

RISK MANAGEMENT NEWS

A RISK MANAGEMENT NEWSLETTER FOR MILLENNIUM INSURANCE CO. INSURED

Taking Control of Your Testimony

Defense Attorneys Reveal Strategies for a Successful Defense

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Few events cause physicians more consternation than being deposed as a defendant in a medical malpractice suit. Although this article will not cover all of the nuances of preparing for and giving deposition testimony, it will however, focus on a few common strategies that plaintiff attorneys sometimes employ during the course of a deposition along with retaliation methods that allow physicians to successfully fight back.

The Control Technique

Many plaintiff attorneys attempt to control a defendant physician by asking questions designed to prevent the witness from responding in his or her own words to justify or better explain his/her treatment. During the course of a deposition this technique, if successful, makes the physician feel boxed in and defenseless in an adversarial setting leading to a potentially damaging deposition.



A good example of the control technique is when a plaintiff's attorney attempts to have a defendant agree to a definition or meaning of various medical terms or phrases. In so doing, the attorney is able to phrase questions that are more likely to elicit a response that is helpful to the plaintiff's case. Having agreed to the terminology, the physician feels compelled to provide the answer that the plaintiff's attorney is seeking. When confronted with his/her deposition testimony at trial, the physician may have little room to maneuver.

Similarly, a plaintiff's attorney may attempt to control a defendant by asking him/her to agree to a generalized and non-specific definition of the standard of care. While the attorney's definition of the standard of care may be accurate in a broad sense, the facts of the case at hand may require variations on that theme. However, if the defendant physician simply agrees with the attorney's generalized definition without qualification, it becomes difficult to obtain the support of an expert witness and it may compromise the case at trial.

Attempting to intimidate a witness by demanding *yes* or *no* answers is another variation of the control technique. In many cases an experienced defense attorney is able to step in and defuse the situation. However, the physician witness may ultimately have to answer the question and whether or not he/she says yes, no, maybe or something else is entirely up to the witness who must be prepared to

withstand the opposing attorney's attempt at intimidation.

Preparation is Key

Being prepared for your deposition is essential. As do most defense attorneys, we consistently provide our clients with the following basic deposition instructions: 1) make sure you understand the question; 2) just answer the question asked; and, 3) do not volunteer any information. To the defendant physician, an instruction not to volunteer any information is a non sequitur. Most defendants see the deposition as an opportunity to bring the matter to a prompt conclusion by volunteering information in an effort to prove he/she

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did nothing wrong. In defending physicians in medical malpractice cases for over 25 years, we have rarely seen a physician successfully talk himself/herself out of a lawsuit during the course of a deposition. There are good reasons for issuing the instructions and every attempt should be made to adhere to them.

Standard of Care Questions

You may be wondering, "If I'm just supposed to answer the question asked and not volunteer additional information, how am I going to deal with the control techniques?" First, make sure that you understand the question. Assuming that to be the case, there are several perfectly acceptable responses that can assist you in deflecting the plaintiff attorney's efforts to get the answers that he/she wants. For example, when asked a *standard of care* question, you are permitted to qualify the question by asking the attorney whether he/she is asking about the standard of care in general, or in the context of the case at hand. Other acceptable ways of managing the control questions is by responding with, "it depends on the circumstances"; or "your question cannot be answered as yes or no, may I explain why?" By responding in this fashion *you* are exercising a certain degree of control over plaintiff attorney and disrupting his/her thought process.

The question then becomes yours not the attorney's. Furthermore, it provides you more latitude in framing an accurate response and it frustrates their efforts to unfairly corner you.

Authoritative Text Questions

Another strategy commonly used by plaintiff attorneys that also deserves some attention is the *authoritative text technique*. Frequently, in "failure to diagnose" cases for example, plaintiff attorneys will attempt to use so-called authoritative texts to identify: 1) signs and symptoms of a particular disease process or condition; 2) diagnostic tests that should be performed in order to rule it in or out; and, 3) the manner in which the particular disease process or condition should be treated. If the plaintiff's attorney refers to a text during the course of a deposition, you can be sure that it contains statements helpful to his/her case. Once a physician acknowledges a particular text as authoritative, it is virtually guaranteed that during the course of trial portions of that textbook will be included in a Power Point presentation and shown to the jury on a very large screen as a physician testifies. Consequently, when confronted with this particular question at deposition, the witness can appropriately respond by not considering any text authoritative on a particular subject. Given this response, the plaintiff's attorney will usually inquire as to what sources the witness consults when he/she feels compelled to research a particular subject. An acceptable response would be, "I go online", which is frequently the case.

Understanding Error in Judgment

In keeping with the "failure to diagnose" case example, the opposing attorney may continue the questioning by asking the witness to list the signs and symptoms of a particular disease process or condition and then compare that list to the clinical information contained in the medical records. After laying this foundation, a plaintiff's attorney may ask, "Did you consider "x" in your differential diagnosis?" Obviously, "x" refers to the condition that was not diagnosed. Once the witness

acknowledges that "x" was in his/her differential, the plaintiff's attorney will want to know the basis for which it was excluded as the diagnosis. Witnesses frequently take the position that the clinical presentation and work up may have been *consistent with* a particular diagnosis, but not necessarily *diagnostic of* it.

In Pennsylvania, case law provides that an *error in judgment* does not constitute negligence. What this means for physicians is that when there are two or more possibilities to consider in the differential but the wrong diagnosis is selected, it may constitute an *error in judgment* as opposed to a breach of the standard of care. Although there is more to this case law, this principle can be advantageous at trial.

In order for the witness to gain the upper hand during the deposition and ultimately prevail in the litigation, the witness must be prepared to explain his/her thought process and the basis for ruling the actual condition out, especially when there has been little in the way of diagnostic testing. That explanation will determine if and to what extent the *error in judgment* principle is available to the defendant. If a physician finds him or herself in this situation, prefacing his/her answers with the phrase, "In my best professional judgment . . .," is usually helpful to their testimony.

Points to Remember

Plaintiff attorneys might appear pleasant and friendly, but make no mistake, they have a job to do and they have the incentive to pursue it aggressively. Consequently you must be prepared for your deposition. Follow your attorney's advice and be thoroughly familiar with: 1) the medical records, 2) the facts as alleged in Plaintiff's Complaint, and 3) the theories of liability. Good preparation will minimize surprises, prevent or minimize damaging testimony, and increase your comfort level in what can be an unpleasant and stressful situation.

Medical Records Reproduction Fees for 2008

Act 26 of 2006 and the Health Insurance Portability and Accountability Act (HIPAA) set limits for medical record copying charges that any individual or entity may be charged.

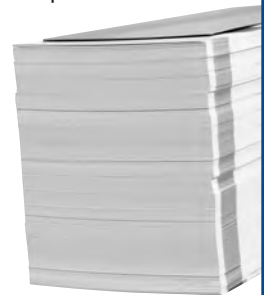
Under HIPAA, medical record copying fees for patients may not include costs associated with searching for and retrieving the medical record. They may be charged for the copying and mailing costs up to the limits set by Act 26. Both HIPAA and Act 26 permit search and retrieval fees for all other requests.

The chart below outlines the updated fees for 2008.

To determine copying and mailing costs for patient requests under HIPAA, consider:

- Salary and benefits of the person who does copying
- Cost of supplies and equipment
- Actual cost of postage, shipping and delivery

- Pennsylvania Medical Society



	ACT 26 (2008)	CHARGE PATIENT	CHARGE OTHERS
Retrieval Fee	\$19.00	\$0	\$19.00
Pages 1-20	\$1.28/page	Up to \$1.28/page	\$1.28/page
Pages 21 – 60	\$.95/page	Up to \$.95/page	\$.95/page
Pages 61+	\$.32/page	Up to \$.32/page	\$.32/page

Medical Record Advisor

One of the cardinal rules for providing quality medical care is maintaining good medical records. Medical records serve many purposes; it establishes and maintains a record of patient care - thereby improving the quality and efficiency of medical care while lowering costs. Equally important however, a complete and accurate chart protects the legal interests of both patient and physician. It provides an account of treatment for state medical boards, peer review panels, and third-party payers.

The first in a series, this column will provide valuable medical record tips to ensure that your documentation practices are not only consistent and efficient, but accurately reflect the time and effort you devote to patient care.

Medical Record Tip #1 – Do Not Write Prescriptions for Family and Friends Without Maintaining Formal Records.

Professional services, no matter how informal, demand formal records. Anytime you provide a service, even for friends, neighbors, or employees, you must maintain a proper medical record. This holds true for minor services including writing prescriptions or treating colds and sore throats. If someone you know well asks you to write a prescription as a favor, don't be tempted to do so if you are not prepared to create a formal record. That's particularly true for prescriptions or medical advice offered over the telephone.



Medical record-keeping rules mandate that for any medical service a corresponding medical record must reflect a complete history, including diagnosis and treatment plans; examination results; drugs prescribed, dispensed or administered; and reports of consultations, referrals and hospitalization.

Capturing this information allows for subsequent care and makes it unnecessary to obtain the information over again. Additionally, keep in mind that if a state-board investigator or malpractice attorney can't understand your records, you may be asked to transcribe them at your own expense or they may conclude that your treatment deviated from the standard of care. The same goes for unrecorded treatment. If it's not written in the chart, there's no evidence that you did it or even thought of doing it.

Move Over HIPAA...Here Comes HIPSA

HIPAA will be undergoing some major developments in 2008. The U.S. Senate bill 1814, the Health Information Privacy and Security Act of 2007 (HIPSA), introduced in July by Senator Edward Kennedy and Senator Patrick Leahy is currently under consideration by the Committee on Health, Education, Labor and Pensions. HIPSA would institute wide-ranging changes to the current HIPAA rule. The Act would not supplant HIPAA, but rather it will require the Department of Health and Human Services (DHHS) to revise HIPAA to be consistent with HIPSA.



HIPSA requires the establishment of an *Office of Health Information Privacy* at DHHS and gives it enforcement powers to impose criminal and civil

penalties for unauthorized disclosure of patient information. It will also prohibit health entities from receiving federal programs if found guilty of wrongful disclosure of protected health information. Moreover, HIPSA would authorize state attorney generals to sue on behalf of state residents for privacy and security

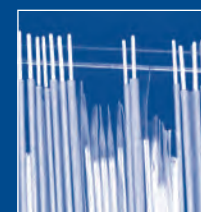
violations and would permit whistle blowers who report violations to be protected from retaliation.

In a strong departure from the current HIPAA statute, HIPSA would govern all those who use PHI rather than only HIPAA-covered entities. If signed into law, the bill would also create a right of private action that would permit individuals to sue health care providers for privacy violations for compensatory damages and receive punitive damages in cases of unauthorized disclosure.

Although tough civil monetary penalties and other sanctions have never been imposed under HIPAA, this about face would now add a tangible urgency to enforcement efforts. The presidential election may also have an effect on HIPAA's future as there may be an out cry for enforcement especially with the increasing awareness by the public of identify theft and, in particular, medical identity theft.

While change is deliberately slow and uneven, there are definite signs that these agencies are getting serious about proactive enforcement.

Medicare Plans Require Physicians to Keep Records for 10 Years



Revised federal regulations for *Medicare Advantage Organizations* require physicians to keep patient

records for at least 10 years – three years longer than Pennsylvania law. Because the revised federal regulations will likely include straight Medicare, it is suggested that all records for patients 65 years of age or older be retained for 10 years or risk disqualification from Medicare and other government-related programs.

Retain records for patients 65 years of age or older for 10 years.



Disclosure Statement

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The Next Issue of TRENDS...

Millennium is preparing for the release of its annual edition of **TRENDS** – a single-article publication devoted to a significant risk management topic. Our second issue explores the topic of *Healthcare Literacy*. The publication will be accompanied by an informative brochure for healthcare providers and a patient information sheet developed by the National Patient Safety Foundation to encourage patients to take an active role in their healthcare by asking three key questions at each visit. Here is a glimpse of what you can look forward to in **Non-Compliant or Health Illiterate: Which Describes Your Patient Population?**

Approximately 90 million adult Americans have trouble understanding health information and its effects are estimated to cost the healthcare system more than \$58 billion annually. Health illiteracy traverses both racial and ethnic lines. Although, the average American reads at the eighth- or ninth-grade level, most health information today is written at a higher reading level. These people lack what the medical profession terms “health literacy” skills.

Health literacy is the ability to read, understand and effectively use basic medical instructions and information. People with low health literacy are less likely to comply with prescribed treatment and self-care regimens. Clinicians not attuned to this problem may categorize their patients as non-compliant as opposed to health illiterate.

Doing Your Part

To deliver equitable, effective treatment in a culturally and linguistically appropriate manner, healthcare providers would need to develop the awareness, knowledge and skills to treat this increasingly diverse population.

1. Guiding Principles

In order to improve healthcare communication and overcome health illiteracy barriers, employing specific principles such as ensuring a shame-free environment and using visual models to illustrate a procedure or condition are a few simple ways to help patients manage their illiteracy.

2. Recognizing Signs of Low Health Literacy

Although it may be difficult to identify a patient with low health literacy skills, there may be characteristic signs indicative of illiteracy, “I can’t read this now, I forgot my glasses.”

3. Speak Up and Ask Me 3 Models

The *Speak Up* and *Ask Me 3* models use effective tools designed to promote effective communications between healthcare providers and patients. Sponsored by national healthcare organizations, the models advocate awareness and develop solutions to the problem of low health literacy.

4. ClearHealthCommunication.com

Physicians and other healthcare providers may access additional resources regarding health literacy at www.clearhealthcommunication.com.

5. AMA Foundation’s Health Literacy Tool Kit

The AMA has developed a CME-approved educational kit to inform physicians, healthcare professionals and patient advocates about health literacy.

It’s Everyone’s Responsibility

Understanding health information is everyone’s right; improving clear health communication is everyone’s responsibility. Improvements in the health literacy field would not only affect the health of Americans and the ability of the health care system to provide effective high quality care, it will be equally valuable in the advancement of patient safety.

Litigation Stress Resource

Physicians and other health care professionals who are, or may become involved in medical malpractice litigation, have a new resource for support and information. The new website, www.PhysicianLitigationStress.org, was developed by the Physician Litigation Stress Resource Center.

The site serves as a resource for those seeking to ease the personal and professional stress associated with medical malpractice litigation. It directs health care professionals to articles, books, and other websites that address the process of litigation. It also provides a list of resources offering support for physicians involved in litigation while helping physicians recognize personal responses to the strain of litigation that may indicate a need for professional consultation or treatment.

www.PhysicianLitigationStress.org

Now available for physicians who are or may become involved in medical malpractice litigation.

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