician who ordered it would have to be satisfied that the extern was capable of unsupervised ear irrigation. Competency judgments are generally the result of personal observation and discussion with other staff members in the office who have appropriate qualifications to evaluate MA extern competency. But in this case, neither physician had made any determinations about the competence of any of the externs with whom they worked. Had they observed the MA who caused the eardrum injury, they might have provided the guidance necessary to avoid patient injury. Experts believed the MA extern's ear irrigation was below the standard of care.

Another problematic issue was the medical director's unfamiliarity with the operation of the group practice. He was unable to clearly answer questions about reporting relationships, oversight and supervision. He had to defer all questions about the externship program to the HR person. Unfortunately, the HR person's records were incomplete – there were no copies of agreements with the externs (the paperwork was completed by and retained by the trade schools from which the externs were recruited) and supervision and evaluation documentation was sparse. This made it extremely difficult to locate the MA extern who did the irrigation. (The MA's externship was long over by the time the matter was litigated.)

The case was settled on behalf of Physician 2 and the practice.

Risk Management Recommendations

Managing Trainees

The purpose of an unpaid educational externship is for the trainee to learn about the medical practice. However, delegation of duties to externs should only occur under appropriate circumstances. Physicians who absent themselves from determinations of the competency of externs who treat their patients are exposing their patients to potential injuries and exposing themselves to liability risk. Consider the following recommendations:[4]

- Have training contractual agreements reviewed by a healthcare attorney.
  - Work with the attorney to craft the agreement in a way that fits your practice needs, protects your patient population and your practice and meets all regulatory criteria.
- Ensure your professional liability insurance provides coverage for trainees or that liability for their patient encounters is otherwise covered.
- Create a plan for orienting trainees much like you would a new employee, and for evaluating trainee competency and performance.
  - Do not delegate the responsibility of determining extern competency to anyone not qualified to do so.
  - Be familiar with state laws covering delegation of duties to unlicensed staff.
- Provide adequate orientation and reinforcement to trainees and the people who will be supervising them regarding their specific roles, responsibilities and scope of practice.
  - Ensure written job roles are in place.
  - Ensure all parties involved in the training program understand group/physician/staff and trainee responsibilities.
  - Ensure all parties understand what procedures the trainees are allowed to perform and under what circumstances.
  - Ensure supervising physicians understand proper delegation of responsibilities.
- Ensure all parties involved in the training program adequately document patient care, including setting up the trainee to document under his or her own name in an electronic medical record, as opposed to documenting under someone else's credentials.
- Inform patients of the training program and that supervised trainees may be involved in their care.

Managing Disagreements about Business Practices

Patient safety and risk management depend in part on physicians sharing a common vision of the practice and managing conflict when differences in the understanding of that vision arise. Consider the following recommendations:[5,6]

- Define leadership roles in the practice.
- Create an environment in which clinicians do not feel that raising issues will result in retaliation.
- Before making a change that affects the way clinicians treat their patients, obtain buy-in from affected parties.
- Conduct regular clinician meetings to encourage discussion, dispel misunderstandings and build consensus.
- Define a plan for conflict resolution.
  - Consider involving a third party (e.g., a mediator) to help resolve intractable or complex issues.

Medical Directorships

A medical directorship may seem like a reasonable way to bring in extra income without investing a lot of time and effort. However, depending on the arrangements, a medical director's duties can be extensive, including: ensuring proper protocols are in place and individuals hired are appropriately credentialed and trained, supervising other clinicians and staff, overseeing treatment plans, ensuring HIPAA and Medicare compliance, and approving marketing materials.[7] While many tasks can be delegated, the medical director is frequently held responsible when a patient suffers an adverse event or the entity's regulatory compliance is called into question.[7,8] The defense of malpractice claims and medical board actions can also become complicated when a physician's dual roles as medical director and attending physician become intertwined. Finally, physicians serving as medical directors may be surprised to discover that their professional liability policy excludes medical director duties, and that separate coverage is required. Therefore, it is important to ensure medical liability coverage prior to accepting a medical director position.

Overextension

Allegations against the family physician (FP)/medical director in the following case ranged from failure to hire qualified staff to failure to adequately assess the patient's medications. The FP's reliance on allegedly negligent staff to carry out the patient's treatment plan complicated his defense. If he had not been the medical director responsible for qualified staff, then the otherwise clear-cut staff negligence as a cause of the patient's injuries could have benefited his defense. However, as the medical director, the FP was ultimately responsible for the efficacy of the staff. His misunderstanding of the extent of his duties in both roles put patients at risk and complicated his defense.

Case Two

Allegation:

In his roles as attending physician and medical director, the FP was primarily responsible for the injuries the patient suffered while she was a resident at a skilled nursing facility.

Business Arrangements

An FP contracted with a company that provided medical directors, attending physicians and advanced practice clinicians to skilled nursing facilities (SNFs). Through the company, the FP was medical director at four different SNFs. In his role as medical director, the FP attended quarterly coordination of care and quality assurance meetings. The FP and the nurse practitioners (NPs) he employed also took on the primary care role for patients whose primary care physicians were not attending them at the SNF.

Among the four SNFs, the FP and his two NPs provided primary medical care for approximately 150 patients. The FP visited each facility approximately one to three times per week. When he arrived, he checked in with the administrator and director of nursing, who told him whether there were any patient complaints or any patients he needed to see. He generally did not initiate patient examinations.

Adverse Event

A formerly healthy, cognitively intact 65-year-old man was involved in a major car accident in which he suffered a broken hip and femur, rib fractures and a brain injury. He was admitted to the hospital. Following a lengthy hospitalization, he spent time in a rehabilitation facility and was ultimately admitted to an SNF on July 1, 2012. Because he did not have a primary care physician, he was assigned to the SNF medical director, the FP. The patient's discharge summary from the rehabilitation facility noted he had a "rash" on his buttocks. Agitation associated with his brain injury was being treated with anti-psychotics and benzodiazepines.

On July 7, the patient was examined by the FP. During the examination, the FP failed to identify any skin breakdown and instead noted the patient's skin to have good turgor. Medications for agitation and combativeness were increased. By July 8, nursing notes indicated the patient was minimally responsive when awakened and had developed pressure ulcers on the coccyx, buttock and heels.

The FP next examined the patient on July 28. He ordered labs, discussions with a dietician and nutrition supplementation – presumably because the patient had lost 10 pounds since admission. (His reasoning was not documented.) Consultation with the wound care physician was ordered – although the FP would later testify that he had never examined the patient's wounds. Consultation with physical therapy was ordered – although the patient's somnolence made physical therapy impossible. The FP noted the patient was progressing satisfactorily and was continuing toward the goal to transition him home.

On August 15, the patient was transferred to the hospital with multiple stage IV pressure ulcers on the coccyx and buttocks and other wounds. He was diagnosed with osteomyelitis, and after a month of intensive treatment in the hospital, he died.

The patient's family filed a claim against the FP (in both his role as the medical director and attending physician) and the various other administrators and staff involved in the patient's care, alleging:

- Negligent hiring of untrained and unqualified individuals to care for patients
- Failure to order and coordinate wound care in a timely manner
- Failure to adequately supervise staff
- Failure to create treatment policies and protocols
- Failure to properly assess the effect medications were having on the patient's cognition
- Failure to prevent malnutrition and dehydration
- Failure to transfer the patient to a higher level of care when he developed life-threatening pressure ulcers, malnutrition and dehydration

Elder abuse was also alleged against the FP, for which the plaintiffs were seeking punitive damages.

Discussion

Although the FP believed he should be dismissed from the lawsuit because he had little involvement in the patient's care, the plaintiff's attorney viewed him as the target defendant with the greatest level of malpractice exposure. The defense team believed any jury would have a difficult time parsing the care provided by each defendant and evaluating the quality of that defendant's care without thinking about the overall care and outcome. With the plaintiff's attorney focusing on the FP, his documentation and supportive testimony from other members of the patient's healthcare team would be extremely important to the success of his defense. Unfortunately, there was neither.

Issues Regarding the FP's Medical Care of the Patient

A major problem underlying this claim was the physician's misunderstanding of his roles and responsibilities. He thought of his roles as very narrow. However, he had signed a medical director contract that gave him a broad set of responsibilities. He also viewed his responsibilities as the patient's attending physician more narrowly than what experts considered safe or standard of care.

Defense experts were unable to support the FP's care of the patient for a variety of reasons. They were critical of the sparse and seemingly inconsistent documentation. For example, the FP consistently described the patient as making satisfactory progress, even though the original plan was for a 30-day stay, at the conclusion of which the patient would be able to return home. Defense experts were also critical of the FP's complete reliance on the wound care specialists and nurses to manage the treatment of the patient, and failure to review the nursing and wound care team's documentation of the care they were providing. They believed the documentation evinced an overall inattentiveness to the patient's ongoing medical problems. One expert described the FP's treatment as "cursory."

Because the physician had very little independent recollection of the patient or discussions he might have had with the nursing staff or administrators regarding the patient, there was little evidence to defend the malpractice and elder abuse allegations.

Issues Regarding the FP's Medical Directorship

The FP's minimal involvement in the administration of the SNF became problematic during litigation. He had signed a medical director contract that made him responsible for overseeing nursing staff, ensuring nursing care was appropriate and ensuring treatment plans were carried out. The fact that he was charged with overseeing nursing care made it difficult for him to criticize the nurses for not providing adequate care to his patient. Furthermore, although the FP's agreement with the SNF indicated he would, he did not make staffing decisions and did not know how the decisions were made. This became an issue when it was discovered that LPNs (not RNs, as required by state law) had been handling the patient's assessments and care plans. Also, the wound care physician attending the patient had no training in wound care – he was employed by a group that advertised as wound care specialists. There had been no effort on the part of the administration to confirm the qualifications or verify the credentials of the wound care physicians and staff with which it contracted.

Elder Abuse Allegations

In addition to alleging malpractice, the plaintiffs alleged elder abuse and made a claim for punitive damages. Unlike malpractice, elder abuse judgments are usually not restricted by tort reform measures (e.g., caps on damages for pain and suffering).[9] The patient's condition when he entered the hospital provided convincing evidence of neglect, which supported the elder abuse allegations.

Medical Liability Insurance Issues

In this case, the FP had not made arrangements to have his medical directorships endorsed onto his medical malpractice policy, which specifically excluded liability arising from "administrative or management services provided by an insured to another organization not owned by you unless specifically endorsed on to this policy." The FP's policy also excluded indemnity for punitive damage awards.

The case was settled on behalf of the FP and the other defendants.

Off-Site Supervision

Although they might not look like medical facilities, medical spas are subject to the same rules and regulations as physicians' offices when medical procedures are being performed. In the following case, a dermatologist was influenced by the laser company's and aesthetician's assurances of the propriety and low risk of serving as the medical spa's medical director.

Case Three

Allegation:

The medical director's failure to adequately supervise an aesthetician providing laser treatments contributed to the patient's injuries.

Business Arrangements

An aesthetician wanted to add laser treatments to her existing business. She offered a dermatologist a monthly fee to serve as the medical director and "supervising physician" at her spa. State law required a "supervising physician" for the type of laser treatments she planned to provide. The state law allowed for indirect supervision (i.e., the physician had to be available by telecommunication, but was not required to be on site). The aesthetician told the dermatologist there was no expectation for her to be on site or provide laser treatment or any other spa treatment. The laser equipment company would provide the aesthetician the training she required to be credentialed to operate the laser. The aesthetician would retain her own professional liability insurance. The dermatologist signed the agreement, assuming everything proposed was legal and low risk.

Adverse Event

Within the first year of the arrangement, an incident occurred in which a patient sustained second- and third-degree burns to her arms during laser hair removal. The laser settings were too high because the aesthetician had failed to take into account the patient's tan. Within a year the spa closed and the aesthetician filed for bankruptcy. Shortly thereafter, the dermatologist and aesthetician were sued for malpractice. The patient claimed the dermatologist's supervision of the aesthetician was negligent.

Discussion

Defense experts who reviewed this case believed the aesthetician was negligent. However, they questioned how the dermatologist could supervise the aesthetician when the physician had no training in laser hair removal. They noted the state practice statute required supervising physicians to be knowledgeable in the laser procedures they were supervising. Experts were also critical of the dermatologist's lack of oversight of patient treatment plans and non-involvement in treatment protocols. Experts believed the plaintiff's attorney would cite as standard of care evidence the "American Academy of Dermatology Position Statement on Medical Spa Standards of Practice," which holds medical directors responsible for treatment delegated to non-physician personnel in a medical spa and advises against off-site supervision. The position statement also holds medical directors responsible for performing initial assessments, preparing written treatment plans, obtaining informed consent, creating and maintaining medical records, reviewing and signing patient charts, and obtaining appropriate training in all of the medical and aesthetic services performed in the medical spa.[10]

The case was settled.

Risk Management Recommendations: **Medical Directorships**

Whether serving as a medical director of a medi-spa, SNF or some other type of healthcare practice, it is important to understand the legal and regulatory issues associated with the position that may or may not also apply to your role as an attending physician.

General Medical Director Duties

Laws in the practice jurisdiction and the terms of the medical directorship contract make every medical directorship unique. Consider the following recommendations:[10,11,12]

- Promulgate and enforce policies and protocols that ensure:
  - Appropriate initial assessments of each patient completed by an individual with an appropriate level of training
  - Written treatment plans for each patient completed by an individual with an appropriate level of training
  - Appropriate and documented informed consent from each patient
  - Creation and maintenance of medical records in accordance with local, state and federal laws and regulations, which would require periodic review of patient medical records to ensure compliance
  - Immediate notification of the medical director about adverse events
  - Appropriate processes for screening, hiring and credentialing all licensed staff and clinicians
  - Appropriate clinician and staff instruction, training and licensure for every procedure they perform, including continuing education in appropriate subject matter, which would require ready availability of documentation of training and education
  - Appropriate emergency and treatment sequelae response
  - Appropriate delegation and supervision for all procedures
- Take a leadership role in quality management and risk management activities.
- Monitor clinicians and staff to ensure adherence to policies and protocols.

Physician Duties Potentially Associated with Medical Directorship

It may be difficult to separate physician duties from medical director duties. Consider the following recommendations:[8]

- If you are serving as the medical director and attending physician at a facility, treat the patient within the standard of care of a physician.
- If your medical directorship contract also designates you as the "supervising physician," follow the supervision laws in your jurisdiction.
- Do not supervise or delegate medical tasks outside of your own specialty. For example, an OB/GYN who has no training or experience in laser sun spot removal should not supervise/delegate to an aesthetician, even if the aesthetician is qualified to operate the equipment.
- Only delegate a task to or supervise an individual consistent with his or her practice scope. For example, a cosmetic surgeon who is qualified to use a laser should not task another staff person who is not trained, certified, and/or licensed (as indicated) to use that equipment.

Due Diligence before Signing a Medical Director Contract

Before signing a medical directorship contract, consider the following recommendations:[8]

- Consult with a healthcare attorney.
- Ensure the proposed business arrangement does not violate state or federal laws.
  - Comply with corporate practice of medicine laws in your jurisdiction.
  - Ensure your payment arrangements are in compliance with fee-splitting laws.

- Understand your duties under the contract and consider whether you can appropriately perform those duties; for example:
  - Are the procedures you will be supervising within your specialty?
  - Do you have time in your schedule to fulfill the contractual obligations?
  - Is the entity staffed adequately for you to appropriately delegate clinical and/or administrative duties?
- Consult with the underwriting department of your medical malpractice insurance carrier to ensure the medical directorship and the procedures and services the entity is offering are covered by your policy. (NORCAL Group companies' policyholders should contact their agent or call 844.4.NORCAL for this purpose.)
- Check the Better Business Bureau, the internet healthcare rating websites such as Health Grades and the medical board to gauge the compliance, liability risk and goodwill of the practice.

DOWNLOAD the Free MyNORCAL App NOW

MyNORCAL® App

Earn CME Credit for This *Claims Rx* Article

The MyNORCAL app for iOS and Android provides fast, simple and convenient access to CME articles and interactive quizzes, allowing you to receive CME credit and certificates while on the go or away from your computer. Now you can read the CME materials, take the quizzes, and print/email your CME certificates right from the app.

The MyNORCAL app has all the same CME materials available in your MyAccount, plus it automatically syncs your CME activity with your MyAccount and with your other devices. You may even receive a discount on your insurance premium by participating in NORCAL Mutual CME activities.

- **Read the *Claims Rx* article**
- **Open the MyNORCAL App using your existing MyACCOUNT credentials***
- **Take a short quiz using the intuitive mobile interface**
- **Print or email your CME certificate or transcript**

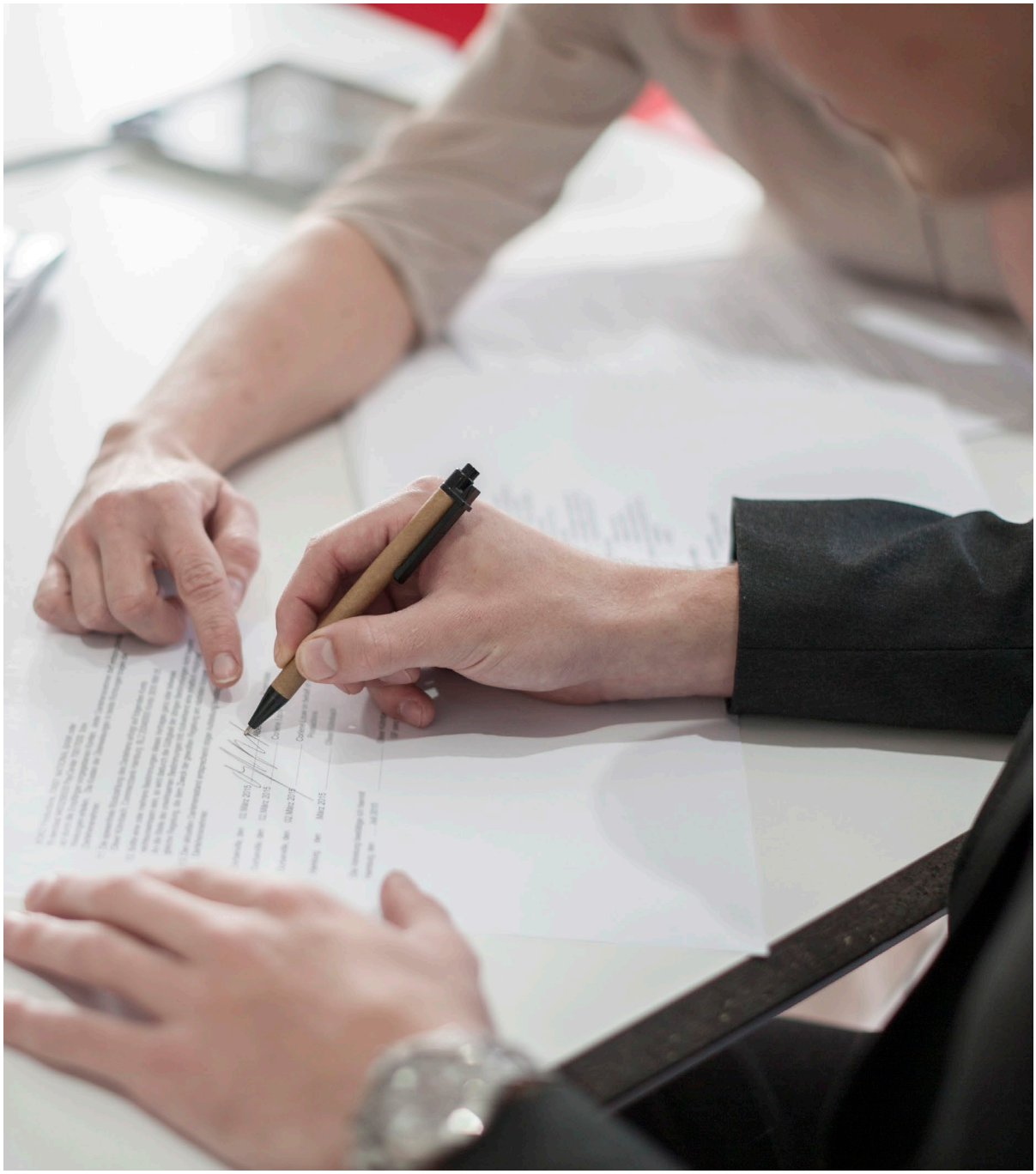
Search 'MyNORCAL'
in the App Store or Google Play

Download on the App Store | ANDROID APP ON Google play

*This app requires a NORCAL Mutual MyACCOUNT login. Contact NORCAL Customer Service at 844.4NORCAL to obtain your MyACCOUNT credentials

Adequately Screening Clinicians and Staff

Like other people, physicians and clinical staff members may commit crimes and engage in other noncriminal activity that can expose their healthcare employers to liability and regulatory violation risk.[13] Although healthcare employers are generally not vicariously liable for the criminal actions of employees, they can be sued for negligent hiring, supervision or retention when a clinician or staff member's criminal behavior results in an injury to a patient.[14] When this happens, the employer also leaves itself vulnerable to the negative publicity that follows an incident of this type, whether substantiated or not.



Hiring a Physician with a History of Sexual Misconduct

A healthcare employer can be held directly liable when an employee or contractor injures a patient, and the employer knew or should have known of the danger.[15] If the employer's hiring process is challenged in court, the jury will consider the reasonableness of the process, including the foreseeability of the risk of injury to the patient and whether the hiring process (or lack of it) caused or contributed to the patient injury.[16] It is, therefore, important to have appropriate hiring policies and protocols in place and to follow protocols, even when a potential hire is known to one of the physicians in the group.

Case Four

Allegations:

The group's negligent hiring and retention of the physician resulted in the patient being assaulted.

A physician was terminated from his position at a clinic for inappropriately touching a number of patients. Before he resigned, he had learned from an acquaintance that a family practice group in the next town was hiring. It just so happened that a friend of the physician's was also a member of the family practice group. The acquaintance was not aware of the physician's resignation, and connected him to the group's office manager. She brought him in for a series of interviews. He told the office manager that he was still employed at the clinic and requested that they not contact the clinic – a request they honored. Because his friend vouched for him, the group did not follow normal hiring protocols. Had they contacted his former employers, they might have discovered he had been asked to resign under suspicion of inappropriate conduct with patients in other instances.

Within a few months of being hired, the physician saw a 17-year-old female patient who came in for a sports-related physical. In the course of the examination the physician put his hands inside her underwear and touched the outside of her vaginal area for 5-10 seconds. (The patient had chosen the option of being examined without a parent in the room, so the mother was waiting outside of the examination room door when the inappropriate touching occurred.) The patient later reported the incident to her mother.

The mother contacted the group's medical director. He discouraged the mother from contacting the police and advised her it would be unpleasant for her daughter to go through a criminal investigation. No one reported the incident to the police or the medical board. When questioned by the medical director, the physician denied inappropriately touching the patient. He continued to see patients.
Two months after the incident, the group received notification from the medical board that the physician's license was being suspended – eight women had come forward to report inappropriate sexual behavior and touching at the physician's prior places of employment. He was then fired from the group.

Eventually, the local media picked up the story. The 17-year-old patient's parents, upon hearing about the prior instances of sexual misconduct, filed a lawsuit against the physician and reported him to the medical board. They alleged the group should have discovered the prior complaints of inappropriate touching and, as a result of the group's negligent hiring and credentialing, the patient was sexually battered.

Discussion

The group had difficulty defending its failure to completely investigate the physician's background. Because none of the employers had reported the physician, and he had lied during his interview, the only way to discover his dangerous proclivities was to contact his former employers and convince them to share the reasons for his termination.

Hiring Administrators with Prior Fraud Convictions

Fraudulent Medicare billing can expose healthcare employers and medical directors to potential criminal and civil liability, and may lead to imprisonment, fines and penalties, including exclusion from participating in all federal healthcare programs.[7,17]

Case Five

Allegation:

The SNF was responsible for the systematic billing fraud committed by its director of nursing and director of rehabilitation, both of whom had criminal records involving fraud.

A SNF patient's record indicated she had been essentially nonresponsive for close to one month due to medication issues; however, the Medicare billing records indicated the patient was getting the highest level of rehabilitation services on a twice-weekly basis. The billing fraud came to light during litigation of a medical malpractice/elder abuse claim. The plaintiff's attorney then discovered the directors of nursing and rehabilitation had past fraud convictions.

It is important to have processes in place to conduct background investigations on any staff member involved in the reimbursement process, including billers, managers and administrators.

Discussion

The fraud convictions were a matter of public record that could have been discovered during the hiring process; however, the SNF either overlooked the convictions or did not discover them. There was no documentation of criminal background checks in the administrators' files. The convictions for fraud complicated the defense of the SNF and its medical director in a variety of ways. The coincidence of both administrators having fraud convictions bolstered the plaintiff attorney's allegation that the SNF had hired the two administrators with intent to perpetuate billing fraud, which would not be received well by a jury. On the other hand, if the fraud convictions were unintentionally overlooked, it evinced lax hiring policies. Finally, if allowed in evidence, the prior fraud convictions would most likely be used by the plaintiff's attorney to discredit any positive testimony the director of nursing or director of rehabilitation could provide to the defense of the medical director in the medical malpractice claim. The SNF was investigated and fined.

A detailed discussion of Medicare fraud and abuse risk management is beyond the scope of this article; however, there are several online sources of information, including: Medicare Fraud & Abuse: Prevention, Detection, and Reporting, available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_abuse.pdf (accessed 5/23/2017).

Hiring Clinicians and Staff Who Are Not Licensed

Hiring clinicians and staff without appropriate licensure can result in allegations of negligent hiring and even aiding and abetting the unlicensed practice of medicine.

Case Six

Allegation:

A physician's failure to ensure his PA was licensed resulted in aiding and abetting the unlicensed practice of medicine.

A physician who owned a small group practice learned about a physician assistant (PA) from a colleague who had previously employed the PA, and brought him in for an interview. The PA showed the physician some papers, one of which appeared to be a physician assistant certification. The physician assumed the paper was the PA's license, but it wasn't. He did not have a license. When a patient filed a medical board complaint against the PA, the board discovered he was not licensed. The medical board then revoked the owner physician's license for aiding and abetting the unlicensed practice of medicine.[18]

Risk Management Recommendations: **Adequately Screening Clinicians and Staff**

Consider the following recommendations:[13,19]

- Implement a formal hiring process.
- Check for criminal, licensure, healthcare, insurance and regulatory actions, and any other disqualifying personal history.
  - State laws limit criminal record inquiries in various ways. Know what you can ask and how you can ask it.
  - Obtain reports from the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).
  - Request an explanation of any disciplinary actions from the applicant's previous healthcare employers, medical societies, specialty boards and state boards of medicine.
  - Request a list of all closed, open, or pending malpractice actions, settlements or claims for which the applicant has been served within seven years of the date of application.
  - Request a list of closed, open or pending state medical board disciplinary actions.
- Obtain proof of current DEA controlled substance registration.
- Obtain proof from the Office of the Inspector General of eligibility to participate in federal health plans.
- Obtain primary source verification of undergraduate, graduate, residency and fellowship training.
  - Investigate training programs the applicant did not complete. The reason for termination may be relevant to hiring decisions.
- Obtain proof of current unrestricted license(s) and board certifications (and subsequent re-certifications).
  - Inquire about licensure in other states.
- Obtain a complete employment history.
  - Obtain written consent from the applicant to obtain a narrative job reference from former employers.
  - If the candidate has not given consent and the past employer is not forthcoming with employment history details, ask: "Is the person eligible for rehire with your organization?"
  - Make hiring contingent on obtaining a complete and detailed employment history.

- Conduct comprehensive reference checks.
  - Ask the candidate for the names of individuals willing to provide professional references.
    - Obtain written or documented oral recommendations from people with past or current supervisory authority over the applicant and/or from those with close professional work experience with the applicant.
  - Obtain the names of individuals who suggested the applicant apply for the position.
- Conduct an internet search.
- Investigate any gaps in the applicant's employment history.
- Investigate any inconsistencies between materials requested and materials obtained independently (e.g., a background check indicates the candidate has a misdemeanor conviction, but he or she did not provide that information independently).
- Document all efforts that go into determining whether a candidate is qualified. If a clinician's/staff member's employment file does not substantiate a reasonable process, it can be difficult to defend allegations of negligent hiring.

Service Recovery

Service recovery refers to making things right following a service failure. In a physician's office, service failures can range from long patient wait times to a patient's dissatisfaction with a surgical outcome. Steps in a service recovery process may include apologizing for a service failure or making a small goodwill gesture, such as handing out a $5 Starbucks gift card or a parking voucher to a patient who had to wait for an hour to be seen by her physician. Good service recovery programs can turn a frustrated, angry patient into a loyal one, who is more likely to comply with treatment recommendations and less likely to file a malpractice suit, make a report to the medical board or write a negative online review.*†

Healthcare Service Recovery Resources
There are a variety of healthcare service recovery resources available online, including:

Agency for Healthcare Research and Quality. Service Recovery Programs. 2016 Mar. Available at: www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6p-service-recovery.html (accessed 4/14/2017).

Pruthi S, Stevens S, VerNess C. Service Recovery In Healthcare: Movement From Reactive To Proactive. Available at: http://c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/2015_Conference_Presentations/Pruthi.Stevens.Verness.pdf (accessed 4/14/2017).

Fottler MD, Ford RC, Heaton CP. Fixing Healthcare Service Failures. In: Achieving Service Excellence. 2nd. ed. Chicago, IL: Health Administration Press. 2011; 359-382. Available at: www.ache.org/pubs/pdf_excerpts/Fottler%20Excerpt.pdf (accessed 4/14/2017).

More information about responding to an unanticipated outcome and apology is available in NORCAL Risk Management Resource disclosure documents. Click here to view.

Resources

* Agency for Healthcare Research and Quality. Service Recovery Programs. 2016 Mar. Available at: www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6p-service-recovery.html (accessed 4/14/2017).

† Pruthi S, Stevens S, VerNess C. Service Recovery In Healthcare: Movement From Reactive To Proactive. Available at: http://c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/2015_Conference_Presentations/Pruthi.Stevens.Verness.pdf (accessed 4/14/2017).

Challenging Indemnity Clauses in Contracts

To "indemnify" or to "hold harmless" means to insure another party's risk. Indemnity clauses appear in a wide variety of business contracts, including those between physicians, their groups and the hospitals in which they treat patients. When a physician signs a contract to join a medical group, and the contract has indemnification language, the physician may be agreeing to take responsibility for the group's malpractice liability if both are named in a lawsuit. For example, if a patient files a medical malpractice case against a physician, and alleges vicarious liability against the physician's group, and the physician signed a contract agreeing to indemnify the group, the physician may have agreed to pay for the group's attorney fees, court costs, verdict or settlement.[14,20] In general, malpractice insurance policies do not provide coverage for indemnification agreements.[20] For example, NORCAL medical professional liability policies exclude any liability that an insured has assumed under a written or oral contract or agreement, with few exceptions. Consequently, in many cases, indemnity agreements create an uninsured risk for the physician who signs the agreement. Frequently, contracts appear to make the liability obligations mutual. For example, using the above example, the group may also agree to indemnify the physician. But the nature of malpractice litigation can undermine any apparent obligation this creates on the part of the group. Plaintiffs rarely allege primary negligence on the part of the group and then claim the individual physician has vicarious liability.[20] Consequently, physicians should be wary of signing any contract with an indemnity/hold harmless clause.

Examples of Indemnification/Hold Harmless Clauses

Indemnity/hold harmless clauses take a variety of forms, use a variety of terms and create a variety of obligations. The words "hold harmless" and "indemnify" do not have to be in the contract clause to create a duty to indemnify. The following are examples of what an indemnity clause in a contract between physicians, groups and hospitals might look like:

Indemnification by Physician [Group] of a Hospital

Physician [Group] shall indemnify and hold harmless Hospital, its Affiliates, and their respective directors, officers, employees or agents, from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs, including reasonable attorneys' fees and costs (including the reasonable costs of Hospital's in-house counsel), arising out of, resulting from, or relating to (i) the breach of this Agreement by Physician [Group] or (ii) the negligent acts or omissions of Physician [Group] or any employee or agent of Physician [Group].[21]

Indemnification by Hospital of a Physician [Group]

Hospital shall indemnify and hold harmless Physician and Group from and against any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs, including reasonable attorneys' fees and costs, arising out of, resulting from, or relating to (i) the breach of this Agreement by Hospital, or (ii) the negligent acts or omissions of Hospital or any employees or agent of Hospital in the performance of Hospital's obligations under this Agreement.[21]

Indemnification by Physician of a Group

Physician agrees to indemnify Group from all liability, loss, damage, or expense, including court costs and attorney's fees, which result from the alleged or actual negligence or intentional acts of Physician in performance of this Agreement including losses solely due to the acts or omissions of the Group.[21]

Case Seven

Allegation:

The ED group had agreed to indemnify the hospital for all of its defense costs associated with defending the lawsuit filed against the hospital and the group's physician who had treated the patient.

An emergency department (ED) physician was part of a group that contracted with a hospital to provide emergency medicine services to patients. Within the contract between the group and the hospital there was an indemnification clause stating:

Group agrees to indemnify Hospital from all liability, loss, damage, or expense, including court costs and attorney's fees (or upon the option of Hospital, Group shall provide a defense to Hospital), which result from the alleged or actual negligence or intentional acts of Group and its members.

The ED physician failed to diagnose a patient's condition, which resulted in the patient sustaining significant injuries. The patient filed a lawsuit against the ED physician, group and hospital.

The hospital demanded, pursuant to its contract, that the group indemnify it for any costs, etc., associated with defending the lawsuit. The group's liability insurer refused to indemnify the hospital based on an exclusion in the group's insurance contract stating: "We will not defend any claim, nor will we pay any damages, defense costs or additional benefits for a claim, arising out of, directly or indirectly…any liability that an insured has assumed under a written or oral contract or agreement."

Discussion

The group's governing board was unaware that, through the indemnity clause, they had agreed to pay for the defense of the hospital. They also had not connected the indemnity clause to the exclusion in their medical liability policy. The group was surprised to find themselves in a situation in which the group's assets could be at risk. Defense costs and indemnity payments that were not covered by insurance could force the group into bankruptcy. The fear of bankruptcy put the group in a weak position when it became time to consider whether the case should be settled.

Risk Management Recommendations

Consider the following recommendations:[21]

- Carefully review all contracts and consider having your business attorney provide a review.
- Do not agree to a term in a contract if you do not understand the effect it will have on you, your practice or your business.
- Do not ignore an indemnity clause and assume it can be resolved at a future date. In general, it is more difficult to negotiate the terms of a contract after it has been signed.
- Have an attorney review any contract containing the terms "indemnity," "hold harmless" or anything similar. (An indemnity clause does not have to include the terms "indemnity" or "hold harmless" to shift indemnification to you.)
    - Review any liability policies for exclusionary language that may apply with any contract being considered.

Handling Patient Requests for Refunds

Issuing a refund or reimbursement to a dissatisfied patient may seem like a simple solution to a potentially complicated problem. However, there are many different issues to consider, including the amount in contention, the clinical picture, physician and patient personalities, treatment history, the number of individuals and entities involved in treatment, third-party payer requirements and regulations, whether the outcome was unanticipated (or a known risk of the procedure) and whether a lawsuit has been threatened. Also, refunds and reimbursements do not guarantee closure of the issue. Some patients will seek additional funds or services, will file lawsuits and will attempt to use the offer as an admission of liability – even after they have signed a waiver of rights to bring additional claims against you in exchange for the refund. Because of the potential complexity of a refund demand, it is a good idea to obtain input from the NORCAL Risk Management Department and/or the Claims Department when patients demand refunds and reimbursements following dissatisfaction with services or an adverse outcome or event.

Policyholder Inquiries

Policyholders frequently call the Risk Management Department seeking advice about responding to a patient request for a refund, reimbursement or fee waiver. Consider the following questions:

Question: Should I refund the patient's co-pay?

The patient experienced extreme pain while an inexperienced medical assistant was doing an ear lavage. The patient was upset and demanded a refund of her co-pay.

Question: Should I be reimbursing the patient for a different physician's services?

A piece of medical equipment fell on a patient during an examination in an FP's office. The FP made arrangements for her to get an x-ray. The x-ray department was located in the same building, but was a separate entity. The FP did not charge the patient for the office visit, but the patient received the bill for the x-rays. She asked the FP to pay for them.

Question: Can I waive the fee for the initial procedure, even though there was no negligence, and refuse to reimburse the patient for the hospital stay?

A gastroenterologist perforated the patient's colon during a colonoscopy, which resulted in the patient later being admitted to the hospital for observation. The patient was discharged after one day, and had no further issues. The gastroenterologist agreed to waive the fee for the colonoscopy, even though perforation was discussed in the informed consent. When the patient received the hospital bill, she wanted the gastroenterologist to pay for that too.

Question: Can I waive the fee for an initial potentially negligent procedure, but still charge the patient for the second successful procedure?

A dermatologist removed a lesion from the patient's thigh. Because the margins were not clear, the patient underwent follow-up surgery. The follow-up surgery margins were clear, but the patient had a complicated recovery. The patient claimed the initial surgery was negligent and that it caused the residual problems. She demanded the fees for both procedures be waived. The dermatologist offered to waive the fee for the initial procedure, but requested payment for the second procedure. The patient never made a payment, and the matter was sent to collections. In response, the patient threatened to file a lawsuit and/or post negative comments on various physician review social media websites.

Discussion

In general, patients are expected to pay for their medical treatment, even when the experience is unpleasant. However, in some circumstances, patient satisfaction may be more important than collecting a fee. Using a service recovery approach when a dissatisfied patient requests a refund can increase patient retention and de-escalate a situation that could result in negative online comments and/or malpractice litigation. In all likelihood, patient satisfaction will require adequately discussing the patient's issues and working out a solution. It is important to be able to frame the gesture as one of goodwill that is being made because the patient is unhappy and not because the doctor is guilty of malpractice or has rendered poor care.

Risk Management Recommendations

Patient refunds, reimbursements and fee waivers can be complicated. Refunds may not be necessary if the outcome is a known risk of the procedure and the patient has been informed of that risk. Therefore, requests should be granted on a case-by-case basis, after balancing the benefits and risks of doing so and obtaining the input of legal and or professional liability advisors when necessary. Consider the following recommendations:

- Create standardized policies and procedures for patient refund requests.
  - Ensure your policies on waivers and refunds do not violate agreements with private health insurers, Medicare and Medicaid.
- Be aware of which types of transactions with patients trigger an obligation to report to the National Practitioner Data Bank.
- If a patient requests a refund or reimbursement due to dissatisfaction:
  - Acknowledge his or her dissatisfaction, even if it initially seems unfounded or overreaching.
  - Determine, to the best of your ability, why the patient is unhappy (for example, excessive wait time, failure to notify of test results, etc.).
  - Apologize for any systems failures that contributed to the outcome.
    - Explain the steps you will take to have the systems issue evaluated in an effort to prevent similar outcomes in the future.
  - Try to answer the patient's questions, but do not speculate as to liability.
  - If there is more than one party involved in a refund request, coordinate and determine whether they will also be waiving their fees and, if not, whether you will cover those fees and, if not, how the patient will be notified that a portion of the care and treatment will not be paid by you.
  - Determine whether third-party payers need to be involved in the refund request. Refunding copayments and deductibles may violate the policies of the patient's health insurer and/or violate state and federal laws. Therefore, offers to waive, reimburse or refund co-payments, deductibles or fees to patients with private insurance or Medicare/Medicaid should be carefully considered.
  - Document in the patient's record the refund request, the basis of the request, what has been offered to the patient and the patient's acceptance or refusal of the offer.
    - File in the patient's record a copy of the refund check cover letter and/or any correspondence related to the refund.
    - Do not document in the medical record interactions with your liability insurance representatives or your attorney.
- Use information gained from the service recovery process to identify systems and/or practices that could be improved.

Responding to Negative Online Comments

Physicians sometimes call the Risk Management Department for advice after a patient has posted a negative review online. Some callers want confirmation that fighting back in court or online is appropriate, but these seemingly satisfying solutions can backfire.

Suing the Reviewer for Defamation

"Absolutely the worst place to go to…Avoid this place."
— Brian R., Yelp Physician Review

Overall, healthcare entities and clinicians have not been successful in defamation lawsuits against patients for negative reviews.[22] Negative patient reviews are generally protected by the First Amendment, unless the post is a statement of incorrect facts. Opinions, regardless of how hurtful, are not defamatory. For example, Brian R's Yelp claim that his physician's office was "absolutely the worst place to go" is Brian R's opinion. Not only are defamation cases difficult to win, they are expensive. The reviewer most likely will not have the solvency necessary to satisfy a judgment, and the lawsuit will attract more online attention, thus directing more internet traffic to the negative review.[22] Additionally, Yelp is now warning consumers if a business has sued reviewers. Consequently, litigation should be considered a last resort.

Engaging in Online Battle

Responding to a negative review may be appropriate, but should only be undertaken after careful consideration. Trading insults online with a disgruntled patient can quickly escalate, and the back-and-forth conversation will remain on the rating site for future patients to consider. An angry or defensive response from a physician can also prompt the patient to post negative reviews on various other physician review sites. Some physicians and dentists have taken to responding by posting the patient's medical information, offering to remove it if the patient removes the negative comment. This is an obvious HIPAA violation that can result in federal investigations, which can, in turn, drive more traffic to the negative review.[22,23] In addition, entering into any online dialogue with the patient may lead to an inadvertent HIPAA violation by the physician. While the patient has a right to post any personal information he or she wishes, doing so does not mean the patient has waived his or her HIPAA/privacy rights. The physician may not post personal health information about a patient without a patient's specific authorization.

Risk Management Recommendations

An occasional negative review can be expected in our online culture. Having a plan of action in place can reduce the impact of the review and facilitate a response, should one become necessary. Consider the following recommendations:[23,24,25]

Social Media Action Plan

- Set up your own practice website, where you can control the content and message you want to share with the community. Work with your group administrator or medical director as necessary.
- Develop a social media plan for your practice where postings can be controlled.
  - Link to your website and other controlled accounts on the rating websites to drive patients to positive content.
- Periodically check rating websites to identify any specific issues or trends relative to your practice. Consider setting up online alerts that advise when comments have been posted under your name.

- Provide a patient satisfaction survey. If appropriate, use positive information gathered from the survey in your marketing and social media campaign.
    - Provide a patient complaint process so disgruntled patients can express their concerns or frustrations and receive timely resolution.

Negative Comment Action Plan

- Don't panic.
- Do not respond immediately or impulsively.
    - Take time to consider the comment, reflect on why the individual felt compelled to post it and decide if it is worthy of response.
- If you feel the information is untrue, inappropriate or simply meant to be provocative, try contacting the website administrator. Since rating sites have content guidelines, the administrator may remove information that violates the site's terms. For example, Yelp will remove posts for various reasons, but they "don't typically take sides in factual disputes and generally allow Yelpers to stand behind their reviews."[26]
- If you choose to respond in writing on the website:
    - If you are part of a large group, contact your group administrator and/or medical director regarding policies related to online social media prior to posting or responding to information.
    - Limit the response to general information or updates about how specific issues are addressed.
    - Attempt to move the discussion to a private forum.
        - Do not use patient identifiers, reveal protected health information or confirm that the person posting is a patient of yours.
    - Do not directly or personally attack the individual posting the comment.
        - Understand if you do resort to a personal attack, your response may not be well received by the general public or the patient in question. Have a strategy to help prevent a scenario that may lead to irreparable harm to your reputation.
- If you can determine the identity of the posting individual:
    - Review the medical record for potential issues.
    - If it is appropriate, follow up with the patient in a non-confrontational manner to resolve the issues that led to the negative review.
        - Discuss any concerns the patient may have and address them to the best of your ability.
            - If the matter is resolved, ask the patient to remove the negative review.
        - If the issue(s) directly affect patient care, document all communication and follow up with the patient in the medical record. Include dates and times you spoke with the patient, the patient's exact concerns (use quotation marks as appropriate), your responses and recommendations, and the patient's responses.
        - If there are significant issues and/or a lawsuit is threatened or probable, contact the Claims Department of your medical malpractice carrier.
- Honestly look at yourself and the way you practice in light of the review.
    - The review may contain useful information you can use to improve your practice.
- Periodically follow up a negative review with positive information about your practice on the review website.
    - Do not post fake consumer reviews, as this may result in significant fines and penalties.
- Consult with a trusted attorney before taking any steps towards filing a lawsuit against a reviewer.

Risky Advertising

Physician advertising is controlled by state and federal laws and regulations. Physicians can run afoul of these laws and regulations in a variety of unintentional ways, including: advertising discounted or free services; misrepresenting their credentials and those of other clinicians and staff; using before-and-after photographs; using celebrity testimonials or endorsements; or stating the effectiveness, safety or painlessness of treatment. State laws may also allow patients to sue the physician for damages if they were injured by the false or deceptive advertising.[27]

Case Eight

Allegation:

The physician's false advertisements of his board certification fraudulently induced the patient to choose him for treatment.

A physician's website falsely stated he was board certified. According to the patient, she chose the physician based in part on the board certification claim. Her procedure was completed without complications; however, the patient was never satisfied with the results. She ultimately underwent a revision with a different physician, who told her the first surgeon had been negligent. The patient called her state medical board to file a complaint. During that process, she discovered the physician was not board certified. She then filed a lawsuit alleging malpractice, negligence per se, and negligent representation and fraud associated with the false claims of board certification.

Discussion

Defense experts believed the medical care rendered to the patient met the standard of care. However, the false board certification information on the website complicated the defense. Negligence per se allegations can be difficult to defend. In this case, state law prohibited physicians from falsely advertising board certification. There was no doubt that the physician had violated this statute. The patient argued the statute against physicians' falsely advertising board certification was put in place to protect patients like her from injuries caused by inadequately trained physicians. To support her fraud allegations, she claimed the false certification statements were made to induce her to undergo treatment with the physician and she, in fact, relied on the false statements when she chose to undergo treatment. Not only did the false advertising claims complicate the defense, indemnification for advertising, misrepresentation and fraud claims were not covered by the physician's medical liability insurance policy.

The case was settled.

The physician was also disciplined by the medical board, which ordered him to remove the false claims from his website, pay a fine and undergo continuing medical education (CME) in ethics and professional responsibility.

Risk Management Recommendations

Consider the following recommendation:[28,29]

- Know the physician advertising laws in your practice jurisdiction.
  - Know the physician advertising laws in any other state in which you will be advertising.
- Be truthful.
- Do not promise or guarantee results.
- Avoid making claims related to cures and outcomes.
- Avoid using terms that rank your competence over other physicians, (e.g., "top," "world-famous," "world-class").
- Carefully review fee structure, cost, refunds and financing information to ensure it is complete and not misleading.
- Accurately state board certification and ensure statements are specifically associated with the appropriate physician in the practice.
  - Do not imply board certification or specialty training that does not exist.
- If a procedure is experimental or unproven, do not imply it has proven value or is accepted practice.
- If you hire a marketing or advertising company, ensure they are familiar with healthcare advertising restrictions.
- Have advertisements reviewed by a healthcare attorney.

Conclusion

If a business opportunity seems too good to be true, it probably is. Vendors and business promoters without healthcare practice expertise may not understand why a business proposal is illegal or unethical. Using advisors and approaching the uncertain business issues head on instead of avoiding them can protect patients and avoid the risk of lawsuits and regulatory actions. A common thread in many of these cases is misunderstood contract obligations. The cost of having an attorney review a contract is money well spent, particularly when one considers the time and effort it takes to litigate overreaching contractual obligations. Another commonality among these cases is accepting the risk when cutting corners, but then discovering the damages are far greater than anticipated. It may take time to do something right, but if something goes wrong, there will be evidence of a reasonable process – assuming everything has been adequately documented.

Endnotes

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of the *Claims Rx,* are available in the *Risk Solutions* area of MyACCOUNT, or by policyholder request at 855.882.3412.

1. Zuzek C. Business Basics for Physicians. 2014. *Physicians Foundation Website.* Available at: www.physiciansfoundation.org/uploads/default/Complimentary_Copy_Business_Basics_for_Physicians.pdf (accessed 3/26/2017).
2. Fox R. Physicians Need Business Training to Run Their Practices Well. 2013 Oct. *Physicians Practice Website.* Available at: www.physicianspractice.com/blog/physicians-need-business-training-run-their-practices-well (accessed 3/26/2017).
3. Kreimer S. Five Ethical Challenges in Healthcare. 2010 Jul. *AMN Healthcare Website.* Available at: www.amnhealthcare.com/latest-healthcare-news/five-ethical-challenges-healthcare/ (accessed 3/26/2017).
4. American College of Emergency Physicians Medical Legal Committee. A Risk Management Program for Emergency Medicine; basic components and considerations. 2013 Jan. *ACEP Website.* Available at: www.acep.org/WorkArea/DownloadAsset.aspx?id=90838 (accessed 3/26/2017).
5. Kandell E. Conflict In The Healthcare Arena: What Physicians Can Do About It. 2011 Jan. *Mediate.com Website.* Available at: www.mediate.com/articles/kandellE1.cfm (accessed 3/26/2017).
6. Andrew L. Conflict management, prevention, and resolution in medical settings. *Physician Executive.* 1999 Jul-Aug;25(4):38. Available at: www.researchgate.net/profile/Louise_Andrew2/publication/12742428_Conflict_management_prevention_and_resolution_in_medical_settings/links/55a6a7d808ae51639c573979.pdf (accessed 3/26/2017).
7. Hernandez N. The Responsibilities and Risks of Being a Medical Director. 2016 Jun. *The Doctor Weighs In Website.* Available at: https://thedoctorweighsin.com/the-responsibilities-and-risks-of-being-a-medical-director/ (accessed 3/26/2017).
8. Coover RE. Want to be a Medical Director at a Medical Spa? Beware. 2014 Mar/Apr. *Modern Aesthetics.* Available at: http://modernaesthetics.com/2014/04/want-to-be-a-medical-director-at-a-medical-spa-beware (accessed 3/26/2017).
9. Tan SY. Lawsuits against skilled nursing facilities. 2015 May. *Family Practice News.* Available at: www.mdedge.com/familypracticenews/article/99611/practice-management/lawsuits-against-skilled-nursing-facilities (accessed 3/26/2017).
10. American Academy of Dermatology Association. Protecting Patient Safety & Ensuring Quality Care: State Regulation of Medical Spa Facilities. 2011. *AAD Website.* Available at: http://www.aad.org/file%20library/global%20navigation/member%20tools%20and%20benefits/aada%20advocacy/state%20affairs/advocacy%20toolkit/medical%20spa%20standards%20of%20practice/aada-state-regulation-of-medical-spa-facilities-toolkit.pdf (accessed 3/26/2017).
11. Medical Spas – Legal Considerations for Physicians. 2013 Jan. *Michael R. Lowe, P.A. Website.* Available at: www.lowehealthlaw.com/Articles/Medical-Spas-Legal-Considerations-for-Physicians.shtml (accessed 3/26/2017).

12. Swaye LE, Duncan JW, Ginter PM. Strategic Management of Health Care Organizations. "So, Doctor , Can You Fix This?" A Case Involving a Medical Spa. John Wiley & Sons. 2012. 717-741. Available at: http://www.wiley.com/legacy/wileychi/ginter/supp/Case_15.pdf (accessed 3/26/2017).
13. If job candidate has a criminal record, ask questions. 2009 Aug. *amdenews.com* Available at: www.amednews.com/article/20090810/business/308109998/5/ (accessed 3/26/2017).
14. Thornton RG. Responsibility for the acts of others. Proc (Bayl Univ Med Cent). 2010 Jul; 23(3): 313–315. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2900989/ (accessed 3/26/2017).
15. Kavaler F, Alexander RS. Risk Management in Health Care Institutions: Limiting Liability and Enhancing Care, ed. Jones & Bartlett Learning. Burlington, MA. 2014:77.
16. Nonprofit Risk Management Center. Staff Screening Tool Kit. 3d. 2004. Available at: www.nationalservice.gov/sites/default/files/resource/staff-screen-tool.pdf (accessed 3/26/2017).
17. U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. Medicare Fraud & Abuse: Prevention, Detection, and Reporting. 2016 Oct. *Corporation for National & Community Service Website.* Available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf (accessed 3/26/2017).
18. Case Study based on *Kahn v Medical Board.* 12 Cal. App.4th 1834 (California Court of Appeals, 2d District, 1993) Available at: http://law.justia.com/cases/california/court-of-appeal/4th/12/1834.html (accessed 3/26/2017).
19. Ponsioen F. Negligent Practitioner Credentialing: Avoid Being in the Headlines. 2017 Feb. *Greeley Website.* Available at: http://greeley.com/negligent-practitioner-credentialing-avoid-headlines (accessed 3/26/2017).
20. Weiss LD. Law and Emergency Medicine: Indemnification Clauses in Emergency Physician Contracts. 2012 July/Aug; 19(4): 7. *CommonSense.* Available at: http://www.aaem.org/UserFiles/file/commonsense0812.pdf (accessed 3/26/2017).
21. Armer WD. Indemnification in Healthcare Contracts: Concepts, Coverage and Clauses. 2016 Nov. Available at: www.dallasbar.org/sites/default/files/Nov%202016%20Indemnification%20in%20Healthcare%20Contracts_%20Concepts,%20Coverage%20and%20Clauses%20(Armer)%20(2016.11.15).pdf (accessed 3/26/2017).
22. Ornstein C. Doctors fire back at bad Yelp reviews – and reveal patients' information online. 2016 May. *Washington Post and ProPublica.* Available at: www.washingtonpost.com/news/to-your-health/wp/2016/05/27/docs-fire-back-at-bad-yelp-reviews-and-reveal-patients-information-online/?utm_term=.5581dd676944 (accessed 3/26/2017).
23. Pho K, Gay S. Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices. Greenbranch Publishing. Phoenix, MD:153-169.
24. Lagu T, Hannon NS, Rothberg MB, Lindenauer PK. Patients' evaluations of health care providers in the era of social networking: an analysis of physician-rating websites. *Journal of General Internal Medicine.* 2010; 25(9):942-946. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917672/ (accessed 4/11/2017).
25. Pho K. Doctors should not sue patients for negative online reviews. *KevinMD.com.* May 14, 2011. Available at: www.kevinmd.com/blog/2011/05/doctors-sue-patients-negative-online-reviews.html (accessed 3/26/2017).
26. Yelp Support Center. Will Yelp remove a False or defamatory review? 2017. *Yelp website.* Available at: www.yelp-support.com/article/Will-Yelp-remove-a-false-or-defamatory-review?l=en_US (accessed 3/26/2017).
27. Harris SM. Advertise with Caution: State laws restrict how physicians can market themselves. 2010 Dec. *ENTtoday.* Available at: www.enttoday.org/article/advertise-with-caution-state-laws-restrict-how-physicians-can-market-themselves/ (accessed 3/26/2017).
28. Gandolf S. 7 Dangerous Legal Issues to Avoid in Doctor Advertising. 2014 Jul. *Healthcare Success Website.* Available at: www.healthcaresuccess.com/blog/doctor-marketing/dangerous-legal-issues.html (accessed 3/26/2017).
29. American College of Obstetricians and Gynecologists. Ethical Ways for Physicians to Market a Practice. Committee Opinion No. 510. 2011 Nov. *ACOG Website.* Available at: www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Ways-for-Physicians-to-Market-a-Practice?IsMobileSet=false (accessed 3/26/2017).

CME ACTIVITY

Managing Risk on the Business Side of Medicine

ACCME ACCREDITED WITH COMMENDATION

INSIDE

UPCOMING LIVE EVENTS

norcal-group.com/cme

Don't forget to download the free

MyNORCAL® App

to complete your CME credits for this article (Details on page 12).

Search 'MyNORCAL'

in the App Store or Google Play

Download on the App Store

ANDROID APP ON Google play

50% Recycled, 15% Post-Consumer Waste