Risk Rx

Vol. 11 No. 2 | April—June 2014

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Florida Fine Tunes its Definition of "Expert."

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Expert witnesses. What comes to mind? Medical and legal analysts? Talking heads on various news channels? Sadly, the term "expert" has been sullied over time due to a range of issues, including the middle-of-the-night infomercial medical "experts" purporting the ability to lose five hundred pounds in one week versus garden-variety charlatans. In the context of the medico-legal area, however, the value of an "expert" has long been scrutinized due to questionable medical expert reviews, sworn testimony and muddy waters about what is considered "fair game" for opinion.

What makes a credible expert witness? Do we imagine the proverbial Marcus Welby? Do we prefer the intellectual appearing physician from a renowned institution? It depends. Most critical, however, is whether the proffered expert is qualified. Is the expert well trained? Is the expert board certified in the area in which he or she is providing testimony? Is the expert actively practicing in the realm of medicine in which he or she is offering testimony? Has he or she been retired for years? While such questions appear basic, they have not always been basic to Florida. Well…. until now.

Vigorously opposed by the trial lobby, HB 7015 and SB 1792 were enacted on July 1, 2013, having been signed by Governor Rick Scott in June 2013. HB 7015 concludes the use of the Frye standard of 1923, which has been long-followed by the state of Florida. Frye essentially allowed expert witnesses to offer subjective opinions in civil matters and Florida was the only remaining southern state utilizing the standard. Through HB 7015, Florida joins the land of living by adopting the Daubert standard set forth in a 1993 Supreme Court decision. Daubert has been the standard applied in all federal courts and many other states. Under Daubert, and now in Florida, an expert will only be allowed to testify if he or she is able to prove to a judge that the pertinent theory has been tested and has been subject to peer review, has a low rate of error and is generally accepted within the scientific community. Such standard will certainly up the ante as to the nature of the testimony elicited from expert witnesses, arguably resulting in a substantial decrease of expert testimony that cannot be substantiated by means other than "that's my opinion."

Senate Bill 1792 also presents a significant change for expert witnesses in Florida. Under this new law, expert witnesses may provide testimony in a medical malpractice action regarding the prevailing standard of care if they have practiced in the same specialty as the defendant physician. Prior to the enactment of this law, Florida allowed expert witnesses to provide testimony if they had similar specialties or practiced in the same general field. Thus, s. 766.102, Fla. Stat. has been amended as follows, in part:

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless the person is a health care provider who holds an active and valid license and conducts a complete review of the pertinent medical records and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same specialty;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general

practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice or consultation as a general practitioner;
2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

See s. 766.102, Fla. Stat.

Was all of this really necessary?

These new pieces of legislation come on the tails of the requirement that an out-of-state expert witness obtain an expert witness certificate from the Florida Department of Health. Such law, now codified as 458.3175, Fla. Stat., is applicable to all causes of action accruing on or after October 1, 2011. It requires that the expert complete an application containing the expert's legal name, contact information, jurisdictions where licensed with license number and pay a $50 application fee. Following approval, the certification lasts for two years. Most significantly, however, while obtaining the certificate does not permit the expert to practice medicine in Florida, an expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board. Of course, this law certainly was unpleasant for experts, for both plaintiff and defendant alike. Not only would they need to deal with the hassle of obtaining the certificate every two years, they now would also potentially be subject to discipline in Florida, where they are not licensed. [1]

The trial attorney lobby has passionately argued that SB 1792 will only further deprive worthy plaintiffs of having their day in court. However, it is likely that plaintiffs with meritorious claims will not experience any problems. As it relates to requiring medical experts to practice in the same specialty as a physician defendant, such just makes good sense. Its very premise is to ensure the likelihood that the expert will be well versed in the prevailing standard of care in the medical specialty at issue. What does this mean? Well, many of us have seen cases where an expert provides testimony regarding care and treatment provided by a defendant physician, when the expert has never provided such care to a patient. Or much worse.

One recent case regarding this very issue was considered by the Florida Board of Medicine at its meeting on June 7, 2013. At that time, the Florida Board of Medicine rejected a proposed reprimand of a Florida emergency room physician who was board certified in emergency medicine and frequently serves as an expert witness. It was alleged that the physician signed two (2) affidavits in 2010 stating that he was board certified in emergency medicine, though his certification had lapsed the year before. Despite the 74 year old physician's statement that such was an unintentional oversight that resulted from sloppy paperwork, the Florida Board of Medicine unanimously voted to revoke the physician's license to practice medicine in Florida. Though the physician stated that there was no intent to deceive any party, a Board member argued that the physician lied under oath. Therefore, based upon an expert witness law passed in 2011 which punishes medical expert

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witnesses who lie under oath, the Board rendered its decision, revoking the physician's license and his ability to serve as an expert witness in Florida. The physician can currently continue to practice, pending his ongoing appeal of the Board's decision to the First District Court of Appeal.

Given the nature of the work of our firm, we are noticing an appreciable uptick of investigations and matters relating to expert witness testimony. More specifically, we have noticed an increased number of investigations by certification boards and the Department of Health, based upon complaints by plaintiffs, defendant physicians and attorneys that the testifying expert provided false, inappropriate or unsubstantiated testimony. Such investigations are quite serious in nature, particularly as they may result in discipline of the testifying expert's state medical license or loss of board certification.

It is anticipated that these laws may potentially cause a resultant decrease in medical malpractice cases due to the inability to find a supportive expert. It is further expected that there will be a concomitant increase in Department of Health investigations as patients seek an avenue to address their complaints against providers, which may actually negatively impact physicians who will experience increased discipline. Ultimately, however, it would not be surprising that such legislation will frighten potential experts from providing expert testimony.

1. It should be noted, however, that the Florida Supreme Court issued a per curiam opinion on December 12, 2013, at which time it considered the recommendation by the Florida Bar Code and Rules of Evidence Committee that the statutory provision be adopted as a rule of procedure to the extent that it is procedural. The Board of Governors voted to recommend that the Court reject the Committee's proposal on the grounds that the provision is unconstitutional, will have a chilling effect on the ability to obtain expert witnesses and is prejudicial to the administration of justice. Following oral arguments and consideration of the Committee's recommendation, the Florida Supreme Court declined to follow the recommendation and declined to adopt the legislative changes to the Code or newly created s. 766.102(12), Fla. Stat., to the extent that they are procedural. See In Re: Amendments to the Florida Evidence Code. SC 13-98. It will be interesting to see how the law will be challenged in a civil or administrative area against an expert witness who has failed to secure a certificate prior to offering testimony. (Back to Article)

Tips on Being an Effective Witness at Deposition

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A lawsuit consists of snapshots, often taken out of context, in the day in the life of a health care provider. It is focused on one patient to the exclusion of all other patients with whom that health care provider interacted. A series of sound-bites will be stacked end-to-end by the plaintiff's counsel, who hopes to convince a jury that the plaintiff was injured by an act or omission of the health care provider, and deserves compensation. Therefore, careful choice of words is essential at a deposition, as deposition testimony may be admissible at trial to influence the jury.

Successful defense of a lawsuit is dependent in large measure upon demonstrating the plaintiff received competent, conscientious, compassionate and professional health care services. Proof hinges upon you – the involved health care provider. Your demeanor and how you answer questions posed, always truthfully, whether in deposition or trial, are critical. You need to devote substantial time to be fully prepared for your deposition. Generally, expect to spend a minimum of two hours in conference with your attorney. Preparation consists of two parts: Initially, you will conduct a thorough review of the record and discuss the facts with the defense counsel. You need to understand how your role relates to the roles of the other health care providers involved in the care and treatment of the plaintiff. At this time you will have the opportunity to put in perspective apparently odd or unusual chart entries in context of the chart as a whole. Secondly, you need to understand deposition "lingo." Deposition testimony is not like normal conversation. Your attorney can assist you in understanding traps that may be tossed your way.

Some commonly encountered traps include:

Mixing "standards of care" with "standards of documentation:"
Everyone is familiar with the old adage, "if it isn't documented, it didn't happen." Never agree with that statement if made by the plaintiff attorney. It is impossible to document in detail everything that is done. The plaintiff may ask, "Doesn't the standard of care require you to document …?" Florida Statute 766.102 defines the prevailing standard of care as that "level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers." Documentation is not mentioned in the statute. The key is the actual care provided to the patient. Of course, proving what actual care you provided, without independent recollection by the health care provider, may be difficult if the care provided is not clearly documented. Often, however, when viewing the chart and outcome in combination, one can confidently say "… was done because …"or one can testify "I know it was done because I always do it that way."

Mixing "standards of care" with "wouldn't it have been better …" or "it wouldn't have hurt would it to have …" are "slippery-slope" questions. Intuitively, you may feel compelled to agree, but don't play the game. Once you start sliding, you can't stop. Keep in mind the definition of standard of care set forth in the Florida Statutes. Respond to questions by drawing the plaintiff back to the standard of care. Start your answer by saying something to the effect, "The standard of care required …, which is what I did. The standard of care did not require what you are suggesting. I did what a reasonably prudent health care provider would have done under the

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circumstances." And if he persists with the question, "Again, the standard of care required …, which is what I did. You are suggesting a course of action through the retrospective scope that was not required by the standard of care." And finally, if the plaintiff persists in this line of questioning, a proper response would be, "Again, the standard of care required …, which is what I did. You continue to suggest a course of action that was not required by the standard of care." If pushed further, a proper response might be "I can only speculate in retrospect that the results might have been better." The key word is "speculate".

The difference between "probably/probable" and "possible" is critical in answering a question: To prevail in a lawsuit, the plaintiff must prove his or her case by the greater weight of the evidence, i.e., that it is more probable than not that the medical negligence occurred and that the plaintiff was damaged as a result of the medical negligence. Use of the word "probably" in response to a question by the plaintiff equates to the greater weight of the evidence. You need to think twice before you use the word "probably" in response to a question. Use of "possibly" or "I can speculate" in your answer gives away nothing to the plaintiff. If a hypothetical question is posed to you that asks you if something is "possible", and you know that such a possibility existed, then respond that it is "possible" or it is a "possibility". Unless you are convinced that something is more likely than not to have occurred, never respond that it is "probable" that the event could occur.

Use the "first bite": You can answer a question posed anyway you like. Remember, the plaintiff is asking questions seeking a sound-bite that can be used at trial to your detriment. You have the opportunity to phrase your answer to fairly put in perspective what transpired. Question – do you "recall" brushing your teeth on November 21, 2011? You answer "no." The answer is truthful, but it is not fair. You should answer, "I know I brushed my teeth because I brush them everyday, but I can't recall doing so on November 21, 2011".

The "wrap-up" question: You are in hour three of your deposition. The plaintiff says he is about done. He then asks "We would agree then that …" essentially summarizing your testimony. The plaintiff is doing this to have you agree to his word choice. If you say "yes," you are essentially agreeing with both the context and concept of the question. Avoid agreeing with the "wrap-up" question. Respond by saying something to the effect, "I don't know what you agree with, but I have previously testified on that matter and will stand on the answers that I have given."

If pushed, make the plaintiff break the question down into bite-size subparts, and then give the answer using your own words.

To succeed in a deposition, you need to be a good listener. Some critical tips to remember:

Listen to the question.

Repeat the question word-for-word in your own mind. If you cannot do this, ask that the question be repeated.

Ask yourself if you understand the question. If you cannot do this, ask that the question be repeated or clarified. Be prepared, if you ask that it be clarified, for the plaintiff to ask what part don't you understand. Don't respond with a monologue. Respond with something simple like, "your use of the medical terminology makes no sense."

Prepare your answer in your mind after you understand the question.

Now answer the question. A short phrase is normally sufficient. A simple "yes" or "no" would also be appropriate, provided it cannot be taken out of context as a damaging sound-bite. If you agree with the question by responding "yes", you are agreeing to the word choice of plaintiff's counsel. Answer only the question asked. Avoid longwinded answers. Your job is not to educate the plaintiff. Your job is to demonstrate that you provided competent, conscientious, compassionate and professional health care services, which complied with the professional standard of care.

Veterinary Medicine and the Law:

How to Provide Good Care and Protect Yourself in the Process.

Part II: Medical Records

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You have all likely heard the adage perpetuated by Plaintiff's attorneys that, "If it's not in the medical record, it didn't happen." Certainly, you cannot be expected to memorialize absolutely everything that is said and done during an appointment. However, well documented medical care is not only beneficial to the patient and their owners, but to you and your practice should you ever be placed in the position of having to defend that care. The medical record is very often helpful, especially where memories have faded and the only recollection of the event is the written record.

Regardless of all the benefits of a well-documented medical record, it is also a requirement and condition of Florida statutes and administrative codes, and the retention of your license. Florida Statutes require that, "Each person who provides veterinary medical services shall maintain medical records, as established by rule."1 Though Florida Statutes do not go into greater specificity about what should be included in the medical record, Florida Administrative Code for the Board of Veterinary Medicine provides specific guidelines for the creation and content of medical records.2 Florida Administrative Code requires

that the medical record be created, "as treatment is provided or within 24 hours from the time of treatment."[3] It goes on to state that the medical record shall include:

- Date of each service performed
- Name of owner
- Patient identification
- Record of any vaccinations administered
- Complaint or reason for services
- History
- Physical exam including weight, temperature, pulse and respiration
- Any present illness or injury
- Provisional diagnosis

The primary purpose of the medical record is to communicate the condition of the patient at the time of their examination or treatment. It serves to document what you have done and why. Inversely, it also serves to document what you have not done and in some circumstances, why you have chosen not to do so. Therefore, the medical record corroborates your actions, thought process and decision making with respect to your care of the patient. The patient's history is also relevant, especially where different veterinarians within the practice will be seeing the animal, so that each veterinarian is fully informed of the patient's condition in one accessible place and optimal care can be provided. Remember as well that patients may leave your practice and therefore, your medical record becomes important to the continuity of care provided by subsequent treating veterinarians.

Depending on the number of patients seen in the day and the requirements of your practice, it may be difficult to complete your documentation contemporaneous with your care or within 24 hours. Contemporaneous documentation is so important, however, that Florida Statutes[4] allows disciplinary action for the failure to do so, and Florida Administrative Code allows for the issuance of a reprimand, up to one year of probation, and a fine of up to $2,000 for the failure keep contemporaneously written medical records.[5] Therefore, it is advisable that you make every effort to document as much as is reasonably possible as soon as is reasonably possible.

In addition, Florida Administrative Code also requires that if the following services are provided, they shall also be documented in the medical record[6]:

- Laboratory reports
- Radiographic studies
- Consultation
- Medical or surgical treatment
- Hospitalization
- Medications prescribed or administered
- Pathology reports
- Necropsy findings

Note that this section of the Florida Administrative Code deals primarily with the actions taken by the veterinarian after having assessed and examined the patient. Though the mere decision to perform these tests, administer medications, or perform surgery speaks to your thought process, it remains beneficial to document your reasoning. These tests, medications and procedures are very often where a majority of costs to the client are incurred and the ability to explain and justify their performance can become an issue should billing be brought into question.

One of the key components of this medical record documentation, and which is frequently the cause of adverse incidents, is medication administration. Medication is a critical component of the record and often takes the place of other treatments or is the primary treatment before other procedures are explored. It is also advisable to document by whom the medication was ordered, administered and dispensed, as well as the route, strength and dosage of the medication. It is of such critical importance, that the failure to appropriately document medication administration can also lead to disciplinary action pursuant to Florida Statutes and Florida Administrative Code. Florida Statutes allow disciplinary action for failure to document the, "… storing, labeling, selling, dispensing, prescribing and administering of controlled substances."[7] Sanctions can include an administrative fine from $1,500 to $5,000, and up to two years probation.[8]

Though not required by statute or administrative code, client communications are an essential component of the medical record. Because so much of the care provided to animals is an option presented to the client, you should ensure that the treatment plan, recommendations for tests and procedures, the client's agreement with or refusal of, and the possible consequences of these decisions be documented. A client's recollection can at times be clouded by their

emotional involvement in the outcome. The medical record, therefore, can provide a factual recitation of the offers presented and the risks, benefits and costs associated with these. Florida Statutes do provide for disciplinary action when, "Performing or prescribing unnecessary or unauthorized treatment."[9] For that reason, documentation of the need for treatment and the client's authorization may also serve to protect the veterinary provider from disciplinary action. Further, some clients may be non-compliant with the care of their animals and treatment is rendered ineffective. It is recommended that this also be documented so that in the event of an undesired outcome the veterinarian can refer to their good care and recommendations.

Significant complications, adverse incident or unexpected outcome should also be disclosed to the client as timely as possible. A good guideline is to make disclosure if the incident is material to the care, the client has required another procedure or additional care as a result, and certainly if they have suffered a serious injury. Medical record documentation of such an incident is not required by statute or code, but depending on your institution or practice, you may be required to document disclosure of the incident in the medical record. This need only be a brief summary of when the disclosure was made, to whom it was made and a factual recitation of the event free of speculation. Do not criticize other healthcare providers as the medical record is not a vehicle for assigning blame. When in doubt, call your malpractice insurer for advice and guidance on whether disclosure needs to be made and how to appropriately accomplish that.

Florida requires veterinarians to retain medical records for a minimum of three years after the last patient treatment entry, terminated their practice or relocated their practice.[10] In the event of the veterinarian's death, their executor should retain the records for two years from the date of their death.[11] Though certainly good guidelines, your particular facility or practice may have more specific guidelines you are required to follow. You should also consider the statute of limitations, whether there were significant complications with the care of the animal, and whether there existed a contentious relationship with the owner, in determining how long to keep particular records as having these available is a vital part of the defense of any malpractice action.

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— Francys C. Martin, Esq

In Florida, records are confidential and may not be furnished to any person other than the client, his or her legal representative or other veterinarians involved in the care or treatment of the patient, without written authorization.[12] Several exceptions exist, including exceptions for a subpoena from a court of competent jurisdiction with proper notice, statistical and scientific research (provided the information is de-identified), a medical negligence action or administrative proceeding, disciplinary actions against veterinarians, and suspected animal cruelty.[13]

The importance of medical records cannot be overstated. Medical records not only provide the veterinarian with an outlet to document the care provided, but also encourages continuity of care within the practice and with other veterinarians if necessary. Within the context of a possible claim or

litigation, they are of tantamount importance to the defense of good veterinary care. Words have power. When those words are used concisely and thoughtfully in the medical record they have the ability to deliver optimal care to the patient and afford the veterinarian a great deal of protection.

In the final segment of this article, we will discuss veterinary malpractice litigation.

1. 474.2165(2) Fla. Stat. (2013) (Back)
2. Fla. Admin. Code R. 61G18-18.002 (Back)
3. Fla. Admin. Code R. 61G18-18.002(3) (Back)
4. 474.214(ee) Fla. Stat. (2013); .474.214(2) (Back)
5. Fla. Admin. Code R. 61G18-30.001(ee) (Back)
6. Fla. Admin. Code R. 61G18-18.002(4) (Back)
7. 474.214(1)(mm) Fla. Stat. (2013); .474.214(2) (Back)
8. Fla. Admin. Code R. 61G18-30.001(mm) (Back)
9. 474.214(1)(l) Fla. Stat. (2013) (Back)
10. Fla. Admin. Code R. 61G18-18.0015(1) (Back)
11. Fla. Admin. Code R. 61G18-18.001 (Back)
12. 474.2165(4) (Back)
13. Id. (Back)

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