

Risk Rx



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HSC Self-Insurance Program

Editor's Welcome

Welcome to the first edition of **Risk Rx**. This publication provides us an opportunity to communicate with you on a regular basis about the many issues impacting health care providers. It is also our intent to share and promote risk management strategies we hope you will find useful as we strive to enhance patient safety, prevent loss, and minimize liability exposure.

Email us at rmeduc@shands.ufl.edu and let us know how you like **Risk Rx** and we encourage you to submit any relevant topics you would like addressed.

A handwritten signature in black ink, appearing to read "Jan Rebstock".

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UF SIP History

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In 1971 the Florida Board of Governors (the ultimate successor to the Florida Board of Regents) promulgated Rule 6C-10.001 Florida Administrative Code, creating the University of Florida J. Hillis Miller Health Center Self-Insurance Program and in 1987 created the University of Florida JHMHC/Jacksonville Self-Insurance Program (hereafter collectively referred to as UF SIP).

UF SIP was created to provide comprehensive general liability protection, including professional liability insurance, for the University of Florida Board of Trustees and faculty, other employees, agents and students of the UF Health Science Center.

UF SIP is authorized, subject to approval of the UFSIP Council, the University President and the UF Board of Trustees, to extend protection to any not-for-profit corporation that is operated for the benefit of the UF Board of Trustees. Section 1004.41(5) FS, specifically authorizes the UF Board of Trustees to provide comprehensive general liability, including professional liability insurance to Shands Teaching Hospital and Clinics and Shands Jacksonville Medical Center for the organizations and their clinical employees.

In 1995, 6C-10.001(2) of the Florida Administrative Code was amended authorizing the UF SIP to create the University of Florida Healthcare Education Insurance Company (HEIC) which provides excess coverage for UF SIP participants.

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DOH Practitioner Investigation- What to Expect

Gregory A. Chaires, Esq.

In order to practice medicine in the state of Florida, a physician must be licensed to practice medicine by either the Florida Board of Medicine or the Florida Board of Osteopathic Medicine (collectively, the "Boards"). Once a medical license is obtained it becomes a property right of the physician.

All physicians are subject to disciplinary control by the Boards and their practice is regulated by the State. Investigations conducted by the Department of Health (DOH) generally result from reporting mechanisms put in place by the Florida Legislature. Complaints may originate from a variety of sources including patients, closed claims for medical negligence, newspaper reports of criminal activity, Code 15 Reports, other practitioners and plaintiff attorneys. After receipt of a complaint, the Department assigns the case to a field office the locality of the physician.

All physicians whose licenses are under investigation are notified of the investigation via certified mail from the Department.¹ Before a physician is notified of a complaint, however, the Department first must ensure that there are legally sufficient grounds for doing so.² A complaint is legally sufficient if it contains facts which show that a physician may have violated any rule or regulation applicable to that physician under Florida Law.³

Once a complaint is assigned to a field office, an investigator collects information and evidence concerning the allegations of the complaint. This is done by conducting interviews, obtaining medical records or policy and procedures or any other

information that may bear on the alleged violation(s). This also includes a statement from the physician. *It is important that health care providers understand they have a right against self-incrimination and do not need to reply personally to the investigation.* Many physicians believe that he or she can make a phone call to the investigator, tell them their side of the story and the matter will be dismissed. Investigators have no decision-making authority, they merely prepare a report stating what they think you said. *It is much more important that the physician obtain competent legal counsel that is familiar with the administrative law to assist in preparing and submitting any response concerning the investigation.*

The notice of the investigation received by the physician includes a copy of the complaint document and a uniform complaint form. The uniform complaint form sets forth the specific allegations against the physician and the alleged violations of Florida law. *Physicians are afforded approximately 45 days to respond in writing to the allegations stated in the uniform complaint form.⁴ The response should be from the physician's legal counsel, not the physician.*

The investigator compiles information and generates an investigative report that summarizes his or her findings, including any statement submitted by the physician through his or her attorney, and the case is

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forwarded to a Department prosecutor for further review. It is the prosecutor's job to first determine whether there is evidence to proceed with the case. The prosecutor thereafter makes a recommendation to the Probable Cause Panel charged with reviewing the case whether to proceed with a disciplinary action or dismiss the case. For cases dismissed without a finding of probable cause, the investigation itself and all materials generated during the investigation remain confidential.⁵

The Probable Cause Panel (the "Panel") is made up of two physicians and one consumer member of the respective Boards. One physician is a current member and generally, the other physician is a former member. The Department presents the investigation to the Panel to ultimately determine if the matter should proceed or be dismissed based upon a recommendation made by the Department prosecutor. The Panel may, but is not obligated, to follow the recommendations of the Department prosecutor. The Panel's job is to determine ultimately if probable cause exists to direct the Department to file a disciplinary action against the physician. *Probable cause simply means that there is evidence that there has been a violation of Florida law.*

If the panel finds that there is insufficient evidence to support a finding of probable cause, the matter is dismissed and the matter is closed. If the panel believes that there is sufficient evidence to find probable cause, it will direct the Department to file an Administrative Complaint against the physician. The Panel occasionally issues a letter of guidance to the physician in lieu of a probable cause finding. If a letter of guidance is issued, the investigation remains confidential.

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If an Administrative Complaint is filed against the physician, there are several options for the physician to consider which will be set forth in an Election of Rights form received with the complaint. Among the available options:

- 1.) **Settlement Agreement.** A physician can enter into a *settlement agreement* with the Department. By entering into a settlement agreement, the physician can negotiate the terms with the prosecutor and does not admit nor deny the allegations set forth in the administrative complaint. *The settlement agreement must be approved by the respective Board.* Typically, the physician will pay an administrative fine which can range in amount depending upon the severity of the violation. The physician will also likely be required to partake in community service and complete additional hours of continuing medical education. In addition, the physician is always required to pay Departmental costs.
- 2.) **Board Hearing.** If the physician admits to the facts presented in the administrative complaint, but cannot come to agreeable terms with the prosecutor or believes there are strong mitigating factors to consider, the physician can choose to have a hearing before the Board. If the physician chooses a hearing with non-disputed facts, the physician is forced to adhere to the determinations of the Board. *It is recommended that this alternative only be used in rare circumstances and with the advice of legal counsel.*
- 3.) **Formal Administrative Hearing.** A third alternative is to opt for a more formal hearing before an

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Administrative Law Judge (ALJ). A formal hearing before an ALJ from the Division of Administrative Hearings is held when there are disputed issues of material fact.⁶ Each side presents their evidence and at the end of the presentation of all the evidence, the ALJ issues a recommended order. The recommended order is then forwarded to the Board for final approval and issuance of a penalty. *The Board always has the last word in disciplinary matters and is the final determiner of the appropriate penalty.* Penalties can range from complete revocation of a physician's license, suspension, or in the case of less severe infractions, monetary fines.⁷ Other penalties include additional continuing medical education, community service and payment of the costs of the investigation.

The purpose of discipline by the Boards is to improve the quality of health care services. Sometimes this means educating a physician or providing the physician with a warning; other times it is by removing an incompetent physician from the practice of medicine altogether. It is an extremely important function and one that should be respected.

When a physician receives notification from the Department that an investigation has been initiated, it is important the physician takes the matter seriously whether or not he or she feels any wrongdoing occurred. Unlike medical malpractice actions, the risks involved with a disciplinary proceeding are more than monetary. The physician can permanently lose the ability to practice medicine. *Obtaining prompt, competent legal advice and assistance can ensure that your rights are appropriately preserved.*

Should Self Insurance Program participants receive a notification of investigation from

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the Department of Health, we ask that you promptly inform the on-call SIP Risk Manager at 273-7006 who will assist and guide you through the process.

¹ If it is determined notification would be detrimental to the investigation, the Department may withhold notification.

² Fla. Stat. Ch. 456.073(1)(2004)

³ Id at 1

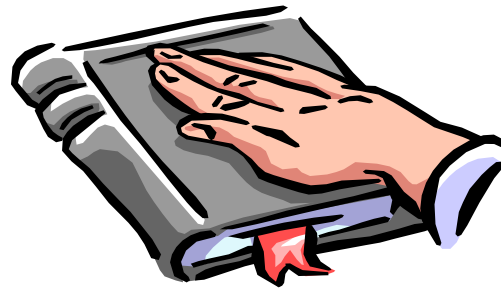
⁴ Fla. Stat. Ch. 458.331(9)(2004) Fla. Stat. Ch. 459.015(9)(2004)

⁵ Fla. Stat. Ch 456.073(2)(2004)

⁶ Fla. Stat. Ch. 456.073(5)(2004)

⁷ See 64B8-8.001, F.A.C. at

<http://fac.dos.state.fl.us/faonline/chapter64.pdf> for a list of recommended range of penalties.



Tips on Being an Effective Witness at Deposition

Ray Kreichelt, Associate Dir. Claims
UF HSC Self-Insurance Program

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.

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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

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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 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

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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, 2003? 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, 2003."

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- 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

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"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.

Legal Case Review:

Cris Palacio, Esq.



Case Summary: ([Anne Marie Nolen v. Boca Raton Community Hospital, Inc. Et al., 373 F.3d 1151 \(11th Cir. 2004\)](#)) This pediatric nurse presented to the above hospital on May 4, 2000 for a labor check. The patient was 22 weeks pregnant with triplets and was complaining of cramping and mucous discharge. A hospital nurse took the patient's vital signs and medical history, listened to fetal heartbeats, put the patient on a fetal monitor, performed an initial abdominal exam and paged her physician. The physician performed a cervical exam, a vaginal culture and an ultrasound to evaluate each of the three fetal heart rates.

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The patient's cervix was found to be neither dilated or thinned and culture results were negative. Fetal monitoring for more than an hour revealed only one conclusive episodic contraction. After almost two hours of testing and observation, the physician determined the patient was not in labor and discharged the patient to follow up with a scheduled appointment with her perinatologist the next day. After leaving the hospital, the patient began having cramps but did not contact the hospital or her OB physician. The next day, her perinatologist concluded, following examination, that the patient may have been entering pre-term labor at that time but that she could not have been in pre-term labor at the time she was in the hospital. The patient was admitted to suppress her pre-term labor, however, this was unsuccessful and the first baby was stillborn and the other two babies did not survive for more than a few weeks.

Allegation: The patient sued the hospital and both physicians alleging that the hospital did not provide an initial adequate medical screening examination; did not stabilize her labor condition adequately and discharged her in violation of the EMTALA.

Analysis: First, the court addressed the patient's contention that EMTALA requires a hospital to have a written screening procedure. Relying on a previous decision by an 8th Circuit Court on the same issue, and based on the language of the statute itself, the Court found that there is no requirement under EMTALA that a facility have a written procedure for Medical Screening Examinations. In reviewing the facts of the case, the Court found that the hospital nurse performed exactly the type of screening that would have been given to any other patient in that position. In fact, the Court found that the patient received "superior" care from the hospital, in that the nurse summoned the physician to perform

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an in-person exam, which was done in only 6% of the patients under similar conditions. (Note that the Court did evaluate statistics related to care provided to similar patients!) The Court held that, so long as the patient received the same quality screening that a similarly situated patient would have received, the hospital satisfied its EMTALA obligations.

This decision is consistent with an earlier decision by the 11th Circuit Court in *Holcomb v. Monoham* (30 F.3d 116, 1994), where the Court found that Humana Hospital-Montgomery had provided the patient with an "appropriate" MSE. In that case, the court stated that EMTALA "is not designed to redress a negligent diagnosis by the hospital...as long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate...the Act."

The U.S. District Court for the Northern District of Florida came to the same conclusion when addressing the issue of what constitutes an "appropriate" MSE under EMTALA in *Rose Lane v Calhoun-Liberty County Hospital Association, Inc.* 846 F. Supp. 5432 (1994). In *Rose Lane*, the Court states that the important question is whether the hospital conforms to its "standard screening procedures," holding that there is no EMTALA liability if there is consistency, "even if those procedures are deficient under state medical malpractice law."

Risk Reduction Strategies: To avoid allegations of inappropriate medical screening exams, it is important that patient's presenting with the same or similar symptoms are provided the same quality medical screening exam. This can best be demonstrated by thorough and timely chart documentation and assuring that existing policies, protocols and procedures are up to

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date and reflect your department's actual practice.

It is recommended that Emergency Room Departments conduct periodic self-assessments to determine compliance with all EMTALA regulations.

<p>LOG ON AND TUNE IN!</p> 	<p>Current Online lectures:</p> <ul style="list-style-type: none">Baker Act; EMTALA;Chain of Command;Credentialing, Peer Review and Medical Staff Monitoring;Informed Consent;Patient Safety;Pressure Ulcer Prevention;Wrong Site Surgery;Retained Foreign Bodies.
<p>One of SIP's best kept secrets is our risk management website: www.riskmanagementeducation.com which offers many lectures that have been approved for CME and CEU credit (free for SIP participants), downloadable brochures, legislative updates, sentinel event alerts, and other "hot" information links.</p>	