

## A doctor on trial

### David Sugarbaker tells his story

By Amy Johnson Conner

**I** have never been through anything like this before. It was unsettling to say the least," said Dr. David Sugarbaker, who spent more than two weeks on trial this summer after a patient filed a medical suit against him that alleged a post-operative stroke was caused by a drug he prescribed.

"People put their trust in you, [and a trial] is so aberrant, so different from what we're trying to do - help people, feel their trust and come through for them," said Sugarbaker, Brigham & Women's Hospital's chief of thoracic surgery and Dana Farber Cancer Institute's chief of surgical services. "It can be a time of confusion and self-doubt and self-judgment."

In the end, Sugarbaker won. He was sued, but he engaged in trial preparation, made himself available anytime his attorney needed him and came out on the other side of

**Dr. David Sugarbaker (inset) was on trial for malpractice at Suffolk Superior Court for nearly three weeks this summer.**

the trial with his sanity, practice, relationships and confidence still intact. Or at least repaired.

James L. Wilkinson of Boston, Sugarbaker's defense attorney, helped make him feel at ease throughout the process, he said.

Boston attorney Mark Breakstone, who represented the plaintiff, did not return calls requesting comment for this story.

#### The facts

The plaintiff in the case, Paul Vaskas, sought the best surgeon to remove a portion of his lung after a sequestration developed. This abnormal portion of lung tissue was cut off from the rest of the organ and had developed its own blood supply to the heart. If left to grow, an area like this becomes a haven for bacteria, can become infected and inflamed and can cause all kinds of health problems, some of which Vaskas had already suffered, according to Wilkinson.

Vaskas, who was 41 at the time, selected Sugarbaker to perform the routine operation for this not-so-routine condition.

"He's quite an accomplished physician and internationally known," Wilkinson said.

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## Medical I.D. theft is a prescription for legal headache

By Sylvia Hsieh

A rising trend of medical identity theft - where a patient's personal information is used fraudulently to obtain or to bill for medical services - is raising tricky legal issues for medical providers.

When misinformation finds its way into the medical file of the identity theft victim, doctors and hospitals must juggle the competing interests of the patient's demands, federal privacy requirements and their own liability.

Unlike simple identity fraud, medical identity theft carries more than just financial consequences.

"Medically, it could be extremely dangerous both to the person who is an unauthorized user as well as the person whose identity was stolen," said Dr. Marylou Buyse, a practicing family physician and president of the Massachusetts Association of Health Plans.

Medical identity theft most commonly occurs in the following ways:

- A patient may use a relative's insurance card - or steal someone's wallet and use their insurance information - to obtain medical services.
- An "insider" in a hospital or doctor's office may misuse a patient's insurance in-

**Curing medical identity theft**  
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## 'Stick to your guns'

### Lessons from the defense verdict in the Charlie Weis med-mal case

By Eric Berkman

Some football fans may have been surprised that the doctors prevailed when former New England Patriots offensive coordinator Charlie Weis sued them for malpractice after complications from gastric-bypass surgery.

But physicians and medical malpractice defense lawyers say they weren't surprised at all. They say the defense verdict shows that the jury system properly vindicates physicians who operate within the standard of care.

"I'd tell a doctor in this position, if you honestly believe a claim doesn't have merit and you believe the reviewers who agreed with you, take it to trial," said Boston lawyer Jim Vaccarino, who was Massachusetts General Hospital's director of legal affairs in the 1970s and now creates and manages professional-liability insurance programs for health care providers. "Stick to your guns no matter how much it may hurt to be characterized negatively in the press until vindicated."

The case provides valuable lessons on the importance of going above and beyond when it comes to informed consent, documentation and dealing with high-powered patients, experts said.

"The key thing is to get [a high-powered patient] to see the interaction with you as a partnership so you're both working together toward a common goal," said Dr. Adam Glasgow, director of the weight-loss surgery

program at Caritas Norwood Hospital.

Weis, now the head football coach at Notre Dame, claimed he bled internally after the operation, falling into a coma and almost dying as a result of the negligence of surgeons at MGH.

The plaintiff's role in delivering three NFL championships to a region whose self-esteem famously hinges on the success of its pro sports teams - coupled with testimony from superstar Pats quarterback Tom Brady - created the potential for a jury dazzled by the glare of multiple Super Bowl rings.

But jurors ultimately looked past emotional testimony from Weis, Brady and others to deliver a defense verdict after two hours of deliberation.

Michael E. Mone Sr. of Boston, who represented Weis, attributes the verdict partly to society's attitude toward the overweight.

"They look upon [obesity] as a lack of self control ... and [the public views] gastric bypass surgery as a cosmetic thing when it's life-saving surgery," said Mone. "I think that hurts you a lot in a case involving gastric bypass, especially when Mr. Weis acknowledged he understood the surgery had substantial risk."

William J. Dailey Jr. of Boston, who represented the doctors, declined to be interviewed for this story.



**Charlie Weis lost his medical malpractice case against two MGH surgeons.**

#### Risky procedure

According to Dr. Charles Ferguson, Weis - in a hurry to be ready for training camp in 2002 - demanded to have gastric-bypass surgery quickly rather than go through the recommended six weeks of preoperative preparation.

Shortly after Ferguson performed the surgery, Weis began bleeding internally and

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# Demystifying the doctor-lawyer relationship

Nearly all health care professionals I talk to have no question in their minds about the importance of the doctor-patient relationship.

At its foundation, it is the doctor's relationship with his or her patient that makes the health care system function.

It transcends everything in medical offices of all sizes, in community hospitals, in academic medical centers, in surgi-centers and nursing homes.

The trust built between a patient and his or her physician can even mean the difference between health and sickness or life and death. Clearly, it is the most paramount relationship in our health care delivery system.

But what about the relationship between a doctor and his lawyer?

For Dr. David Sugarbaker, who won a medical malpractice trial this summer, it was his relationship with his lawyer that made all the difference.

It took two years of producing this publication to find a doctor who was willing to share the details of the emotional process of being tried for malpractice – when you know in your heart you did everything you could to help your patient.

With his candor, Sugarbaker's story de-

mystifies the courtroom, the law office, even the lawyers.

He makes clear that the experience brought with it "confusion and self-doubt and self-judgment."

However, working closely with his lawyer, James L. Wilkinson of Boston, Sugarbaker learned in advance about the tough moments that would make the trial, discussing the case

"page by page," so nothing that came up would be a surprise to him.

They met at their offices and at home. Together, they visited the courtroom, and Wilkinson went through a play-by-play of what Sugarbaker could expect.

Making the best of a tough situation, their story is a glimpse into the strongest a doctor-lawyer relationship can be.

And that made a difficult process just a little bit easier for Sugarbaker.

## Editor's Note

Reni Gertner, MPH



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# Surgi-center report signals tighter regulation

By Sylvia Hsieh

A report released by a special commission on ambulatory surgery centers (ASCs) suggests that while physician-owned surgi-centers are here to stay, they can expect to see new regulations in the future.

These centers have been a contentious issue, pitting doctors against hospitals in some communities.

Hospitals have argued that surgi-centers are taking away the most profitable areas of practice thereby compromising their ability to subsidize less profitable areas such as mental health services, while physicians say they can perform surgeries more efficiently by opening surgi-centers and stay competi-

by creating a special accreditation process with oversight and transparency;

- Surgi-centers that receive reimbursement from the Health Care Safety Net Fund share in the cost of the assessment that hospitals currently pay into the fund (and the amount hospitals pay would be reduced correspondingly);
- The department of health implement reporting requirements on surgi-centers to analyze potential negative financial impact on hospitals.

## End of the physician exemption?

A number of state legislative initiatives had been proposed before the report, and some are likely to be encouraged by the commission's recommendations.

"The recommendations lead us in the direction of getting some reasonably effective legislation passed," said Thieme.

One of those bills is House No. 2063, which would require existing surgi-centers to meet the same licensing requirements and determination of need showing that hospitals are required to meet.

The bill would essentially eliminate the "physician exemption," which allows doctors who open a surgi-center as an extension of their practice to do so without additional licensure procedures or a determination of need from the state department of health.

"Nothing in the commission's report would

close the door on this bill," said Thieme.

The report noted that while "the physician exemption was originally intended to protect traditional physician practices from sweeping regulatory changes, it has allowed certain [surgi-centers] to operate without going through the DoN [determination of need] process or undergoing associated regulatory oversight by the state."

Hospitals say removing the physician exemption would simply "even the playing field" between hospitals and physician-owned surgi-centers.

"Things have changed from the traditional physician practice to adjoining ASCs and it makes perfect sense to go back and make sure there is appropriate oversight and accountability," Gens said.

Surgi-centers, on the other hand, say that

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tive in a worsening professional environment. (See "Physician-owned surgi-centers: Fight them, join them or ignore them?" Massachusetts Medical Law Report, Summer 2007)

"The commission tried to strike a balance between various concerns and made sound recommendations," said Timothy Gens, a member of the commission who represented the Massachusetts Hospital Association.

Physicians were relieved the commission did not call for a moratorium to halt surgi-centers, as some recent budget bills had done.

"People are breathing a lot better now," said Dr. Peter Bentivegna, a hand and plastic surgeon, who part owns a surgi-center on Cape Cod.

"Is the commission jumping up and down to help doctors open surgi-centers? No. But they did not come out strongly against ASCs either," said Dr. Ted Calianos, president of the Barnstable District Medical Society.

Despite the recommendations, some observers noted that the commission did not indicate when new regulations might come to fruition.

"There's no one taking a shoe and banging it on the table saying there's a crisis," said Thomas Crane, a health care attorney with Mintz Levin in Boston.

"What does not come through is a degree of urgency," said Donald J. Thieme, executive director of the Massachusetts Council of Community Hospitals. "This is not something that can be deferred year after year. Otherwise, community hospitals will suffer death by a thousand cuts."

While the commission did not come out with specific legislative proposals, it recommended that:

- The state department of public health (DPH) create a separate set of licensure and determination of need procedures for surgi-centers, including those operating within the physician exemption;
- Surgi-centers that are Medicare-certified be eligible for reimbursement from Medicaid and the Health Care Safety Net Fund (formerly the Uncompensated Care Pool)



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# Listening In

## The news beat of the medical profession



### 'YouTube' for doctors

A new website, [www.thedoctorschannel.com](http://www.thedoctorschannel.com), is being billed as an educational YouTube for busy doctors, where physicians can view videos posted by other doctors, keep up with surgical trends and get tips on the medical convention hot spots, according to the Boston Herald.

Physicians are used to getting their information quickly,

whether it's by reading an e-mail on a BlackBerry or scanning an RSS feed, Doctor's Channel Inc. co-founder Dr. David Best of New York told the Herald.

On the website, physicians can post and view short videos of themselves and their colleagues opining on medical advances and new technology and seeking help with difficult cases.

### Med-mal 'occurrence' coverage reemerges

A select number of medical liability insurance carriers are now offering "occurrence" coverage, providing another option for professional medical liability insurance buyers, according to William Gallagher Associates in Boston.

After dealing with complex litigation over the concept of occurrence, insurers began to issue policies – know as claims-made policies – that are triggered at the time claims are presented.

Under occurrence-based policies, a loss is covered if the occurrence happens during the policy period, no matter when the insured is faced with a claim for damages, according to Peter Reilly, healthcare practice leader at WGA, which provides insurance brokerage, risk management and employee benefits services.

### Mass. doctors rank highly

An online report from Watertown-based Massachusetts Health Quality Partners suggests that physicians in Massachusetts outperform their national counterparts in most categories, according to the Worcester Telegram & Gazette.

However, there are significant variations across the state, especially in how physicians care for teenagers, test for colorectal cancer and monitor kidney functions in diabetics.

The non-profit group of doctors, health plans, state agencies and hospitals summarized the clinical performance of primary care physicians at 150 of the state's largest medical groups.

The report used 2005 claims data from the state's five largest health plans, and focused on how well medical groups at various locations rated in 17 categories of disease management and preventive care.



### Hospitals tackle HIPAA issues

The U.S. Department of Health and Human Services is stepping up its enforcement of HIPAA, making secured e-mail communications a top priority for hospitals.

Any hospital that is not securing electronic health information sent over public networks could be considered out of compliance with HIPAA regulations, says Mark Bower of Voltage Security, which offers

information encryption services and recently helped Boston Medical Center implement systems to protect its electronic patient information.

HIPAA rules are very specific about the handling of patient data when it is transmitted over insecure networks, explains Bower, so securing e-mail communication is one of the key areas to address with HIPAA compliance.

### EHRs have limited effect on care

A study in the Archives of Internal Medicine suggests that electronic health records have little or no effect on the quality of care provided during ambulatory visits to certain physicians, according to the Washington Post.

Jeffrey Linder, an associate physician in the division of internal medicine and primary care at Brigham and Women's Hospital in Boston, and his colleagues looked at ambulatory care

visits to non-federally funded, community, office-based practices across the country and compared those visits using 17 indicators of quality care.

Linder's study found no general difference in quality of care during visits with and without electronic records, the Post reports.

However, some critics are concerned that the study may be misinterpreted by some as proof that EHRs are not useful.

### Abbreviations to blame for Rx errors

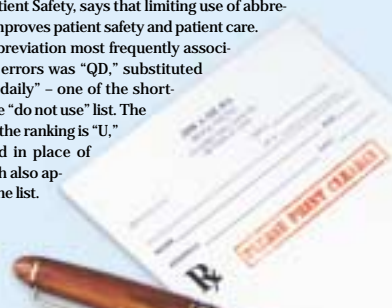
Physicians should watch their shortcuts in prescriptions, according to the results of a recent Joint Commission study.

The "Impact of Abbreviations on Patient Safety" report stated that about 5 percent of all errors listed in the national medication error-reporting program Medmarx between 2004 and 2006 were attributed to abbreviations.

During that same time, hospitals' compliance with the commission's "do not use" list of abbreviations fell to 64 percent from 75 percent.

The report, published in the Joint Commission Journal on Quality and Patient Safety, says that limiting use of abbreviations improves patient safety and patient care.

The abbreviation most frequently associated with errors was "QD," substituted for "once daily" – one of the shortcuts on the "do not use" list. The second in the ranking is "U," often used in place of unit, which also appears on the list.



### Campaign 2008: Health on the web

With health care at the forefront of domestic issues in the 2008 presidential election, the Kaiser Family Foundation has launched a new website – [www.health08.org](http://www.health08.org) – that will provide analysis of health policy issues, public opinion surveys and news and video coverage from the campaign trail.

Kaiser, while tracking health and the 2008 election, has found health care to be a top domestic issue that the public wants addressed by the candidates. Kaiser says 41 percent of adults are personally worried about health care and insurance costs, trumping concerns over housing costs, terrorism, crime, jobs and the stock market.

### E-messaging as a cure?

A study by researchers at Kaiser Permanente health care system reveals that patients who had access to their physicians by way of an electronic messaging service made fewer office visits than they did before enrolling in the service.

E-messaging users also visited their doctors fewer times than members of a randomly-selected control group not enrolled in the web-based service, the Health IT Strategist reports.

The study also shows that patients using the service made fewer telephone calls to their physicians than members of the control group.

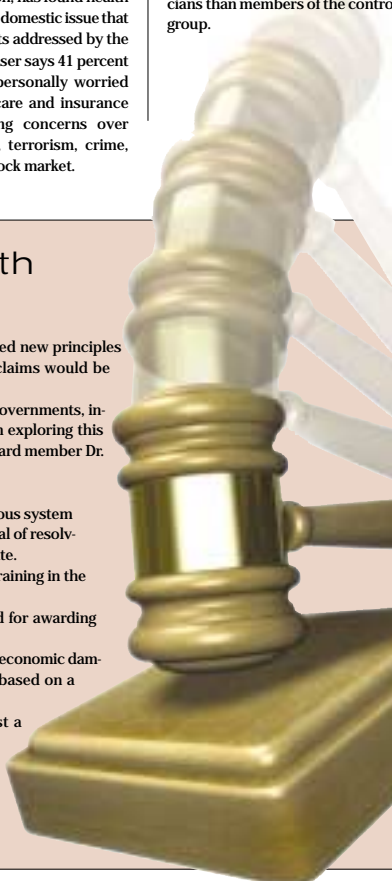
### AMA adopts health court principles

The American Medical Association has adopted new principles for health courts, where medical malpractice claims would be heard by specialized judges and experts.

The principles "should assist state and local governments, insurers, hospitals and other entities interested in exploring this option for medical liability reform," said AMA board member Dr. William A. Hazel, in a statement.

The six principles are:

- Health courts should create a fair and expeditious system for resolving medical liability claims, with a goal of resolving all claims within one year from the filing date.
- Health court judges should have specialized training in the delivery of medical care.
- Negligence should be the minimum threshold for awarding damages.
- Judgments should not be limited to recovering economic damages, but non-economic damages should be based on a schedule.
- Qualified experts should be utilized to assist a health court in reaching a judgment.
- Health court pilot projects should be able to "sun-set" if they prove unsuccessful at reducing costs.



# Surgi-center report signals tighter regulation

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so far the determination of need process has been a closed process.

"Anytime you are subject to a DoN, you cannot exist. If you call the department of public health, they will tell you it's a closed process," said Calianos.

### Medicaid eligibility

Doctors who own surgi-centers agree with the commission's recommendation that they be eligible for Medicaid.

"One of the hospitals' biggest moans is that they think we cherry-pick. But the only reason we don't take Mass Health is because we need a license, and we can't get a license. We would apply for Mass Health tomorrow if we were allowed to," said Bentivegna.

However, the report also suggested that surgi-centers that are eligible for the Health Care Safety Net Fund pay an assessment to fund uninsured patients.

Currently, hospitals collectively pay \$160 million based on their percentage of private pay patients, and are then reimbursed for patients who are uninsured.

"Seven days a week, 24 hours a day, our doors are open to all. Hospitals are not receiving full costs under Medicare, Medicaid or free care patients. We also pay an assessment and a surcharge as an employer. Hospitals contribute in multiple ways and we think that ASCs should contribute too," said Gens.

He added that although the new health care law will dramatically reduce the number of uninsured patients, there will always be some patients who do not have health insurance.

But physicians who own surgi-centers



said that the assessment should account for the fact that centers bill at a lower rate than hospitals for the same services.

"The big sticking point will be how can you make it equitable on the payout side if it's not equitable on the pay-in side," said Calianos, who added that one reason hospitals have shied away from entering joint ven-

tures with surgi-centers is that they would have to bill at the lower rate.

### Physician selfreferral

The report cited a 2007 McKinsey Global Institute report that physicians who own equipment and surgi-centers refer between two and eight times more patients than their

peers without equity interest.

But the commission was silent on recommending tighter rules on surgi-centers regarding physician self-referral.

"The very liberal exceptions to the federal Stark law and anti-kickback laws frankly allow physician-owned ASCs to proceed with very little regulatory oversight," said Crane.

The report, however, did recommend that physician letters of exemption be phased out for doctors who own diagnostic and imaging services, such as MRI centers.

Crane, who has written about physician self-referral and served as an expert advisor to the commission, had recommended the creation of state rules to piggyback on the federal ones.

The fact that the commission did not adopt this recommendation for surgi-centers "reflects a comfort with the structure of physician-owned ASCs and a lack of any proven quality or utilization issues," said Crane.

He added that the commission had good reason to be less concerned about self-referrals by physicians who own surgi-centers than by doctors who own diagnostic and testing centers.

This is because a surgeon who refers a patient for unnecessary surgery at his own center would "clearly be out of bounds," whereas for a doctor who refers a patient to get an MRI at an imaging center he owns, "it's less clear-cut whether the request is unnecessary - it's much more of a judgment call," Crane said.

The report can be found at:

[http://www.mass.gov/legis/reports/ASC-MRI\\_REPORT-wTransmittal.pdf](http://www.mass.gov/legis/reports/ASC-MRI_REPORT-wTransmittal.pdf) MMLR

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# Verdicts & Settlements

## Doctor not negligent for late diagnosis in colon cancer case

The patient was a 54-year-old male in good health who presented to the local hospital in January 1995 with complaints of rectal bleeding.

A referral was made to a gastroenterologist, who suspected diverticulosis due to the patient's history. The patient stopped bleeding and a bleeding scan was cancelled.

The patient had a colonoscopy, but due to poor preparation and pain, the scope did not reach further than a small portion of the transverse colon and the cecum was not visualized.

The next day, the patient was given a barium enema with single contrast, but it didn't locate the source of the bleeding. The patient was discharged and not seen until around 15 months later.

At that time, the gastroenterologist recommended sigmoidoscopy, but the patient didn't follow up on the recommendation.

Fifteen months after that, in June 1997, the patient felt ill and turned out to have an obstruction. He was taken by ambulance to the hospital and, after a colonoscopy, was diagnosed with ulcerating cancer of the cecum.

Despite surgical resection, radiation and chemotherapy, the patient died of advanced colon cancer in August 2000.

The plaintiff's gastroenterology expert asserted that the defendant violated standards of care in not assuring adequate preparation for the colonoscopy in 1995 and that the single contrast barium enema was not appropriate to determine the source of the bleeding. The expert claimed that a double contrast barium enema or an angiogram would have been more effective.

The expert also claimed that the gastroenterologist was the "captain of the ship," but the court ruled that the doctor is only responsible for his own care and treatment, not such things as the interpretation of the barium enema.

On cross-examination, the gastroenterology expert admitted that he had not performed an endoscopy since 1987, and that he is not board certified in gastroenterology.

The plaintiff's colorectal surgery expert claimed that if the cancer had been diagnosed in 1995, it would have had a 100 percent cure rate, but that by the time it was diagnosed, it was incurable.

The defense countered that the bleeding in 1995 could not have been the result of cancer because cancer continues to grow and the bleeding would have been expected to be a continuing problem. The expert also opined that the bleeding almost certainly came from the lower colon – not the cecum where the cancer was later found – because

## Defibrillator investigation, suits settled

Three units of Natick-based Boston Scientific Corp. will pay nearly \$17 million to 35 states to settle an investigation about potentially fatal flaws in implanted defibrillators.

Boston Scientific, which purchased the three companies last year in its \$27 billion acquisition of Guidant Corporation, did not admit any wrongdoing.

Boston Scientific will extend the warranty on some of its heart devices by an additional six months.

The Oregon Department of Justice announced a multistate investigation of Guidant in 2005.

That came after two cardiologists said the company continued to sell the implantable defibrillator even after it discovered a wiring problem that could cause it to fail.

At least one patient is known to have died as a result.

In July, Boston Scientific officials agreed

to pay \$195 million to resolve lawsuits filed by defibrillator patients.

The patients' claims were all consolidated in federal court, with the first trial due to start July 30. The agreement included an undetermined number of other similar claims from across the country, but not all of them.

Boston Scientific faced approximately 1,430 lawsuits stemming from recalls and warnings involving Guidant's implantable defibrillators and pacemakers. It had set aside \$732 million to cover expenses in the cases as of March 31, it said in a regulatory filing.

Since June 2005, Guidant has issued safety warnings or recalled more than 88,000 defibrillators and has recalled or issued warnings on about 200,000 pacemakers. The company was criticized for dragging its feet in notifying doctors, patients and regulators about the problems.

the plaintiff initially presented to the hospital with fecal material and blood. Further, the expert contended that the patient's rapid short bleed was consistent with diverticulosis, while cancer would have been likely to cause continued oozing.

According to the defense expert, the single contrast barium enema is as effective as the double contrast. The double contrast may reveal small polyps but in this case, the bleeding could not have been caused by a small polyp. In 1996 when the patient returned, the standard of care for screening was sigmoidoscopy, considering that he already had a recent colonoscopy.

The jury deliberated a little more than an hour before finding no negligence.

**Type of action:** Medical malpractice  
**Injuries alleged:** Delayed diagnosis of colon cancer leading to metastasis and death  
**Date of verdict:** January 5, 2007  
**Submitted by:** Peter C. Knight, Morrison Mahoney, Boston (for the defendant)

## Epidural hematoma case settles for \$2 million

The plaintiff, a 62-year-old man, had an indwelling epidural catheter for pain relief following an endarterectomy in his groin.

A day after the catheter was removed, the patient began having progressive neurological symptoms, including numbness in his feet,

loss of strength in his legs, a distended bladder and, 14 hours after his symptoms began, paralysis of both legs and one arm.

A senior surgical resident was notified by nurses of the plaintiff's progressive neurological symptoms, for which he ordered an abdominal CT scan and inserted a urinary catheter for the distended bladder.

The resident left the hospital at 4:00 p.m. and didn't return to see the plaintiff until 1:00 a.m. – notwithstanding calls regarding progressive weakness – when a hospitalist he had asked to examine the plaintiff confirmed paralysis. The resident called his attending physician, who suggested that he call a neurologist.

The attending physician testified in deposition that had all of the plaintiff's neurological findings been told to her by the resident, she would personally have come to the hospital to make emergency preparations for surgery to evacuate an expanding spinal epidural hematoma.

The resident called the neurologist, who testified that he suggested a spinal CT scan to rule out an epidural hematoma, but did not come to the hospital to examine the plaintiff. The resident testified that he would have ordered the CT scan if he was instructed to do so.

The following morning, the plaintiff had a spinal CT scan which showed a large epidural hematoma. The hematoma was evacuated surgically, returning function to the plaintiff's arm, but he remained paraplegic. Subsequently, the plaintiff had an above-knee amputation because of severe vascular disease.

The defense contended that the plaintiff's vascular disease would eventually claim the

plaintiff's other leg, which was already being closely monitored, and that his life expectancy was similarly shortened.

The case settled for \$2 million.

**Type of action:** Medical malpractice  
**Injuries alleged:** Paraplegia  
**Date of settlement:** April 17, 2007  
**Submitted by:** Barry D. Lang and Zachary B. Lang, Barry D. Lang, M.D. & Associates, Boston (for the plaintiff)

## Hospital settles pressure ulcer suit

The plaintiff was a 72-year-old woman who was an unrestrained passenger in an automobile accident.

She sustained a tibia plateau fracture, which required that she undergo the surgical installation of hardware. She was fitted with a straight leg knee immobilizer. In the days that followed, she frequently complained about discomfort in her knee, but her physicians thought her complaints concerned the underlying fracture and surgical repair. In reality, she had developed a stage III pressure ulcer on her right lower leg which hospital staff was late in discovering and treating.

Pre-trial discovery revealed that hospital staff did not routinely remove the knee immobilizer contrary to accepted practice.

The plaintiff argued that regular removal of the brace would have prevented the pressure sore from developing. In the alternative, scheduled removal of the brace along with regular inspection of the plaintiff's leg should have alerted hospital staff to identify and begin treating the ulcer sooner.

The hospital, however, contended that it performed adequate skin checks regarding the plaintiff and that she received appropriate care. Moreover, the hospital opined that given the gravity of the plaintiff's original injury, as well as the obvious necessity of immobilizing her leg to promote the joinder of the bone, the development of a pressure sore was an acceptable risk and not evidence of negligence.

As a result of the ulcer, the plaintiff underwent both a debridement and multiple hyperbaric oxygen treatments. Fortunately, she responded well to such treatments and the ulcer soon healed without leaving an appreciable scar.

The case settled for \$100,000.

**Type of action:** Medical malpractice  
**Injuries alleged:** Pressure ulcer due to failure to remove knee immobilizer  
**Date of verdict:** April 30, 2007  
**Submitted by:** Dino M. Colucci, Colucci, Colucci, Marcus & Flavin, Milton (for the plaintiff)



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# Verdicts & Settlements

## Anesthesiologist not negligent in cancer case

The patient, a 73-year old male, was admitted to the hospital for colon cancer surgery.

He weighed 250 pounds and had a history of snoring. There was extra tissue found on pre-anesthesia examination in the area of the glottis and the pre-anesthesia worksheet failed to indicate an examination of the airway.

A 7 mm endotracheal tube was inserted blindly as the vocal cords were not visualized. Following the surgery, the patient began to cough and at that time, the anesthesiologist elected to extubate the endotracheal tube.

The patient immediately obstructed and arrested. The patient was initially bagged and then CPR was performed. After a few minutes, he was reintubated. During recov-

ery, the patient was slow to respond and was diagnosed with anoxic encephalopathy, leading to disability.

The plaintiffs claimed that the pre-anesthesia evaluation was incomplete, the choice of endotracheal tube was too small (a 7 mm tube is used for children), and that the extubation and resuscitation violated the standards of care required for anesthesia in such circumstances.

The anesthesiologist countered that the pre-anesthesia evaluation was appropriate. The defense maintained that the selection of the endotracheal tube, intubation and extubation were appropriate.

According to the defendant, the patient's cough showed that he was clinically ready to be extubated and that he had regained strength, that his vital signs were good and that he was breathing spontaneously.

Further, the obstruction was recognized very quickly and when the pulse was lost, it was quickly recognized and CPR was performed. The defense claimed that waiting for

improvement with bagging met the standard of care. It was only after there was no improvement that the patient was reintubated.

The plaintiffs' expert admitted that many of the important anesthesia textbooks offered opinions that differed from his. Initially, he had claimed that there was no such thing as a "cough" with an endotracheal tube in place. Nevertheless, he later recognized that several textbooks refer to this so-called "cough" as an indicator that the patient is getting ready to wake up.

The defense was founded on an argument that the anesthesiologist used the best clinical judgment. The jury agreed that the anesthesiologist was indeed in compliance with all standards of care in the provision of anesthesia and found in his favor.

**Type of action:** Medical malpractice

**Injuries alleged:** Brain injury associated with anesthesia extubation and delayed intubation

**Date of verdict:** April 11, 2007

**Submitted by:** Peter C. Knight, Morrison Mahoney, Boston (for the defendant)

## Woman's arm injury allegedly worsened by bone surgery

A 29-year-old plaintiff suffered a crush injury to her right arm in an accident at work in October 1998 when her arm became caught in a paper roller.

She came under the care of an orthopedic surgeon shortly after the injury and was treated for several months with anti-inflam-

matory medications and physical therapy.

The surgeon eventually released the plaintiff to return to work. Due to continued pain in her arm, the plaintiff returned to the surgeon, who determined that the cause of the ongoing symptoms was probably related to a congenital ulnar deviation superimposed on the crush injury.

In August 1999, the surgeon performed surgery to lengthen the ulnar bone, but the plaintiff continued to experience pain in the arm and ultimately came under the care of another surgeon, who performed a corrective surgical fusion procedure in August 2001.

The plaintiff was noted to have significant improvement with respect to the pain in her arm. She had further surgery one year later to remove the hardware and was ultimately released from further medical treatment.

The plaintiff contended that the surgery performed by the surgeon in 1999 was unnecessary and contributed to an exacerbation of the symptoms in her arm associated with the crush injury, causing her to experience increased pain and suffering and further lost time from work.

The surgeon claimed that the procedure had improved the plaintiff's symptoms and that any ongoing impairment associated with her condition was related to the underlying crush injury.

The case settled at mediation for \$350,000, shortly before trial.

**Type of action:** Medical malpractice

**Injuries alleged:** Worsening of arm injury

**Date of verdict:** February 2007

**Submitted by:** Charlotte E. Glinka, Keches & Mallen, Taunton (for the plaintiff)

## Verdict & Settlement Reports

Massachusetts Medical Law Report compiles the summaries of verdicts and settlements on this page from reports sent by attorneys to us or to Massachusetts Lawyers Weekly. The report information is generally provided by one of the lawyers in the case, although occasional reports may be based on court records and news reports. We edit the material for style, grammar, length and, where appropriate, content. We are interested in printing verdicts won by health care providers as well as plaintiffs, in addition to settlements.

**If you have an item you would like to submit, please contact Alyssa Cutler at [alysa.cutler@lawyersweekly.com](mailto:alysa.cutler@lawyersweekly.com) or 617-218-8152.**



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# Good Medicine

What doctors are talking about now



## Q: Do you think legal action against insurers' physician-rating systems would be justified?

"Doctors have every reason to want and expect rating systems that are fair and accurate, but I would like to think that it wouldn't require legal action to make that happen. If they are constructed with the correct data, rating systems may be a useful tool, in combination with other factors, for evaluating the performance of doctors. The best approach would be for doctors and insurers to work together on a system that ensures fairness, accuracy and objectivity."

— **Charlotte E. Glinka, Esq.**  
Partner and medical malpractice department senior litigator, **Keches & Mallen, Taunton**

"I do think it would be justified. I think the interests and priorities of health insurance companies and physicians are quite different. Physicians factor only a patient's health into their decision-making equation. It is the doctor's one and only priority. Health insurance companies factor many other things into their priorities – cost being a huge component. So, I do think these ranking systems likely factor in costs and not just quality, and that is unfortunate, as patients should only be concerned about the quality of the care provided."

— **A. Bernard Guekguezian, Esq.**  
Partner, **Adler, Cohen, Harvey, Wakeman & Guekguezian, Boston**

"Physician-rating systems need to be based on accurate data; accessible for review by physicians prior to public release in a transparent, easily understandable manner; and subject to a fair, objective and timely appeals process. In the absence of the high standards for physician ratings outlined on the MMS website, ratings may cause serious harm to the reputation of physicians and financial harm to patients, and should be subject to legal action for damages."

— **Michael W. Yogman, M.D.**  
Pediatrician, **Cambridge**

"Accurate ratings of physician quality and efficiency could be extremely useful to patients. Increasingly, patients are being asked to take more responsibility for decisions about their health care, including making more-informed choices of physicians. But physician concerns about inaccurate data may be legitimate, and insurers need to proceed carefully and work with physicians to provide accurate data about both cost and quality that can help consumers choose higher-performing physicians. Physicians have every right to oppose ratings that they are not comfortable with, but it is also appropriate for the public to raise questions about whether this is really a campaign for accuracy or a campaign to preclude competition among physicians."

— **Paul B. Ginsburg, Ph.D.**  
President, **Center for Studying Health System Change, Washington, D.C.**



## Rating MDs: Collaboration offers best solutions

By **B. Dale Magee, M.D., M.S.**

The "pay for performance" movement is part of a trend in health insurance to use data about physicians and their practices to provide incentives for higher quality or less expensive care.

With pay for performance, a doctor is given extra money if certain goals are met, usually related to processes of care felt to be universally necessary for certain patients – for example, Pap smears for women over 20 or mammograms for women over 50.

A related trend known as "tiering" takes a somewhat different approach: patients going to doctors with better scores are asked to pay less for visits than those seeing doctors with poorer scores.

Although these trends are often grouped under the "transparency" category, both of these movements suffer from the same problem: they aren't *transparent* to physicians. Procedures used to select and screen patient data are proprietary, and doctors do not see the data to even validate that the patients are theirs and that the tests being measured are appropriate for these patients.

Further, at the individual physician level, only one or two patients can make the difference between winning and losing in this game. You can see why doctors feel frustrated by a movement that is pretending to be something that it isn't.

In Washington state, some doctors and the state's medical society, in partnership with the American Medical Association, sued Regence BlueShield over a plan based on these same approaches.

The issues centered around the use of inaccurate data, old information and contracts

that were being subverted by a process that was limiting patients' access to contracted physicians who were themselves being libeled and denied due process.

In response, Blue Shield withdrew the plan and adopted procedures which should bring more integrity and utility to the use of the medical information.

In Connecticut, the Fairfield County Medical Association has sued three insurers, accusing them of trying to cut costs by steering patients to certain doctors designated as "elite" and of damaging the reputations of physicians not so designated. And New York's Attorney General has warned insurers that ratings based on claims data may be unsound and could be considered confusing and deceptive.

Health insurers, the government and others have tried to use similar approaches for payments to hospitals with modest success. But physicians aren't the same as hospitals. An infrastructure of management and information technology enables a hospital to generate data and turn it into action.

With doctors' offices, these layers of management and IT usually do not exist.

Also, the data on physicians' patients is the result not of a single admission for care under one roof, but of years of care from many different providers. The center of this information, even for those physicians with electronic medical records, is not the doctors' offices but health plans, where all of the claims come to roost.

But the trouble with claims is that they are generated to get payment, not to transmit clinical data. Yes, some clinical information is there, but there's a limit to how much we can torture the data to get it to tell us about the patient.

As a result, patients may be labeled with a disease they do not have, a billing glitch may not properly credit an individual with having a test that was in fact performed and, for reasons that aren't clear at all, a patient may be attributed to a doctor that he or she never saw.

Like those in Washington, Connecticut, and New York, we in Massachusetts are concerned that the current rating systems may have unintended consequences and that no formal way exists to detect these if they happen.

Physicians' reputations could be ruined, access to care delayed and costs unfairly shifted to patients. We believe that the best solutions will come through collaboration.

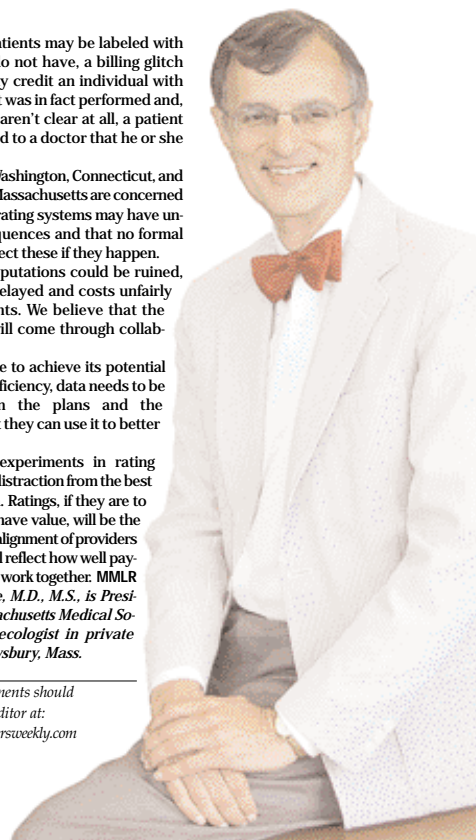
For health care to achieve its potential for quality and efficiency, data needs to be shared between the plans and the providers so that they can use it to better a patient's care.

The current experiments in rating physicians are a distraction from the best uses for this data. Ratings, if they are to be accurate and have value, will be the byproduct of the alignment of providers and plans and will reflect how well payers and providers work together. MMLR

*B. Dale Magee, M.D., M.S., is President of the Massachusetts Medical Society and a gynecologist in private practice in Shrewsbury, Mass.*

Questions or comments should be directed to the editor at:  
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Doctor's **R<sub>x</sub>**



# 'Stick to your guns': The Charlie Weis case

Continued from page 1

lapsed into a coma, nearly dying before emerging two weeks later. Weis claimed that Ferguson and Dr. Richard Hodin, who was covering for Ferguson when the complications developed, negligently allowed him to bleed for 30 hours before performing a second procedure to correct the complications.

Weis testified that he still suffers from numbness and pain in his feet as a result of the procedure and is often forced to ride in a golf cart during football practices.

The surgeons, on the other hand, testified that they had informed Weis of the dangers of the procedure beforehand, that internal bleeding was a well-known complication, and that – in their clinical judgment – the bleeding would stop on its own. They also testified that they feared a second surgery could result in a pulmonary embolism.

Brady had been at Weis's bedside during the ordeal and appeared at the first trial, in February 2007, to describe Weis's condition before and after the surgery. But the judge called a mistrial after Hodin and Ferguson rushed to help a juror who had collapsed. Brady did not testify at the second trial, which took place this summer. Instead, the quarterback's testimony from the first trial was read into the record.

The jury found for the defendants.

## Post-game analysis

The verdict comes as no shock to Martin Foster, a Cambridge med-mal defense lawyer.

"The risk of mortality or morbidity associated with the surgery is about 3 percent, which is usually prohibitively high for elective surgery," says Foster, whose firm has successfully defended two such cases this year. "I believe juries accept that, to some degree, patients afflicted with morbid obesity have two sets of bad

risks – the risk of surgery or the risk of remaining obese – and that the physician is doing the best he or she can for these very high-risk patients."

Glasgow agreed, adding that Weis came across as an unsympathetic plaintiff.

"From what I understand, he pushed fairly hard to have things done his way and wanted treatment that seemed to be outside what another patient might have been entitled to," he said. "A year later ... he seemed to have regained most of his weight. Patients have a great deal of responsibility for what they do after a procedure, and looking at him, you wonder about his commitment to the whole process."

At the same time, David Gould, a med-mal defense lawyer with Ficksman Connolly in Boston, says Weis's obesity – and willingness to undergo a risky procedure to remedy it – could have just as easily worked in his favor. "But what I think makes the jury unsympathetic is if someone understands that there are risks to a surgery, one of these risks becomes a reality, and all of a sudden he doesn't like it."

The verdict also proves that the jury system works, even in the face of emotional testimony from well-known and charismatic personalities, said Boston defense lawyer Alan Rindler, a partner with Rindler Morgan.

Here, the jury heard testimony from Brady regarding the suffering of a coach who has said he views the quarterback as being "like a son." But these details didn't prove underlying negligence.

"[Brady's] testimony could have been very compelling regarding the pain of his friend, but if the jury's not even going to ever reach damages, it's irrelevant. The jury's not going to be considering damages in determining liability," Rindler said.

## High-powered patients

Many powerful, influential people – both celebrities and noncelebrities – place inordinately high demands on their physicians, said Foster. Some may want to direct their own care while others may expect to be seen without appointments.

"This is especially true in the sports field," said Foster. "They expect to win and need even more attention when they lose."

Doctors and lawyers agree that simply being subject to a claim from such a patient – like Weis – is a harrowing, life-altering experience, even if the doctor wins in the end.

"To sit through a trial in Superior Court for weeks, sitting through an emotional opening statement that's completely ad hominem, to have a professional colleague from your own specialty condemn your medical care as substandard and to have this occur in a public place is something a physician never forgets, regardless of outcome," said Foster.

It can be even worse when – as in the Weis case – media coverage is involved, added Rindler, who mentioned the case of Boston Celtics star Reggie Lewis, who died of a sudden heart attack during a 1993 workout. Lewis's widow unsuccessfully sued the player's doctors for allegedly misdiagnosing a heart condition.

"Can you ever recover from a smear like that whether it's true or not? Many would think not," said Rindler. "[The doctors'] reputations have been tarnished. That's what publicity does in terms of adding extra pressure and taking its toll on the physician regardless of outcome." MMLR

Questions or comments should be directed to the editor at: [reni.gertner@lawyersweekly.com](mailto:reni.gertner@lawyersweekly.com)

## Preventive medicine

By Eric Berkman

Engaging in certain practices from the beginning of a doctor-patient relationship can help head off the risk of a malpractice suit – such as the Charlie Weis case – in the event of a bad outcome, experts say.

The first key is to thoroughly document all conversations with the patient to create a detailed record of informed consent.

In the Weis case, the physicians' demonstration of informed consent helped dictate the outcome. In other cases, it may help avoid a claim altogether.

Patients can have their hospital medical records sent to a plaintiff's lawyer without the doctor ever knowing about it, said Boston lawyer Jim Vaccarino, who was Massachusetts General Hospital's director of legal affairs in the 1970s.

An exquisitely detailed record leaves things less open to speculation, making a case more daunting in the eyes of a plaintiffs' attorney. "Cases are often decided on the contents of the chart long before any other factors are introduced," said Vaccarino.

Building a good rapport with a patient is similarly critical, said Cambridge med-mal defense lawyer Martin Foster.

"A physician who is detached, unresponsive and inaccessible, and pushes his patients too much onto ancillary providers, drives them more quickly to plaintiffs' attorneys," he said.

Finally, Vaccarino emphasized that it's critical for doctors not to react too quickly in the face of a troubling outcome.

"You should *never* evaluate a situation where there is potential misunderstanding without the benefit of consultation with others," he said. MMLR



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# Bills, Rules & Regs



## From Capitol Hill

### Medicare claims data to be released

Data on physicians' claims paid by Medicare will be released under a decision from a U.S. District Court in the District of Columbia.

Consumers' CHECKBOOK/Center for the Study of Services, a nonprofit consumer research organization, won a Freedom of Information Act (FOIA) lawsuit that will require the U.S. Department of Health and Human Services to release the data.

The data will identify physicians but not patients.

The organization plans to create a free resource on its website at [www.checkbook.org](http://www.checkbook.org) that will report the number of various types of major procedures performed by each physician and reimbursed by Medicare.

Physicians will also be invited to report their total procedure count directly.

The government argued that it couldn't release the data with physicians identified due to an exemption in the FOIA designed to protect personal privacy.

But the court said that the privacy exemption did not apply due to the public interest in disclosure of the information and the absence of any significant privacy interest on the part of the physicians.

The Aug. 22 ruling requires HHS to release Medicare claims from Illinois, Maryland, Washington, Virginia and the District of Columbia.

The group also has a FOIA request pending for Medicare claims data for all 50 states.

### House approves drug safety bill

The House has approved a bill that would expand Food and Drug Administration oversight of prescription drug safety.

Under the legislation, the FDA could require pharmaceutical companies to conduct post-market safety studies of new medications, limit distribution of certain treatments and order product label changes.

The bill would allow the FDA to fine pharmaceutical companies as much as \$250,000 for a single violation of the requirements and as much as \$1 million for multiple violations.

If a company doesn't address a violation after receiving notice, the FDA could fine it up to \$10 million for a single violation, and up to \$50 million for multiple violations.

The legislation also allows the FDA to review and recommend changes to direct-to-consumer advertisements for new medica-

tions and require disclosures in potentially false or misleading ads.

The legislation would establish a "unique identifier number" for all medical devices that would allow the FDA and health care providers to track the devices for problems.

The Senate approved a similar bill in May. It is still unclear whether President George W. Bush will veto the bill if it reaches his desk.

The bill would reauthorize the Prescription Drug User Fee Act and the Medical Device User Fee and Modernization Act, which both expire on Sept. 30.

Industry user fees would fund more than half the FDA's budget for reviewing drugs and granting approval.

### Medicare won't cover hospital errors

Medicare will no longer pay the cost of treating preventable injuries and infections that occur in hospitals – a move Bush administration officials say could save lives and millions of dollars.

Under the new rules, Medicare will no longer pay hospitals for treating certain "conditions that could reasonably have been prevented," such as bedsores, injuries caused by falls and infections resulting from the prolonged use of catheters.

In addition, Medicare will not reimburse for the treatment of "serious preventable events" such as leaving a sponge in a patient during surgery or providing a patient with incompatible blood or blood products.

The new policy is likely to cause physicians to follow clinical guidelines more closely and hospitals to perform additional tests to evaluate patients' conditions when they are first admitted.

The change is expected to save Medicare \$20 million a year.

### Physician Quality Reporting Initiative is established

The Centers for Medicare & Medicaid Services has established the Physician Quality Reporting Initiative, providing a financial incentive for physicians to participate in a voluntary quality reporting program.

The initiative was created as a result of the Tax Relief and Health Care Act of 2006, which was signed by President George W. Bush in December 2006.

Eligible physicians who successfully report a designated set of quality measures on claims for dates of service from July 1 through Dec. 31, 2007, may earn bonus payments from Medicare, subject to a cap of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services.

### Pay-for-performance reduces costs

An experiment gauging the efficacy of a pay-for-performance system demonstrated that coordinating care and reducing hospitalizations can lower Medicare costs, according to a report from the Centers for Medicare & Medicaid Services.

CMS analyzed hospital and physician bills for 224,000 patients being treated by 10 physician groups and compared them with

bills from other doctors and patients in the same geographic areas. Physicians involved in the experiment were required to meet certain quality criteria, including adhering to 10 clinical measures for diabetes care.

The experiment found that all of the participating physician groups improved patient care during the first year, the New York Times reports. However, only two groups – the University of Michigan Family Practice and the Marshfield Clinic in Wisconsin – qualified for bonus payments, receiving a total of \$7.3 million in bonus payments for saving Medicare \$9.5 million.

Although the overall savings of the experiment have yet to be calculated, physician groups said that the experiment likely saved Medicare a combined \$21 million.

The fact that only two of the groups were eligible for bonus payments indicates that it might be difficult for Medicare to provide worthwhile incentives to physicians, many of whom have smaller, less technological practices, the Times reports. **MMLR**



## From Beacon Hill

### Hospitals may pay for surgery data collection

Hospitals performing open heart surgery and angioplasty procedures would have to pay for state-required data collection that measures patient outcomes, under a proposed state rule.

The Public Health Council voted to start an expedited regulatory process that would mandate the financial accountability before the Oct. 1 start of most hospitals' fiscal year, the State House News Service reports.

The original order to collect cardiac patient outcome data stems from the fiscal 2001 budget, which mandated data collection as part of the expansion of cardiac services in the state.

The total cost of collecting data from all 23 cardiac hospitals in the state runs from \$500,000 to \$700,000 annually, Paul Dreyer of Quality Assistance and Control told the News Service. Under the funding regulation, each hospital would pay a fixed cost of \$10,000 and an extra fee on a sliding scale based on cardiac procedure volume.

Dreyer said smaller hospitals would likely pay less than \$15,000 and larger hospitals would likely pay between \$50,000 to \$60,000, with the total negotiated between the Massachusetts Hospital Association and the data collection firm, which is affiliated with Harvard Medical School.

### Group: Hospitals should make mistakes public

The Consumer Quality Council – an advisory panel organized by Health Care for All comprised of former patients who have ex-

perienced medical mistakes – has proposed a bill requiring hospitals to notify patients of such errors.

The proposal would also require hospitals to cut infection rates and make those rates public, as well as release reports on wrong-person or wrong-organ surgeries, according to the MetroWest Daily News.

The News reports that the bill – sponsored by Sen. Richard T. Moore, D-Uxbridge, and Rep. Denise Provost, D-Somerville – would also allow physicians to apologize for mistakes or a misdiagnosis, guarantee that their statements would not be used in a lawsuit, and offer response teams to deal with problems that might arise for a hospital patient.

The bill has the support of more than 40 legislators, according to the News.

### Bill proposed on Lyme Disease center

A state representative has proposed legislation that would eliminate some of the confusion over Lyme Disease by educating front-line medical professionals about the illness, according to the Cape Cod Times.

Rep. Jennifer M. Callahan, D-Worcester, has proposed a Massachusetts Center for Lyme Disease, possibly located at the University of Massachusetts Medical Center in Worcester. The center would educate doctors, nurses and other health care professionals about the complexities of the disease.

The Times reports that Callahan filed the legislation in response to concerns voiced by many patients in Massachusetts that they have been forced to look out-of-state for doctors who can diagnose the disease and treat it properly.

The bill would prohibit insurers from rejecting physicians' recommendations for their patients to receive long-term antibiotic therapy.

Guidelines from the Infectious Diseases Society of America specify that in most cases, a 30-day course of oral antibiotics is enough to cure the disease, the Times reports. But the Lyme Disease Association and the International Lyme and Associated Diseases Society say those guidelines are too restrictive.

Rep. Cleon Turner, D-Barnstable, co-sponsored another Lyme Disease bill that would increase education for medical professionals and prevent doctors from being disciplined for prescribing long-term antibiotics, according to the Times.

### Massachusetts Health Care Trust bills pending

Bills are pending in the state House and Senate that would establish a Massachusetts Health Care Trust – a quasi-public entity – to provide health care access to all Massachusetts residents.

While the Massachusetts Medical Society doesn't oppose the goal of the legislation, it opposes the "single-payer" approach that would be employed.

MMS says it supports a "multi-payer" system that provides a wide choice of health care plans and free-market competition among all modes of health care delivery and financing," and that "whenever possible, placing health insurance purchasing decisions in the hands of individuals would result in a more rational way of delivering health care to all." **MMLR**

# New law, new health plans: What doctors need to know

By now, the basic concept of Massachusetts' new health care reform law is well known: all residents are required to have health insurance.

Less clear is what the impact will be on the state's physicians. While some physicians might see an influx of patients that could strain their offices' resources, others might simply need information to help answer patients' questions about the new health plans.

The Massachusetts Medical Society has compiled a 37-page Physician Guide to Commonwealth Care/Choice, which provides a wide variety of information and resources related to the Chapter 58 law and the new health care products that have been created. Reporter Noah Schaffer spoke with MMS President B. Dale Magee about how the law will affect physicians.

**Q. What questions are physicians most frequently asking about the new law?**

**A.** How to advise people where to get insurance. Physicians need to put in place a process so that when a patient calls and says they do not have insurance, they are connected to the appropriate resources to get themselves enrolled. Often un-enrolled patients have significant prob-

lems - usually the smallest charge for a patient is my fee. If we have to do lab work, the costs escalate rapidly. And the uninsured often have had a health issue smoldering in the background for some time before they have the courage to call. Another challenge is that some aren't embracing the law with open arms and might feel like they are being pressured to purchase something they don't want to pay for.

**Q. Will Chapter 58 benefit physicians by bringing new patients to their practices or cause strains on the system?**

**A.** Particularly with many primary care physicians not accepting new patients, we are concerned that this will put new stress into the system. We can only guess about the im-

pact on practices. We are very aware of the fact that this is a wonderful opportunity for Massachusetts to provide health care access for everyone, and as time passes and the theories become a bit more of a reality, we will need to make adjustments. We can isolate the specialties in the areas that are most impacted and take steps to try to improve things.

**Q. Will the new Commonwealth Care and Commonwealth Choice plans be easier for physicians?**

**A.** They will be easier for hospitals, but not for physicians. The individuals who have to purchase their own insurance are mostly going to be purchasing insurance that has a high deductible - as high as \$2,000. And the majority will spend less than \$2,000 a year on

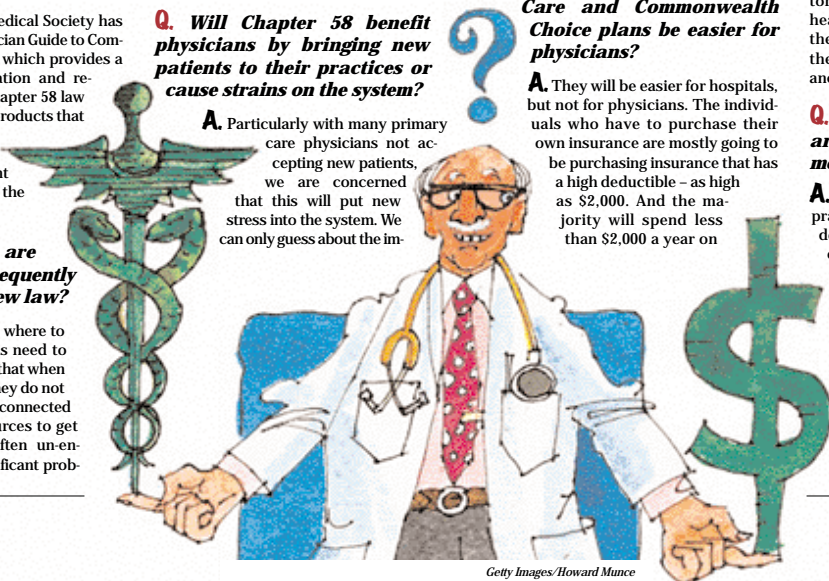
health care, so they will be paying their actual costs out of pocket, with the insurance just for disasters. If they get to a hospital they are experiencing a disaster and will quickly go through that first \$2,000 so the benefit for hospitals will be significant. The benefit for average physicians will be less so - now patients have got \$300 a month less than they did before, because of the premium, and they are faced with a doctor's bill. The plans do cover preventive health visits, but once there is an illness they drop into the deductible unless they've opted for more expensive insurance.

**Q. Will this impact the insurance arrangements for employees of most physicians?**

**A.** I would be very surprised if there are practices with 11 employees or more that don't already have insurance. Although our practice has fewer than 11 employees we have just looked at premiums for the Connector, and compared them to what we're paying, and we feel that there isn't any particular reason for us to change.

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# A doctor on trial: David Sugarbaker tells his story

Continued from page 1

"Some have said Dr. Sugarbaker is the standard of care."

The risks were the same as for any surgery, including bleeding, heart arrhythmia, deep thrombosis, pulmonary embolism and issues associated with undergoing anes-

thesia. Less commonly, stroke or other neurological problems can occur, Sugarbaker explained.

Several hours after surgery, nurses noted an increase in the amount of blood draining from Vaskas' chest tube and that his blood wasn't clotting. They alerted Sugarbaker,

who prescribed the drug Amicar to counteract the symptoms.

The plaintiff later claimed that instead of administering Amicar, Sugarbaker should have gone back into surgery to repair an allegedly lacerated blood vessel that was causing the excess bleeding, Wilkinson said.

But Sugarbaker knew this condition was hyperfibrinolysis – excess bleeding caused when the blood doesn't clot properly on the surface of the lung because the clotting mechanism itself has broken down.

Instead of subjecting Vaskas to the risks of a second surgery, he prescribed Amicar and instructed those at the hospital to intubate. The following evening, after Vaskas was extubated, he showed signs of stroke,

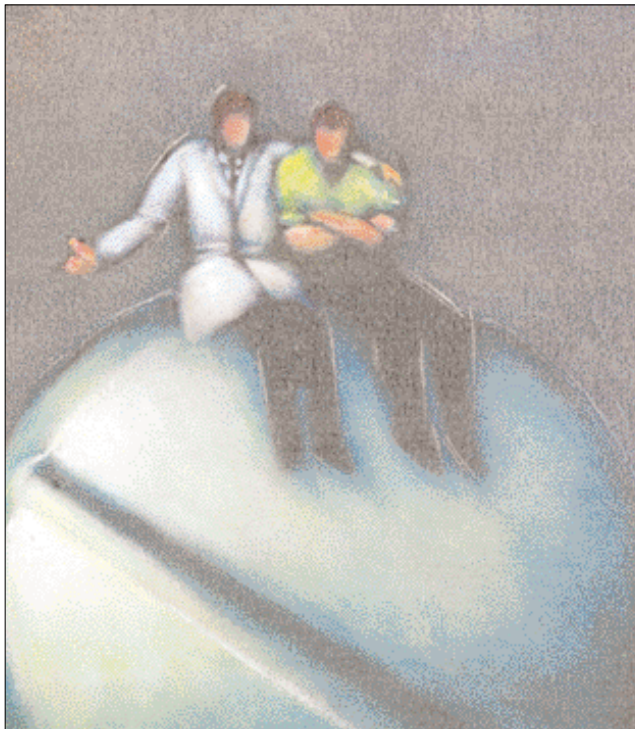
ing the patient to the risk of stroke from Amicar wasn't necessary and therefore a violation of the standard of care, Wilkinson recalled.

However, he later argued, the PDR specifically states no scientific evidence exists that demonstrates Amicar causes strokes or causes clots to develop in the brain. All major studies, he said, have concluded Amicar is safe to administer and will not increase the risk of post-operative stroke.

#### A breakdown

The lawsuit triggered a range of emotions and reactions.

Immediately, Sugarbaker thought there had been a colossal breakdown. A break-



Getty Images/Tim Teebken

**“Physicians are not used to making decisions based on whether they can find experts to back it up. You make a decision because it’s what’s best for the patient at the time.”**

**– Dr. David Sugarbaker**

which was later determined to be caused by a blood clot in a cerebral artery, according to Wilkinson.

The stroke severely affected the right side of Vaskas' brain. His left leg is weak and he suffers from aphasia, a language deficiency in which he understands everything going on around him but can't communicate the words to express himself. He had been a public relations manager with MetLife and was unable to return to his work.

In the Physicians' Desk Reference (PDR), stroke is listed among the many possible adverse reactions that have been reported to the Food and Drug Administration after giving Amicar. The lawsuit claimed that expos-

down in communication between him and his patient. A breakdown in the trust he and other physicians value as the most important part of the relationship they establish with their patients.

"There's a disappointment, in the sense of a loss, that something has happened that shouldn't have happened ... or could have been avoided somehow," he recalled.

Next came the second-guessing of his skills and knowledge. Then it dawned on him he would have to account for every decision he made about this procedure in a way he never had to do before.

"In the beginning, you think, 'I did what I

Continued on page 13



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*Continued from page 12*

did because it was the right thing to do.' Then you realize you have to substantiate that. Physicians are not used to making decisions based on whether they can find experts to back it up. You make a decision because it's what's best for the patient at the time," Sugarbaker said.

Very early on, though, his insurer was in his corner. Wilkinson explained that CRICO's policy is to defend cases when they believe their insureds are right and bring quality experts to support them in court.

Despite what physicians are often told by lawyers and colleagues, Sugarbaker thinks it's imperative a physician facing a lawsuit seek out a confidante.

"The last line of the letter [from the plaintiff's lawyer informing of the lawsuit] says 'don't talk to anyone about this case,'" he said. But "my advice to anyone is to find a confidante, someone with whom you can discuss, maybe not the medical issues as much as what you're going through."

**The nitty-gritty**

Wilkinson prefers that his clients avoid conducting research before the pretrial deposition. Strategically, it's best for physicians to maintain their current level of knowledge and ensure their recollections of the facts remain clear until after depositions are complete, he said. After that, physicians can research the medical literature.

At that point, they can also start making time for their lawyers, Wilkinson added.

Close cooperation with a client is invaluable to preparing a case for trial, and it worked for this defense team. Wilkinson and Sugarbaker say they developed a relationship that transcended the typical attorney-client one. They often met outside

their offices, sometimes at Sugarbaker's home, to discuss the case.

"That was very beneficial because in that setting one is quite relaxed ... and can really get down to the nitty-gritty," Sugarbaker said.

They reviewed the case "almost page by

**Sugarbaker said, "You can't beat yourself up because you got sued. I think that's the toughest thing for a lot of people."**

page," so that every issue that came up Sugarbaker could recall discussing with his attorney at some point pre-trial.

They also visited the empty courtroom where the trial would be held "to get an idea where it was, to get some familiarity with," Sugarbaker said.

Wilkinson briefed Sugarbaker on what to expect, what the dynamics might be like and what kinds of things the plaintiff's attorney and experts might say.

He warned Sugarbaker that the plaintiff's claims might fly in the face of what he knows to be good medicine, but they would have their turn to tell their own story and explain why the plaintiff's theory couldn't work.

"Forewarned is forearmed in a situation like that," Sugarbaker said.

**The trial**

At trial, the defense case centered on convincing jurors the plaintiff was taking the PDR's notes on Amicar out of context, and that Amicar didn't cause the plaintiff's stroke, Wilkinson explained. Defense expert witness testimony proved crucial, both for the trial and for Sugarbaker himself.

"One of the things you realize in situations like this is there are so many understandings of the ways things are done in medicine that may or may not be written down somewhere. So, it is quite comforting when somebody comes in from a different institution and says,

"He did an excellent job of it," Wilkinson said.

Sugarbaker is a professor of surgery at Harvard Medical School and needed little training in how to present the medical concepts to the jury in a language they could understand.

"Look at the jury and believe you [can] teach them," he said. "Pretend you're teaching a group of students or whatever, because your belief they can learn it helps them learn it and helps you teach it."

**Vindicated**

After a nearly three-week trial and about nine hours of deliberations, the jury returned with a verdict for Sugarbaker.

He struggles for the words to describe just how relieved, and what else, he felt. Not only did he feel like someone had removed his head from a vise, but also the verdict restored his trust in his surgical abilities.

After "you put your trust in someone, your physician or your attorney or the pilot in a stormy flight, when you finally touch down and you've landed and everything's fine, it's a mixture of gratitude and a variety of other emotions. Relief, yes, but I would say gratitude, for the jury, for sitting through that trial, for remaining focused and seeing the truth," Sugarbaker said.

"Being sued ... is an unfortunate part of the practice of medicine in 2007. Given that, and given the fact that it happens to everybody and there's a 'malpractice crisis,' you can't beat yourself up because you got sued," he continued. "I think that's the toughest thing for a lot of people."

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# Medical I.D. theft is a prescription for legal headache

Continued from page 1

formation to bill for services the patient never obtained.

- An experienced identity thief might obtain patients' insurance information from an "insider" and bill for services, posing as a health care provider.

No matter how it happens, the common denominator is that the patient's medical record can become contaminated with false information.

## How big is the problem?

Up to half a million patients have been victims of medical identity theft, according to the World Privacy Forum, a non-profit research and educational organization in San Diego.

Marie Whalen, assistant vice president of ambulatory services at University of Connecticut Health Care in Farmington, Conn., said most of the cases she has seen involve someone using a relative or friend's medical card to receive health care.

However, a significant number of cases involve an insider at a hospital or other health care organization who sells or misuses patient information to fraudulently bill for services.

In one notorious Massachusetts case, a psychiatrist obtained the personal data of his patient's relatives and billed Blue Cross for treatment they never received. The doctor was convicted on 136 counts of fraud, but the

patient spent years trying to clear up her family's medical records.

An increasing number of civil suits against medical providers have been settled "quickly and privately," said Pam Dixon, executive director of the World Privacy Forum, who has written a report on medical identity theft and is compiling a state-by-state list of medical identity fraud cases.

Most of the cases have been brought by patients who have notified their doctor's office or hospital that their identity had been stolen but have not succeeded in getting their records corrected, she said.

"There's real potential for a lawsuit if a patient arrives at a hospital unconscious and receives inappropriate treatment," based on fraudulent information in the patient's file,

said Dixon. "I think a jury would side with the patient, not the hospital."

## HIPAA complications

The privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA) can often complicate the issue.

There are three provisions under HIPAA that apply to medical identity theft.

First, the patient has a right to request a copy of his or her medical records. The medical provider can charge the patient a fee for copying costs, as well as for other documents such as X-rays.

On the other hand, a provider cannot "hold the records hostage to the payment," because the patient might need the records for treatment purposes, said Michael Blau, a Boston health care attorney at Foley & Lardner.

However, Dixon said that most medical identity theft victims who call her organization are unable to get their records because the very nature of the crime calls into question the patient's true identity.

There is a "harm" test under HIPAA, in which the records need not be released if it could harm a patient, so depending on how hospitals interpret this provision, sometimes they will refuse to release a patient's file, Dixon added.

"It's kind of a Catch-22 for doctors and health care providers. HIPAA was enacted before medical identity theft became a ma-

JOR problem," said Jacqueline Klosek, an attorney and founding member of the privacy and data security task force at Goodwin Proctor in New York.

A second provision of HIPAA allows a patient to request a correction to his or her medical record.

However, a provider is not required to make the correction, and there is no obligation for one provider to correct information that another provider put in the file.

"If the information came from a third party, the facility has no obligation to even consider correcting it," said Robert Gellman, a privacy consultant in Washington, D.C.

"The only obligation is to document in the record that there has been a request for correction and what information was in dispute," said Blau.

The third right under HIPAA allows a patient to get an accounting of disclosures, such as a list of other entities with whom the provider has shared patient information.

## What providers can do

There are policies that hospitals and physician offices can adopt to help prevent medical identity theft and address it if it does occur.

Here's a look at what experts suggest:

### • Require patients to provide a photo I.D.






Many providers are requiring additional identification, such as a photo I.D., at the door.

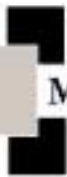
"Will it [stop] identity theft totally? No, but it has cut down on a lot of our issues," said Whalen of University of Connecticut Health Care.

She added that her organization will copy

Continued on page 15

## Curing medical identity theft

-  Require patients to provide a photo I.D.
-  Change the way prescriptions are labeled.
-  Restrict inside access based on an employee's role.
-  Track who has access to audit logs.
-  Work directly with patients.



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the photo and place it in the patient's chart.

Although long-time patients may grumble about having to show ID., "most people are happy because they know we're not doing it to be a pain, but for their own protection," she said.

• **Change the way prescriptions are labeled.**

Another policy adopted by University of Connecticut Health Care is to change the way prescriptions are labeled.

"The doctors used to have labels, and some patients were peeling them off and writing their friend's name on it. We had to tell doctors not to use the labels. Now, they hand-write the patient's name and the doctor's name, so it can't be altered," said Whalen.

• **Restrict inside access based on an employee's role.**

One way to protect against a security breach by someone inside an organization who could misuse patient information is to restrict access to files based on an employee's role.

"In the past, it was easier to have only one level of access and to give everyone absolute access. It may be time to revisit that," said Rebecca Williams, an attorney and registered nurse who co-chairs the Health Information Technology and HIPAA practice at Davis Wright Tremaine in Seattle.

Such a policy is also in step with HIPAA's "minimum necessary rule," which says that only the minimum amount of information

should be used, disclosed or received to accomplish a given purpose, she added.

"For example, the housekeeping staff does not need to see patient records. However, nurses do, and the receptionist might need certain information like name, address and what procedures are scheduled. Even if some people are given access, that doesn't mean they have the right to go into the records, [except] when it's part of their job to review it," said Williams.

• **Track who has access to audit logs.**

An essential element in limiting access to patient files is periodic tracking of who has had access to records.

"The idea is to monitor that access and then train staff and sanction any employee who oversteps those bounds," said Williams.

One audit technique is to pick a random patient or a random employee and trace access that way.

Williams also recommends picking a "celebrity" patient, such as a well-known person in the community, an actual celebrity or the victim of a publicized crime.

"You want to see who has been in the records and how many hits are on the record and to investigate if there is unauthorized access," she added.

• **Use electronic records.**

As more medical providers move to electronic records systems, it will generally be easier to prevent and detect medical identity theft.

"There will be fewer mistakes than when using handwritten paper records, because electronic records are orders of magnitude harder to gain access to," said Ray Campbell, executive director and CEO of the Massachusetts Health Data Consortium in Waltham.

For example, electronic records systems can be programmed so data is never cached or stored locally, so every time a patient

record is closed, it is completely purged, Campbell said.

New software also allows a hospital or doctor's office to scan a patient's photo once, so it will appear each time the electronic record is pulled up.

Massachusetts has the highest concentration of electronic medical records users in the country, with 60 percent of health care providers using electronic records, said Dr. Thomas Sullivan, a cardiologist and co-chair of the Physician's Electronic Health Records Coalition.

Even smaller physicians' practices in Massachusetts are changing to electronic records faster than the rest of the country, Sullivan said.

• **Work directly with patients.**

Experts say medical providers should be willing to sit down and work with patients to disentangle truth from fraud in their medical files.

"When there's a case of medical identity theft, providers should make sure they are working with the patient and not applying the law mechanically. You need to work together and make sure the patient is being treated appropriately so the information can flow. You may need to pay more attention to that record as new information is added to it and make a decision about where the information should go," said Gellman.

Some hospitals have responded to requests to correct misinformation by putting the disputed information in a John Doe or Jane Doe file, so that the disputed information is not completely lost but has been segregated from the patient's record, said Dixon. **MMLR**

Questions or comments should be directed to the editor at: [reni.gertner@lawyersweekly.com](mailto:reni.gertner@lawyersweekly.com)

## State identity theft bill pending

By Sylvia Hsieh

A new bill working its way through the state legislature that applies to general identity theft may also help victims of medical identity theft.

Under House No. 4018, businesses and government entities must notify a consumer if certain personal information, such as a name and Social Security number, has been acquired by an unauthorized person or for an unauthorized purpose.

"We worked with the Massachusetts Hospital Association and the Massa-

chusetts Medical Society to make sure it didn't conflict with HIPAA. HIPAA is already a strict standard and we wanted to make sure providers didn't have to comply with one law at the federal level and another at the state level," said Dr. Marylou Buysse, a practicing family physician and president of the Massachusetts Association of Health Plans.

The bill's notification requirements apply only to unencrypted information, because many health care organizations have spent a lot of money to develop encryption software to protect patient information, Buysse added. **MMLR**

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- Chronic Lymphocytic Leukemia (CLL)
- Juvenile Chronic Myelogenous Leukemia (JMML)
- Juvenile Myelomonocytic Leukemia (JMML)

### Myceloproliferative Disorders

- Acute Myelofibrosis
- Agnogenic Myeloid Metaplasia (myelofibrosis)
- Polycythemia Vera
- Essential Thrombocythemia

### Myelodysplastic Syndromes

- Refractory Anemia (RA)
- Refractory Anemia with Ringed Sideroblasts (RAS)
- Refractory Anemia with Excess Blasts (RAEB)
- Refractory Anemia with Excess Blasts in Transformation (RAEB-T)
- Chronic Myelomonocytic Leukemia (CMML)

### Lymphoproliferative Disorders

- Non-Hodgkin's Lymphoma
- Hodgkin's Disease
- Prolymphocytic Leukemia

### Liposomal Storage Disorders

- Mucopolysaccharidosis (MPS)
- Hunter Syndrome (MPS-II)
- Scheie Syndrome (MPS-III)
- Hunter's Syndrome (MPS-IV)
- Sanfilippo Syndrome (MPS-III)
- Morquio Syndrome (MPS-IV)
- Marfan-Lamy Syndrome (MPS-VI)
- Sly Syndrome, Beta-Glucuronidase Deficiency (MPS-VII)
- Adrenoleukodystrophy
- Mucopolysaccharidosis II (Hurler Disease)
- Krabbe Disease
- Gaucher's Disease
- Niemann-Pick Disease
- Wolman Disease

### Neutrocytic Disorders

- Familial Dyserythrocytosis/Prolymphocytic Leukemia
- Hecht Syndrome
- Hemophagocytosis

### Phagocyte Disorders

- Chediak-Higashi Syndrome
- Chronic Granulomatous Disease
- Neutrophil Adhesion Deficiency
- Reticulo-Dyspoiesis

### Congenital Immune System Disorders

- Ataxia Telangiectasia
- Koller-Snyder Syndrome
- Leukocyte Adhesion Deficiency
- DiGeorge Syndrome
- Bare Lymphocyte Syndrome
- Omenn Syndrome
- Severe Combined Immunodeficiency (SCID)
- SCID with Adenosine Deaminase Deficiency
- Absence of T & B Cells SCID
- Absence of T Cells, Normal B Cell SCID
- Common Variable Immunodeficiency
- Wiskott-Aldrich Syndrome
- X-Linked Lymphoproliferative Disorder

### Inherited Platelet Abnormalities

- Anaplastic erythrocytosis / Congenital Thrombocytopenia

### Plasma Cell Disorders

- Multiple Myeloma
- Plasma Cell Leukemia
- Waldenström's Macroglobulinemia

### Inherited Erythrocyte Abnormalities

- Sickle Cell Anemia
- Pure Red Cell Aplasia
- Sickle Cell Disease

### Other Inherited Disorders

- Leishmaniasis
- Onchocerca volvulus
- Glanzmann Thrombasthenia
- Osteopetrosis

### Other Hematologies

- Breast Cancer
- Esophagus Cancer
- Neuroblastoma
- Renal Cell Carcinoma

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