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Preventive Action

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Sovereign Immunity – Am I Truly Immune?

By Sandra Strickland, RN, MSN and Joseph Putz, Risk Management Consultants

Sovereign immunity is a complex issue. Some physicians may have the mistaken notion that they are sovereign agents if they become involved in a medical malpractice case, when in actuality they may be at increased risk.

The doctrine of sovereign immunity grew out of England's court system, which held that the king could do no wrong, and hence, could not be sued. Our judicial system adopted the same doctrine and substituted governmental entities for the king, thereby providing government agencies with immunity from claims.

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Subsequent court decisions have eroded some of the immunities first granted to sovereigns.

The evolution of sovereign immunity ultimately resulted in the creation of Florida Statute 768.28, which waives sovereign immunity in tort actions, but limits the liability of the sovereign. Although a claim may be brought against a government agency, damages are limited to $100,000 per claimant and $200,000 per incident. The statute of limitations is also decreased to three years. In egregious cases and cases where economic damages far exceed the limits set by FS 768.28, the plaintiff may seek higher limits by filing a claims bill with the legislature.

Sovereign immunity may apply in medical malpractice claims. Physicians actually employed by federal, state, and local government agencies may enjoy sovereign immunity. Some settings where physician employment may provide sovereign immunity include: county hospitals, county jails, state supported medical universities, county health departments, as well as federal, state, or local government funded healthcare facilities.

Physicians working in these situations are not always protected by sovereign immunity. There are, in fact, agency issues that may complicate the application of sovereign immunity. This is especially true in those situations where a physician is not actually employed by the governmental body, but still works there, usually under contract. One issue is the sovereign agency's control over the physician. Even though language in an employment contract may describe the physician as an agent, if the physician is not under the direct control of the sovereign, the physician may be denied sovereign immunity in a malpractice case.

For example, if a physician is employed by a professional association to provide anesthesia or specialty services in a municipal hospital, the hospital may not have direct control over the physician and, as such, the physician may not be entitled to immunity. Decisions regarding control are generally based on employment practices rather than mere labels in a contract, according to defense attorney William Zei. "By determining who is responsible for making employment decisions, providing compensation to the physician, and preparing the physician's assignments and

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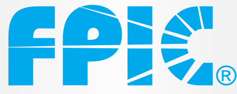

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For comments, questions, or to obtain additional copies contact the FPIC Risk Management Department at 800-741-3742, ext. 3016. rm@fpic.com

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schedules, the sovereign agency's control of the physician can be established and may be used to determine the application of sovereign immunity."

Therefore, physicians practicing independently in a government facility with employed physicians may actually find themselves at greater risk of liability exposure. Because the damages to the sovereign agent are capped, other physicians involved in a malpractice case may be targeted as a "deep pocket" in terms of the plaintiff's theory of liability and thus have greater exposure. In a Broward County case [1], the parents of a young girl born with spina bifida settled with the South Broward Hospital District for $100,000 because of the sovereign immunity liability limits granted to the hospital district. However, a non-employee radiologist also named in the action who was not entitled to sovereign immunity was held liable for $412,500.

Sovereign immunity for physicians involved in malpractice cases has become a complicated issue. According to Laura Thibodeau, Assistant Vice President of Underwriting for FPIC, "The relationship that exists between a sovereign agency and a physician is a very complex issue and each contractual arrangement can be unique. Given the fact that these relationships are subject to interpretation, there is no data to support the application of a premium discount."

It is important to carefully evaluate your role as a sovereign agent before making any assumptions about your immunity. To better understand your risks and protections, it is recommended that you carefully examine your relationship with government agencies in the context of professional services rendered. From a risk management standpoint, it is wise to review any contract with your personal attorney in order to determine exactly what provisions (and exclusions) it contains relative to your entitlement, if any, to sovereign immunity.

Therefore, depending on the circumstances, the impact of sovereign immunity in medical malpractice cases may actually serve to increase your liability exposure.

[1] *Santuchi vs. South Broward Hospital District et al.*

EMTALA UPDATE

Effective September 9, 2003, only off-campus facilities that qualify as "dedicated emergency departments" will remain covered under EMTALA (Emergency Medical Treatment and Active Labor Act). Other off-campus facilities will only be required to call an emergency medical facility if they are incapable of treating the patient and provide any assistance possible until arrival of EMS. A dedicated emergency facility is defined as one that meets at least one of the following three requirements regardless of whether it is off-campus or on a hospital property: 1) licensed by the state in which it is located as an emergency department; 2) held out to the public as a place that provides care for emergency medical conditions on an urgent basis without previously scheduled appointments; or 3) provides emergency care in at least one-third of all outpatient visits. The new rule is designed to relieve off-campus hospital facilities that do not routinely provide emergency care of EMTALA obligations and gives hospitals greater discretion in arranging on-call services mandated by EMTALA.

RISKY BUSINESS:
Practicing with Uninsured Physicians

By Cliff Rapp, Vice President, Risk Management

Under Florida law, physicians that fail to carry malpractice insurance must post a notice to their patients that they are uninsured, or "Bare." However, statutes do not compel that any form of notice be given to ones' colleagues. Commonly it is not until a claim arises that a colleague's lack of insurance is disclosed. Not until then does the impact to those who are insured become painfully apparent – often in tandem with the plaintiff's theory of liability.

In a recent case, our insured oncologist was sued for an alleged failure to diagnose cervical cancer that was missed by the patient's gynecologist, who was uninsured. The gynecologist had referred the patient to our insured because of an abnormal PAP study. Our insured examined the patient and recommended appropriate diagnostic follow-up that was never pursued by the gynecologist. The thrust of the plaintiff's case, however, was against our insured. Not surprisingly, the gynecologist took the position that our insured was at fault for failing to obtain the necessary diagnostic workup.

Practicing with those who are bare can and does increase your risk of being sued. Most physicians understand the term "deep pocket" in the context of malpractice – being targeted by one's insurance coverage instead of culpability. As in the case of our insured oncologist, plaintiff attorneys often direct their case of liability to where there is insurance coverage. When a bare physician is sued, it is almost a given that they will be approached by the plaintiff's attorney with an offer of settlement at some point during the litigation. The attorney will usually offer the bare physician an offer of settlement whereby the plaintiff will not proceed with the case against the bare physician in exchange for the bare physician's agreement to criticize the insured co-defendant physician in deposition or at trial. Refusing to do so subjects the bare physician to aggressive action by the plaintiff attorney.

The rising number of physicians electing to forego professional liability coverage increases your likelihood of participating in healthcare delivery with an uninsured colleague. New legislation designed to enforce financial responsibility of bare practitioners is unlikely to have any direct effect in terms of the risk of being sued. The fact of the matter is that an uninsured physician still faces the same chances of being sued as those who are insured. The issue for those insured is that of increased loss exposure. In terms of effective risk management, carefully consider the potential consequences of practicing along side those whose claim exposure you may ultimately be forced to underwrite.

HIPAA Update: Privacy Rule

There may be situations when it is necessary to disclose an incapacitated patient's protected health information (PHI) to someone who does not meet the HIPAA definition of family and friends involved with the payment or care of the patient. When making decisions involving incapacitated patients in emergency situations, professional judgment may be exercised as long as disclosure protects the best interests of the patient. Disclosures should be limited to that information appropriate under the circumstances.

May medical information be disclosed to a patient's family or friends when rendering treatment to a patient who is unable to speak, much less sign an authorization to disclose protected health information?

Yes. Under the HIPAA Privacy Rule, a covered entity is allowed to disclose to family members, relatives, or close personal friends protected health information that is directly related to their involvement in the incapacitated individual's care or payment related to that care. HIPAA does not prevent you from deciding the extent to which protected health information is disclosed – as long as your disclosures protect the patient's best interests.

Do HIPAA Privacy Rules prevent contacting a priest to provide last rites to an incapacitated patient known to be Catholic, when no family or friends are available to do so?

Under such circumstances, it is up to the individual physician attending the patient to decide if such a disclosure is in the best interests of the patient. Professional judgment can and should be exercised.

How do you determine what is the minimum necessary information that can be used, disclosed, or requested under a specific circumstance or a particular purpose?

The Privacy Rules require that reasonable efforts be made to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. There is no strict standard, but rather a reasonableness standard and thus determination of what constitutes the minimum necessary will vary for each case. Determination should be governed by professional judgment and prevailing standards.

HIPAA UPDATE: Enforcement

The OCR (Office for Civil Rights) recently delivered the following statistics pertaining to HIPAA privacy rule enforcement:

- Total complaints have risen to 1,800 – up from 637 as of June 2003;
- OCR's ten regional offices receive approximately 75 complaints weekly;
- The majority of complaints have been filed by individual patients against provider group practices;
- No civil monetary penalties have yet been issued; and
- 30 percent of complaints have been dismissed due to jurisdictional reasons.

The OCR reports that it does not expect to impose civil monetary penalties unless a covered entity is recalcitrant or unwilling to cooperate with the OCR to resolve a complaint. Most providers have been very willing to cooperate. In terms of criminal penalties, the OCR has referred such matters to the Department of Justice.

Answer To Low Health Literacy: *ASK ME 3*

ASK ME 3 *is an innovative program provided by the* ***Partnership for Clear Health Communication****, a coalition of national organizations that are working together to promote awareness and solutions to low health literacy and its effect on health outcomes – a significant factor in malpractice claims. The* ***ASK ME 3*** *program is available at no cost and is remarkable in its simplicity and loss prevention potential.*

Limited literacy skills are a stronger predictor of an individual's health status than age, income, employment status, or education level. Health literacy - the ability to *read, understand, and effectively use* basic medical instructions and information – is vital to good patient care and positive health outcomes. When patients lack the ability to understand and act upon medical information, it can put their health at risk. Although the effects of the misunderstandings are not always immediately apparent, the adverse outcomes due to non-compliance, improper diagnosis, or delayed treatment frequently result in medical malpractice litigation. Ironically, such claims often include allegations of improperly negotiated informed consent or failure to inform and educate.

People with low health literacy:

- Are often less likely to comply with prescribed treatment and self-care regimes.
- Fail to seek preventive care and are at higher (more than double) risk for hospitalization.
- Remain in the hospital nearly two days longer than adults with higher health literacy.
- Often require additional care that results in annual health care costs that are four times higher than for those with higher literacy skills.

Patients with low literacy skills may be difficult to identify. Often, they are embarrassed or ashamed to admit they have difficulty understanding health information and instructions and may use well-practiced coping mechanisms that effectively mask their problem. Intimidation, fear, and vulnerability are additional factors that may hinder understanding as are shock upon hearing a diagnosis and extenuating stress within the patient's family.

The **ASK ME 3** program is designed to enhance communication. Patients are encouraged to understand the answers to 3 questions:

1. ***What is my main problem?***
2. ***What do I need to do?***
3. ***Why is it important for me to do this?***

The program provides access to tools and resources to help your practice communicate with patients in a way that can better help them understand and act upon your diagnoses and instructions, ultimately improving their health outcomes. Simple techniques are offered that can increase your patients' comfort level with asking questions, as well as in complying with your instructions after they leave appointments.

FPIC now offers a one-hour educational program to explore these concepts and to promote this effective approach to low health literacy. For additional information about the **ASK ME 3** program and resources contact the FPIC Risk Management Department at 1-800-741-3742 ext. 3016 or rm@fpic.com or go to www.AskMe3.org.

CLINICAL PRACTICE PARAMETERS
Successful Management of Diagnostic Testing

By Linda M. Blythe, RN, CPHRM

Failure to diagnose continues to be one of the most prevalent allegations in malpractice claims. Among the most frequent causes are lost or misdirected diagnostic test results. A common factor in these cases is a failure to address abnormal test results in a timely manner. The unfortunate end result is often absence or delay in treatment to the point of irreversible damage to, or poor overall prognosis for the patient.

The PIAA (Physician Insurers Association of America) recently reported that 30 percent of medical office practices fail to document their review of diagnostic test results. Twenty-five percent of practices fail to note a plan of action as a result of those test results. Faulty communication of clinical concerns and stat test results contribute to a significant number of adverse events, which result in severe patient injury and costly medical malpractice claims. Inadequate documentation of the entire process often undermines the defensibility of technically good care.

Consider implementing the following risk management techniques in order to enhance the ability to respond appropriately to diagnostic results in a timely manner:

- A tracking system to monitor the completion of diagnostic studies, that the results are received, and that the physician reviews them before they are filed in the patient's record. Follow-up communication to the patient and subsequent management of the patient's care are also necessary components of the tracking system.
- Give directions for the communication pathway for stat diagnostic test results for both daytime office and after hours (See illustration –a.)
- Use a template stamp to capture complete follow-up documentation on all diagnostic reports when received. (See illustration –b.)
- A filing and chart-flagging system to track patients needing follow-up, repeat diagnostic testing, or monitoring for chronic conditions.
- Educate patients as to the necessity of compliance for diagnostic tests, with the risks and benefits explained – and documented.
- Educate office staff to ensure heightened awareness of the risk exposures related to delayed diagnosis and incomplete follow-up, and the importance of adequate tracking, communication, and documentation.

STAT Diagnostic Results Communication

During office hours of __________ to __________

Phone results to Office: ____________________ FAX results to Office: ____________________

After hours contact Dr. ____________________ On-call phone: ____________________

On-call FAX: ____________________ On-call pager: ____________________

(Illustration - a.)

DIAGNOTIC TEST RECEIVED: Date: ________________

Reviewed by DR: ______________________________ Date: ____________ Time____________

____ Follow-up Orders:

____

____

____ Pharmacy orders: ____

____

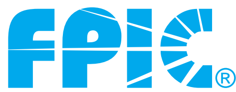
____

____ Phone/Schedule Pt. for office visit to discuss results.

____Patient Contacted: ________________________________ Date: ____________ Time: ____________

Staff signature: ________________________________ Date: ____________ Time: ____________

(Illustration - b.)



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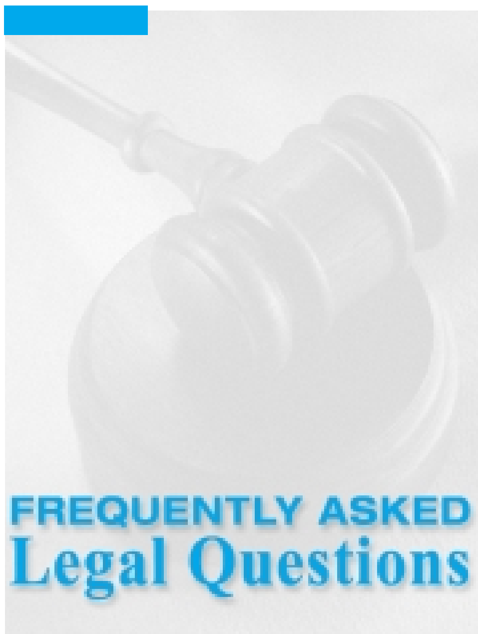

Q. Do HIPAA privacy regulations set forth Privacy Notice requirements for electronic communications such as websites?

Yes. If you maintain a website that provides information about your professional services, a Privacy Notice must be prominently displayed on the website and made available electronically through the website. The Privacy Notice may be made by e-mail if the patient agrees to electronic notice, however, the patient retains the right to obtain a paper copy as well.

Q. Is a specific timeframe set forth when withdrawing professional services to a patient?

No. Although statutes do not specifically set forth the amount of time a patient must be given, managed care contracts and Provider agreements may contain language that does. Generally, a 30-day notice period is sufficient, however, depending on the circumstances, a lesser time period may be appropriate. If the patient terminates you, there is no further obligation to treat the patient. Always review the language of applicable managed care plans before terminating the physician-patient relationship.

Q. What action should be taken when a patient is noncompliant or refuses to undergo diagnostic studies, care, or treatment?

Document your recommendations and the patient's noncompliance. Advise the patient of the potential consequences of their noncompliance or refusal, and document your discussion. Confirm the patient's noncompliance, and your subsequent discussion of the potential consequences, in a letter to the patient sent certified mail, return receipt requested. Send a copy of the letter by regular mail as well. Consider withdrawing from the patient's care, but first review the language of any managed care contracts that may apply to the situation and seek guidance from FPIC's Risk Management Department or personal counsel. If you practice in a group setting, it may be necessary to withdraw on behalf of others in the group and the practice itself.

Q. Do mandatory reporting requirements set forth by Florida statutes pre-empt HIPAA privacy provisions?

Generally, yes. A good example would be FS 381.003 which requires a physician who diagnoses or suspects the existence of a disease of public health significance to immediately report the fact to the Department of Health. However, because the legal waters pertaining to most HIPAA privacy provisions have yet been tested, it is wise to seek legal or risk management guidance.

Q. What action should be taken when a "Notice of Intent" letter is received?

Immediately notify FPIC by calling the Claims Department at (800) 741-3742, ext. 3293. FPIC only has a limited number of days to prepare a response on your behalf to the notice of intent and assign a defense attorney, if necessary. It is important to not discuss the case with the patient, the patient's attorney or other parties involved in the care and treatment of the patient. You should also gather and secure the patient's records immediately.

Q. What is arbitration and what benefit does it provide?

Arbitration is the submission of a dispute to one or more impartial persons for a final and binding decision. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. It is also believed that arbitration panels will help to avoid unreasonable jury awards, thereby further lowering costs. These cost savings would positively impact professional liability rates and the cost and availability of healthcare services.