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## *The Expanded Use of Motions for Summary Judgment in Medical Malpractice Cases*

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In their ongoing effort to stay up to date with trends impacting MLMIC policyholders and medical malpractice litigation, the attorneys at Fager Amsler Keller & Schoppmann, LLP have been monitoring a trend in New York State whereby summary judgment is being more frequently granted to defendants

in medical malpractice cases. This is the result of increased scrutiny by judges of expert affidavits submitted by plaintiffs in opposition to the motions. This article will discuss the use of a motion for summary judgment, the burden of proof on

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## *Live Operators Replace MLMIC Phone Menu System*

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In adherence to MLMIC's core mission—to deliver the highest level of service to our insureds—and to assist our insureds and clients to more promptly connect with the MLMIC employee or department they are attempting to reach by telephone, MLMIC is pleased to announce that we have transitioned to live customer service operators to answer all phone calls.

These operators have replaced MLMIC's phone system of recorded messages, prompts and menus. In making this improvement, MLMIC is now able to be more responsive to callers by ensuring that they are quickly connected with their desired party or an employee who can assist them. As an added feature, callers will still be able to dial directly to an employee's phone extension. ❖



# Effective Coordination of Care: Hospitalists and Primary Care Physicians

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The use of hospitalists has fundamentally changed the way healthcare is delivered. Over the past twenty years, the number of hospitalists has grown to over 50,000 and they are practicing in more than 75% of US hospitals.<sup>1</sup> In this practice model, primary care physicians (PCPs) no longer care for their patients during a hospitalization. Rather, they rely on hospitalists to manage their patients' needs during the admission. By its very nature, this fragmentation of healthcare delivery may complicate the coordination of care.

In the past, the primary responsibility for patient care rested with PCPs, regardless of the setting. With the emergence and growth of the hospitalist model, experience has shown that the responsibility for decision making at admission, during hospitalization, and upon discharge may, at times, be ambiguous. Serious medical errors can occur when communication between providers fails during transitions in care. MLMIC's claims experience indicates that inefficiencies in communication during

critical handoffs can, and do, result in poor outcomes and subsequent claims of malpractice.

Effective communication between hospitalists and PCPs is essential for well-coordinated patient care. At admission, the hospitalist usually has limited knowledge of the patient and their medical history. Often, hospital admissions occur on an urgent basis and, consequently, the risk for incomplete or inaccurate transmission of information is heightened. This puts hospitalists at a disadvantage, may hinder their ability to provide adequate care, and can create the potential for patient injury.

PCPs have a responsibility to communicate directly with hospitalists when they admit a patient or become aware of the admission. Providing the hospitalist with current information, including pending laboratory results or diagnostic studies, a current medication list, and a sufficient medical history, all contribute to providing accurate and timely care. Likewise, during the hospitalization, the hospitalist has a responsibility to keep the PCP apprised of significant changes in the patient's condition and plan of care. This may include a serious deterioration in the patient's clinical condition, a transfer

to a higher level of care, or making end-of-life determinations.

Collaboration among healthcare professionals is essential during the transition process. An effective strategy for communicating information to and from patient care settings is to employ a standardized process. Checklists or templates may be beneficial for this purpose and provide a mechanism that establishes a uniform set of essential information that should be communicated between providers. The National Transitions of Care Coalition (NTOCC) supports the concept of utilizing a standardized transfer tool to facilitate transitions between healthcare settings.<sup>2</sup> The Centers for Medicare & Medicaid Services (CMS) has also developed a tool, The Continuity Assessment Record and Evaluation (CARE) Item Set, for this purpose.<sup>3</sup> Implementing strategies that foster communication and utilizing standardized processes to relay critical information will promote safe patient care and diminish potential exposure to liability.

1. Zero to 50,000—The 20th Anniversary of the Hospitalist. Wachter, Robert, M.D., and Lee Goldman, M.D., M.P.H. NEJM February 7, 2017.

2. [http://www.ntocc.org/Portals/0/TOC\\_Checklist.pdf](http://www.ntocc.org/Portals/0/TOC_Checklist.pdf).  
3. <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-Care.html>.

During hospitalization, handoffs from one hospitalist to another also represent critical transitions in patient care. Inadequate handoffs have been implicated as a source of adverse events and near misses in hospitalized patients.<sup>4</sup> Poor communication during handoffs may involve incomplete, inaccurate, or omitted data which creates ambiguity and the potential for medical error.

To ensure an effective transfer of patient information and continuity of care at these junctures, it is vital that criteria be established for the handoff process. As previously noted, a standardized tool that contains relevant data may be beneficial. At a minimum, this data should include diagnosis, pertinent medications, the results of procedures, pending tests or consultations, and any abnormal studies. The handoff from one hospitalist to another should ideally include a face-to-face conversation with limited interruptions and the delineation of follow-up responsibilities. The use of both a standard template of information and a verbal exchange between providers is recommended.<sup>5</sup>

Medication reconciliation is a key component of effective care transitions. Upon admission, a patient's medications should be reconciled with the list provided by the PCP. During hospitalization, medications may be changed or discontinued as part of the treatment plan or as the result of their unavailability in the facility formulary.

Discrepancies or errors—such as omissions, duplications, contraindications, and unclear information—in the medication reconciliation process have been linked to medication errors, delays in receiving necessary medications, and rehospitalization.<sup>6</sup> An estimated 60% of all medication errors occur during transitions of care.<sup>7</sup> Therefore, it is imperative that an accurate list of medications be provided at discharge to the PCP who will assume responsibility for the patient's care.

Admission, hospitalization, and discharge all represent opportunities for hospitalists and PCPs to share important information. With the advancement of Health Information Technology (HIT), hospitals and physician office practices have the ability to share information instantaneously. The ability to transmit patient health data electronically has improved the timeliness of access to information which, at times, may be critical to the treatment of the patient. When healthcare providers share an interoperable system that provides easy access to electronic health records, access is eased, efficiencies in care are achieved, and the burden of transmitting paper records is lessened.

To facilitate a smooth transition, hospitalists must have an understanding of the patient's needs in advance

of discharge. Timely follow-up with the PCP is essential not only for rendering care, but also to reduce and prevent re-admissions. It is not uncommon for a post-hospitalized patient to see their PCP within a week or so of discharge. The ability of the PCP to deliver care may be hindered if the discharge summary arrives after the patient's first post-discharge visit.

It is incumbent on the hospitalist to ensure that discharge summaries are dictated in a timely manner and contain adequate information including pending laboratory test results and who will be responsible for following up on these results. The facility must ensure that they are expeditiously transmitted to the primary care providers.

Office practices must make the review of discharge summaries and test results a priority. These summaries should not be automatically filed into a paper medical record until a physician or mid-level practitioner has reviewed the information, evaluated the results, and planned the patient's care accordingly. If the office has an EHR system, the physician must document the review of these items and ensure that the results are entered. While the volume and complexity of information received by a PCP may make this a daunting task, physicians must establish a process to obtain and review discharge summaries promptly, assess the need to follow-up on pending test results, reconcile medications, and determine when the patient should be seen in the office.

*continued on page 13*

4. Hospitalist Handoffs: A Systematic Review and Task Force Recommendations. Arora, Vineet, MD, MA, et al., JHospMed. September 2009;4(7) 433-440.

5. Communication Strategies for Patient Handoffs. Committee Opinion. ACOG. February 2012.

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# Case Study

## *Examining Patient Identification Errors*

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Patient misidentification can occur at almost any point in the treatment continuum. In each of the cases outlined below, there were serious deficits in the protocol for correctly identifying the patient.

### **Case #1: Mislabeling of Biopsy Specimens**

A 62-year-old married male with an elevated PSA of 6.0 was seen by his urologist, who performed renal and pelvic sonograms. He recommended a prostate biopsy. The urologist performed multiple biopsies. The medical assistant placed the biopsy samples into vials labeled with the date and what she thought were the correct names of the patient and physician, and the type of specimen. However, the medical assistant had failed to confirm that the patient's specimen had the correct name on it prior to the procedure. The vials were then sent to the laboratory. The pathology report revealed prostate cancer. Therefore, the patient underwent a radical retropubic prostatectomy.

After surgery, the pathology report revealed no cancer present in the specimens. The urologist brought the biopsy slides to the laboratory for DNA testing, together with the surgical slides. The DNA tests confirmed that the biopsy and surgery samples were from two different patients.

Apparently, two patients underwent prostate biopsies on the same day. Therefore, the specimens were incorrectly labeled by the medical assistant before being sent to the laboratory.

The patient sued the urologist, claiming that as a result of this error he suffered from erectile dysfunction and a cancer phobia. Because the case was impossible to defend, it was settled for \$1.3 million.

### **Case #2: Failure to Identify the Correct Patient Prior to Surgery**

A 72-year-old male with a prior history of skin cancers was seen by his dermatologist. He complained of multiple patches of dry, scaly skin which were not healing. Five actinic keratotic lesions on his face were treated with cryotherapy. In addition, Mohs surgery was performed on a lesion on the patient's back.

The patient returned within two weeks for suture removal. The wound was healing well. The dermatologist conducted a full body examination and treated additional scaly and itchy lesions with cryotherapy. At this visit, the doctor informed the patient that the Mohs surgery he had performed was intended for a different patient. On the day this error occurred, two patients with the same name were present at the office. Unfortunately, this patient responded

first when his name was called and, thus, the Mohs surgery was performed on him. Further, in advance of the surgery he signed a consent form for the incorrect procedure but did not question it. Once the staff realized this mistake, they destroyed the patient's consent form and the Mohs surgery report.

The patient sued the physician, alleging that a biopsy should have been performed to determine whether the lesion was a skin cancer. If that had been done, the patient would not have undergone Mohs surgery, nor would he have had a scar. This case was settled for \$30,000.

### **Case #3: Failure to Verify the Correct Patient's Films**

A 62-year-old married male with multiple sclerosis (MS) was admitted to the Hospital's Acute Rehabilitation Service due to complaints of weakness and fatigue. His MS had remained stable for the past 20 years. The patient also complained of abdominal discomfort and fever. The workup confirmed the presence of both gallstones and gram negative bacteria, possibly secondary to a biliary tract infection. A HIDA scan was negative for cystic duct obstruction. An abdominal CT scan revealed thickening of the gallbladder and gallstones. A laparoscopic

cholecystectomy was scheduled. The patient was cleared for surgery.

The anesthesiologist classified the patient as level two risk, indicating mild systemic disease without limitation of activities, and surgery was performed. The patient tolerated the procedure well. The operative report indicated some oozing was seen in the liver bed but good hemostasis was obtained. Therefore, the surgeon did not order heparin postoperatively.

On the second postoperative day, the patient complained of shortness of breath. A CT scan of the chest was ordered to rule out a pulmonary embolism. The radiologist read the film. His verbal interpretation was the CT was negative for pulmonary embolism. Several hours later, the written preliminary report also indicated “no acute p.e.” The patient’s O2 saturation dropped from 90% to 65% and he was wheezing. Respiratory therapy was called to give him a non-rebreather mask and then a code was called. Both the surgeon and the cardiologist attended the code. The patient was intubated, but his BP and pulse were not obtainable. Resuscitation efforts were unsuccessful and the patient expired.

Subsequently, the hospital’s radiologist re-read the patient’s films. Bilateral pulmonary emboli were clearly visible. Apparently, the original



radiologist had read the wrong patient’s films. While he was in the hospital’s emergency department, two sets of films were already open on the monitor at the same time he was asked to view this patient’s films to rule out a pulmonary embolism. There were three sets of films for three different patients on his monitor. Simultaneously, another physician asked him to view the studies of a fourth patient. To do so, he had to minimize the other three studies. When he reopened what he believed to be this patient’s films, he read the study as negative. These findings were then entered into the computer and he did not review the films again. Extensive emboli were noted in the postoperative films.

Experts from three (3) different specialties reviewed this case and found it indefensible. The case was settled for \$1.8 million.

## *A Risk Management & Legal Analysis*

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**W**hen patient misidentification occurs, it can be extremely costly. Deficits in the protocol for correctly identifying patients must be remedied with policy revisions, staff education on appropriate protocols, and monitoring to ensure that procedures are consistently followed.

When there has been misidentification of a patient resulting in injury

*continued on page 11*

# Preventing Patient Identification Errors

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Patient identification errors are a significant concern throughout the healthcare delivery system, and have the potential for dire consequences to patients. The ECRI Institute Patient Safety Organization (PSO) recently analyzed patient identification errors and published their findings. They confirmed that although many patient identification errors are discovered before care is provided, there are instances where unidentified errors have contributed to patient injury, including death.

The ECRI Institute is a nonprofit organization that conducts research to identify which medical procedures, devices, drugs, and processes enable improved patient care. For their analysis, ECRI defined patient identification as “a process of correctly matching a patient to appropriately intended interventions and communicating information about the patient’s identity accurately and reliably throughout the continuum of care.”<sup>1</sup>

ECRI reviewed three distinct phases of the patient care process to analyze identification events:

- Intake (registration, scheduling)
- Clinical encounter (diagnosis, treatment, monitoring, discharge/visit completion)
- Post-encounter (referrals, health information exchanges, electronic prescribing)

Their analysis of 7,613 patient

identification events reported over a 32 month period revealed the following:

1. The majority of errors (72.3%) occurred during the clinical encounters and 12.6% occurred during the intake process.
2. 36.5% of errors involved diagnostic procedures (laboratory medicine, pathology, diagnostic imaging) and 22.1% involved treatment (medications, procedures, transfusions).
3. 91.4% were caught before patient harm.
4. There were 2 wrong-patient events resulting in death that involved documentation failures. In the first event, the wrong patient record was accessed. The second event involved the use of the wrong patient’s information for another patient’s surgical clearance.
5. 15% of all failures were wrong-patient events involving physical identification. These failures were attributed to missing wristbands, patient identity not verified or incorrect wristbands.
6. In 15% of events, technology contributed to the patient identification errors. Some examples of technology errors include:
  - a. retaining previously recorded patient demographic data when a new patient is connected to physiologic monitoring equipment; and

- b. matching portable telemetry equipment with the wrong patient.

## Patient Identification Recommendations

The following risk management strategies are offered to mitigate the risk of patient misidentification throughout all aspects of healthcare.

1. Communicate to the staff that patient identification is an organizational priority and is essential for safe care.
2. Develop a patient identification policy which:
  - a. includes the verification of a patient’s identity using 2 or 3 unique patient identifiers (e.g., name, birthdate, address, photograph);
  - b. uses open-ended questions (e.g., what is your name and date of birth?);
  - c. offers minimal interruptions and distractions during patient identification; and
  - d. emphasizes staff adherence to the procedures, which includes speaking up if a deviation from the patient identification policy is observed.
3. Ensure that all staff receives education on an ongoing basis about the patient identification policy and its importance to patient safety.

4. Use safety-enhancing technologies such as bar-coding, radio-frequency identification, and other patient care technology designed to prevent wrong-patient errors.
5. Register patients using a centralized, common database or master patient index to prevent the creation of duplicate medical records for the same patient.
6. Display the information required to accurately identify the patient on all computer screens, wristbands, and printouts (e.g., last name, first name, date of birth, medical record number, photograph, etc.).
7. Adopt standard features for patient wrist bands, including the information displayed and the location of patient names, to improve usability and readability.
8. Display patient names on adjacent lines of a computer screen in a visually distinct manner to decrease the likelihood of selecting the wrong patient name.
9. Limit the number of patient records displayed on the same computer at the same time to one, unless all subsequent patient records are opened as “read only” and are clearly differentiated to the user.
10. Develop electronically generated patient lists based on specific criteria (e.g., the person entering the data, patient location, time of encounter or service provided). A short list of relevant patients reduces the risk of selecting the wrong patient.
11. Utilize an alert system for patients with the same or similar names.
12. Review the patient database on a regular basis for patient identification errors (orders retracted or reordered) and compare to industry standards for duplicate record error rates.
13. Assign a “temporary” unique patient ID (which is then merged into a permanent ID) in the event that either the patient registration system is unavailable or the patient is not able to provide the required information.
14. Confirm a patient’s identity before affixing a label to a specimen container.
15. Ensure the Universal Protocol, including the time-out protocol, is uniformly and consistently used by all providers for the prevention of wrong-site, wrong-person procedures.
16. Develop a list of invasive procedures performed outside of the operating room (e.g., biopsies, injections into a joint space or body cavity, the insertion of central vascular access devices, and the use of contrast in CT scans) that require the use of the Universal Protocol to prevent wrong-patient errors.
17. Verify the patient’s identity at key points or transitions in the care process (e.g., while placing the patient in a room, recording vital signs, entering orders, administering medications, and during patient hand-offs and at discharge).
18. Engage patients and their families in the patient identification process.
  - a. Encourage patients to speak up if staff members do not ask for patient identifiers, or if they are approached to undergo unexpected tests or treatments.
19. Provide required interpreters for patients with language and hearing difficulties so they can participate in the patient identification process.
  - c. Permit patients to view and access information on a secure patient portal and instruct them to notify staff members if information appears to be missing or incorrect.
20. Develop a Health Information Technology (HIT) event reporting system to identify events and near misses.
  - a. Investigate and analyze events to determine why an error occurred.
  - b. Use this information to improve patient identification processes.
21. Periodically review your patient identification processes to monitor and detect trends in compliance.
22. Report the effectiveness of patient identification initiatives to your practice or facility administration. ❖

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# Reports to Child Protective Services: What Can I Tell the Police?

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The necessity to preserve the confidentiality of patient medical information is now an unquestioned principle in modern healthcare. Although it is tempting to attribute this to the enactment of the federal Health Insurance Portability and Accountability Act (HIPAA) almost two decades ago,<sup>1</sup> the reality is that healthcare practitioners in New York have been subject to laws governing patient confidentiality for almost two centuries.

In 1828, New York was the first state to enact a physician-patient privilege.<sup>2</sup> This privilege was enacted as a rule of evidence in legal proceedings. In 1962, it was re-codified as New York Civil Practice Law and Rules § 4504, and at present it covers physicians, nurses, dentists, podiatrists, chiropractors, and medical practices. Other statutes were later passed to expand the privilege to encompass psychologists, social workers, and rape crisis counselors.<sup>3</sup>

These privileges protect communications between a patient and the healthcare practitioners who attend the patient in a professional capacity with respect to information necessary to enable the practitioner to act in that professional capacity. The goal is to encourage uninhibited dialogue to promote adequate diagnosis and treatment, candid record-keeping by medical professionals, and protection of patients' reasonable privacy expectations against disclosure of sensitive personal information.<sup>4</sup>

In 2015, the New York Court of Appeals—the highest court in New York State—issued a decision clarifying the scope of the New York physician-patient privilege. In *People v. Rivera*,<sup>5</sup> the question before the Court was whether a psychiatrist could testify in a criminal proceeding that his patient, who was being prosecuted, had admitted during treatment that he had sexually abused an 11-year-old relative. In *Rivera*, the 11-year-old child revealed to her pediatrician, in her mother's presence, that she had been sexually abused by the defendant. This allegation was relayed to defendant's mother, who in

turn told the defendant. As a result, the defendant suffered depression and suicidal ideation, and was rushed to a psychiatric emergency department for treatment. It was there that he admitted the sexual abuse to the treating psychiatrist. The defendant was then admitted to the inpatient unit for psychiatric care. Because of the strict confidentiality afforded to psychiatric patients under the Mental Hygiene Law, the police obtained a court order for the hospital to notify them when the defendant was ready for discharge. Upon discharge, the defendant was arrested and charged with predatory sexual assault against a child.

Both the pediatrician and the treating psychiatrist reported the defendant's admission of sexual abuse to the appropriate child protective service. Before the criminal trial started, the prosecution made a motion for a subpoena seeking the defendant's mental health records for in camera review by the trial court.<sup>6</sup>

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1. Enacted as Public Law 104-191, 104th Congress, 1996.  
2. *Williams v. Roosevelt Hosp.*, 66 N.Y.2d 391, 395, (1985), citing E. Cleary, McCormick on Evidence § 98, at 243 (3d ed. 1984); E. Fisch, Fisch on New York Evidence § 541 (2d ed. 1977).  
3. CPLR §§ 4504, 4507, 4508 and 4510.

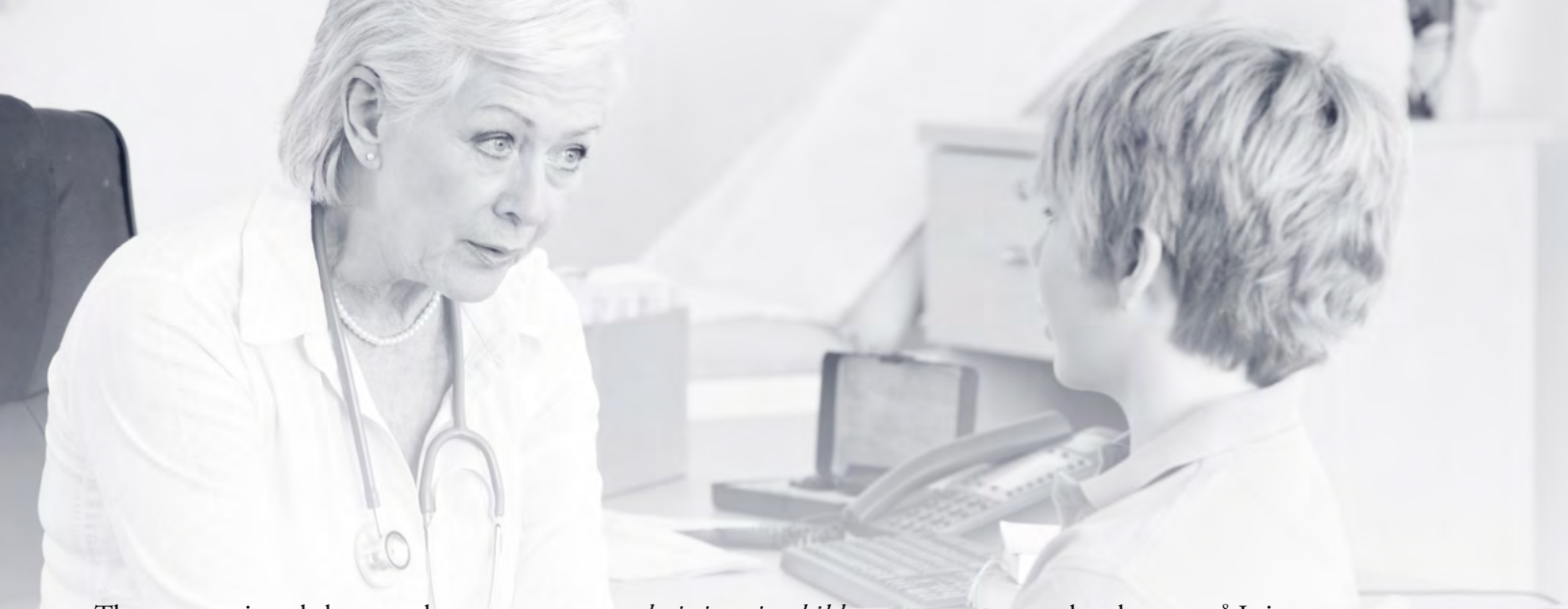
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4. *In re Grand Jury Investigation in New York County*, 98 NY2d 525, 529 (2002).  
5. 25 N.Y.3d 256 (2015).

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6. Under Mental Hygiene Law § 33.13, a subpoena to compel production of a patient's clinical record maintained by a licensed mental health facility must be accompanied by a court order. "In camera review" refers to the process by which the trial judge reviews the records in the privacy of the his/her chambers to determine whether they are relevant and should be disclosed during trial.





The court reviewed the records and decided that, because the psychiatrist had reported the abuse to child protective services, there was no longer a privilege attached to the defendant's statements. Therefore, the judge permitted the psychiatrist to testify at trial that the defendant admitted to having sexually abused the child. As a result, the defendant was convicted as charged and sentenced to a term of 13 years to life in prison.

On appeal, the Court of Appeals determined that the trial court had committed an error and mistakenly allowed the psychiatrist to testify. It stated that regardless of whether a physician is required or permitted by law to report instances of abuse or threatened future harm to authorities, which may involve disclosure of confidential information, reporting does not equate to a waiver of the physician-patient privilege in a criminal proceeding. The Court drew a definite distinction between use of statements or admissions in child protective proceedings versus criminal proceedings:

*[I]t is one thing to allow the introduction of statements or*

*admissions in child protection proceedings, whose aim is the protection of children, and quite another to allow the introduction of those same statements through a defendant's psychiatrist, at a criminal proceeding, where the People seek to punish the defendant and potentially deprive him of his liberty...*

*...Even if a patient is cognizant of his psychiatrist's reporting obligations under child protection statutes, that does not mean that he should have any expectation that statements made during treatment will be used against him in a criminal matter.<sup>7</sup>*

Therefore, absent a waiver by the patient or any specific exception to the privilege which attaches to confidential communications, the psychiatrist's testimony violated the physician-patient privilege, and should not have been allowed in court.

Rivera clarified some of the questions surrounding how providers should treat patient information which is the subject of man-

dated reports.<sup>8</sup> It is not uncommon for law enforcement to ask for patient information which has been reported to child protective, adult protective, or other governmental authorities. However, such information does not lose its cloak of confidentiality simply by virtue of a report, especially when sought by law enforcement. Healthcare providers should not re-disclose information which was originally the subject of a mandated report unless another exception to confidentiality applies.<sup>9</sup> ❖

8. For example, mandatory reporting of child abuse or maltreatment under Social Services Law § 413; disclosing information that a patient who is under the age of sixteen years has been the victim of a crime pursuant to CPLR § 4504; disclosure of any information as to the mental or physical condition of a deceased patient under certain circumstances designated in CPLR § 4504; Mandated reporting of injuries arising from or caused by the discharge of a gun or firearm, or wounds which are likely to or may result in death and are actually or apparently inflicted by a knife, icepick or other sharp or pointed instrument under Penal Law § 265.25; reporting of burn injuries to the office of fire prevention and control under Penal Law § 265.26; reporting cases of communicable diseases under Public Health Law § 2101(1).
9. Exceptions exist, for example, for requests by health oversight agencies and those to which the patient has given consent.

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7. Id at 11.

each party, and the recent trend of the awarding of summary judgment to defendants more frequently.

The motion for summary judgment is an effective litigation tool which is available by statute to defendants to obtain early resolution of a medical malpractice case, sometimes without going to trial. A review of recently decided appellate cases confirms a trend in granting summary judgment to defendants in medical malpractice cases based upon careful review by the judge of the defendant's motion papers and greater scrutiny of the plaintiff's papers in opposition to the motion, especially the affidavits of plaintiff's experts.

### **Historic Origins of Summary Judgment**

Summary judgment originated in England in 1885 as a means to grant a judgment without a trial in situations where there was no basis for the plaintiff's claims or the defendant's defense. It proved so successful in England that it was heralded as the "most beneficent inventions of modern procedure." Summary judgment was enacted into law in New York State in 1921 as a means for granting judgment without trial in certain contract cases, where there was no defense. Based upon the success of the summary judgment motion procedure in contract cases, its use was expanded in 1933 to all types of cases. Finally, in 1962, the existing summary judgment procedure was made into law as Section 3212 of the New York State Civil Practice Law & Rules.

### **The Defendant Must Initially Show Entitlement to Summary Judgment**

A court can grant summary judgment to a defendant in a medical malpractice case when it determines that there are no material issues of fact requiring a trial of the essential elements of medical malpractice which are: (1) a departure from the accepted standards of care in the community; and/or (2) evidence that the alleged departure from care was a proximate cause of the patient's injury or damage.

The defendant healthcare provider must be able to show that either there was no departure from accepted medical practices or that any departure was not a proximate cause of the patient's injuries. In order to make this showing, the defendant must be able to produce admissible proof such as certified medical records, deposition testimony, and an expert affidavit that addresses the specific malpractice allegations raised in the case.

If a defendant fails to meet this burden of proof in the motion papers, the motion will be denied, without the court reaching a review of the plaintiff's papers in opposition. However, when a defendant meets its burden in the motion papers, the burden then shifts to the plaintiff to rebut the motion, using admissible evidence and a sufficiently detailed expert affidavit.

### **The Recent Trend Toward Increased Judicial Scrutiny of Plaintiff's Expert Affidavits in Opposition**

As previously noted, once the defendant has shown entitlement to sum-

mary judgment, the burden shifts to the plaintiff to provide a detailed expert affidavit that shows that there are questions of fact to be decided that require a trial. Several recent New York appellate decisions from 2016 illustrate that there is a judicial trend in granting summary judgment to a defendant when the plaintiff has failed to produce a sufficiently detailed expert affidavit or other admissible proof that rebuts the defendant's entitlement to summary judgment.

In *Whitnum v. Plastic Reconstructive Surgery, P.C.*, the defendant was awarded summary judgment on the medical malpractice cause of action. The defendant produced medical records, deposition testimony, and a detailed expert affidavit showing that there was no departure from the accepted standard of care. The burden then shifted to the plaintiff to rebut this. However, the plaintiff failed to produce an expert affidavit or other admissible proof. The defendant was granted summary judgment and the case dismissed.

Similarly, in the cases of *Moore v. St. James Health Care, Inc.*, *Schuck v. Stony Brook Surgical Associates*, *Wong v. NYCHH*, and *Gallimore v. Allison*, the appellate courts carefully reviewed the expert affidavits submitted by the plaintiffs in opposition to the defendants' motions for summary judgment. In all four cases, the appellate courts found that the expert affidavits submitted by the plaintiffs were conclusory and insufficient. More specifically, the expert affidavits were insufficient because each of the experts failed to set forth the standard of care, explain how the alleged

departure from that standard proximately caused the plaintiff's injury, or relate their opinions to the specific facts of the case. Summary judgment was awarded to the defendants in all four cases.

### Recent Judicial Trends

Since its inception, summary judgment has been an effective legal tool used to bring an early resolution to cases without the necessity of a trial. Summary judgment is also an effective legal tool to narrow issues

and test the plaintiff's proof. Based upon the recent judicial trend toward increased scrutiny of the expert affidavit of a plaintiff in opposition to the motion, the use of a summary judgment motion should be considered when early resolution of a lawsuit is possible, either to limit the issues at trial or to test the strength of the plaintiff's case. Therefore, the use of a motion for summary judgment should be considered from the very beginning of the defense and throughout the life of the case.

Medical Liability Mutual Insurance Company and defense panel firms intend to vigorously scrutinize every lawsuit from inception to determine whether a motion for summary judgment is appropriate to dispose of the case without a trial, to limit issues at trial, or to put a plaintiff's case to the test. Any questions concerning the motion for summary judgment or the trend discussed in this article can be directed to the attorneys at Fager Amsler Keller & Schoppmann, LLP. ❖

## Case Study *continued from page 5*

to that patient, the physician must disclose the error to the patient and family in a timely and factual manner. Not only is this ethical, but literature has suggested that, depending upon the severity of the circumstances, some patients/families will not bring a lawsuit if the provider has been fully honest with them.

The prospect of meeting with a patient or family can be unnerving to say the least. If a provider is faced with having to make such a disclosure, he or she would be well advised to seek expert advice on what to say and, more importantly, what not to say. The disclosure should include only the facts actually known at that time and not conjecture. You may wish to convey your empathy to the patient and the family. In such case, you can and should state "I am sorry that this occurred" but not "I

am sorry I caused this." You should expect to be confronted by frustration, worry, and perhaps anger. You must control your desire to be helpful to the patient and limit your comments to only what is known at the time. The attorneys at Fager, Amsler Keller & Schoppmann, LLP are available to consult with MLMIC-insured providers to discuss how best to make a required disclosure.

Additionally, in the second case mentioned above involving a patient who unnecessarily underwent Mohs surgery, the lack of proper procedures in obtaining informed consent contributed to the misidentification of the patient. This patient was asked to sign a consent form at the physician's office. However, there was no documentation that the physician and patient had an informed consent discussion concerning Mohs surgery.

It appeared that the staff merely handed the patient a consent form to sign immediately prior to the physician performing the procedure. If the physician had discussed the nature and purpose of the procedure as well as the risks, benefits, and alternatives, including no treatment, before commencing surgery, this error would have been averted, since the patient and physician would likely have discussed the results of the biopsy. Since a biopsy had never been performed on this patient, nor were biopsy results in his record, the physician had a clear opportunity to avoid performing this procedure on the wrong patient.

Finally, in that same case, the actions of the staff after the error occurred almost certainly eliminated any possibility of defending the case.

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## *Coverage Levels and Options for Medical Practices and Their Employees*

*Robert Pedrazzi*

*Assistant Vice President, Underwriting*

*Medical Liability Mutual Insurance Company*

In addition to the coverage that is provided under MLMIC's Physicians & Surgeons Professional Liability Insurance Policy for a physician's professional services, limited coverage is also afforded to such an insured's Qualified Professional Entity (i.e., professional service corporation, professional limited liability company, partnership or limited liability partnership). This limited coverage will provide a defense to the Qualified Professional Entity and indemnify it up to and included in the policy's limits of liability. In other words, the Qualified Professional Entity shares the insured physician's limits for claims that are made against the physician for damages arising out of injury to or death of a person or persons because the physician, or a person for whose conduct the physician is legally responsible (who is also insured by MLMIC), provided or should have provided those professional services. It is important to point out that if such person is not insured by MLMIC, there would be no coverage afforded to the Qualified Professional Entity.

Clearly, the coverage in this provision is not intended to, nor does it, afford the broader coverage provided by MLMIC's optional, separate limits policy for a Professional Entity. When a policy is purchased for an eligible

Professional Entity\*, coverage is afforded for the direct liability of certain employees (allied healthcare providers—i.e., RNs, LPNs, Ultrasound Techs, etc.), while acting within the scope of their duties for the Professional Entity. These employees are covered within the professional entity's policy limits of liability.

To further clarify, the term "employee," as defined by the Physicians & Surgeons Professional Liability Insurance Policy, does not include physicians, chiropractors, dentists, nurse anesthetists, midwives, nurse practitioners, optometrists, oral surgeons, podiatrists, psychologists, physician assistants, or specialist's assistants. These employees must hold separate professional liability coverage for their direct liability emanating from their professional services rendered. Additionally, in order for the Professional Entity to have vicarious liability coverage for their acts, the aforementioned policies for these particular employees MUST have limits of liability of at least \$1,000,000 for each person and \$3,000,000 in total.

In addition to the coverage described above, MLMIC offers indi-

vidual professional liability insurance policies for both allied and extender healthcare professionals that are written with separate limits of liability. With annual policy premiums starting at just \$65 per year for allied healthcare providers, this added level of coverage affords additional protection for providers and their employers and acts to further insulate the Professional Entity from legal liability arising from professional services provided, or which should have been provided, by its healthcare professional employees.

As outlined in this article, MLMIC offers various ways of protecting a Professional Entity from legal liability arising from professional services provided by the various types of healthcare providers that the entity is responsible for. Each entity must determine what its business needs are and what level of protection best meets those needs. This is an individual decision that can only be made by the physician(s), partners, and/or shareholders of the professional entity and should be based on several factors such as current litigation climate, geographic location, and/or risk associated with their practice's specialty.

If you wish to obtain additional information regarding MLMIC's products, please contact your assigned Underwriter or call the

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\* A Professional Entity must meet MLMIC's eligibility requirements to obtain such coverage. Please discuss these requirements with your Underwriter.

office nearest your location shown on page 15 of this periodical. To download an application, please refer to our website, MLMIC.com.

*This article is intended to point out certain policy provisions that relate to potential gaps in professional entity coverage. It is not intended to substitute for our policy. The insurance coverage afforded by your policy is subject to all of the terms, conditions, limits and exclusions described throughout the policy. It is essential that you read your entire policy because all sections of the policy are inter-related. If there are any conflicts between this article and your policy, the terms and conditions of your policy will prevail.*

## *As a Result of Continued Fiscal Strength, MLMIC Declares New 20% Dividend*

MLMIC's board has declared a new 20% general dividend for policyholders. The dividend — which will apply to policyholders who are insured on May 1, 2017,

and maintain continuous coverage through July 1, 2017 — will be based upon the annual rate of premium in effect on May 1, 2017. It will provide meaningful financial relief to policyholders.

The board's decision to declare this dividend is based on MLMIC's statutory admitted assets of approximately \$5.8 billion, a surplus of \$1.9 billion and statutory net income of approximately \$100 million. These figures, available in the company's September 30, 2016, statutory financial statement, show the company's overall financial condition remains sound.

The new dividend is separate and apart from MLMIC's agreement to become part of the Berkshire Hathaway family of companies. That process takes a while and is on track to be completed by this year's end. In the meantime, MLMIC's strong financial performance enables it to offer a 20% dividend.

An overview of the September 30, 2016, statutory financial statement is available at MLMIC.com. ❖

## *Effective Coordination of Care*

*continued from page 3*

Upon discharge from a hospital, patients often return to the community with changes in their diagnoses and medication regimen. At this critical point, effective collaboration and communication between the hospitalist and the PCP must occur in order to avoid readmissions, poor outcomes, or errors in treatment, and to allow for a smooth transition for the patient. ❖

### ADDITIONAL REFERENCES:

1. Centers for Medicare and Medicaid Services Transition of Care Summary. May, 2014. Available at: [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/download/8\\_Transition\\_of\\_Care\\_Summary.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/download/8_Transition_of_Care_Summary.pdf).
2. Preventing Medication Errors in Transitions of Care: A Patient Case Approach. Johnson, et. al. Pharmacy Today. March 2015.
3. Gorili, Allan, et. al. Bridging the Hospitalist-Primary Care Divide through Collaborative Care. NEJM. January 22, 2015.
4. Improving Transitions of Care. National Transitions of Care Coalition (NTOCC) September 2010.
5. Mansukhani, Rupal, et. al. Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions. Pharmacy & Therapeutics. October 2015 40(10); 690-694.
6. Pham, Hoangmai, et.al. Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care. Health Affairs. September 2008 vol.27 no.5 1315-1327.

# RISK MANAGEMENT Tips

## Tip# 21: The Use of Computers in Examination Rooms

**The Risk:** The presence of laptops/tablets in examination rooms has become commonplace as more providers implement electronic health records. This method of documentation may place a barrier between the provider and the patient. Providers may miss non-verbal cues and patients may perceive an electronic device as a hindrance to communication. In several recent medical malpractice cases, plaintiffs testified that the provider spent too much time entering information into the computer, and not enough time listening. Utilizing effective communication skills to engage the patient while using a computer will enhance the integration of this technology into healthcare and improve the patient experience.

### Recommendations:

1. Analyze the examination room for placement of the computer. Position the computer in a way that enhances provider/patient communication. Consider using a cart on wheels to position the computer so that the provider faces the patient.
2. Establish eye contact with the patient and listen to his/her concerns before using the computer. Look at the patient while you speak.
3. Reassure the patient that you are listening to him/her.
4. Utilize the POISED<sup>1</sup> model:
  - P = Prepare for the visit
  - O = Orient the patient to what you are doing
  - I = Information gathering—allowing time for conversation

- S = Share what you are looking at on the screen with the patient
  - E = Educate the patient, reinforce the plan of action
  - D = Debrief and assess the degree to which the patient understands the recommendations and plan. Utilize the “teach back method.”
5. Print a copy of the visit for the patient and retain a copy in the patient’s record (e.g., after visit summary).
  6. When computers remain in examination rooms, providers must log-off at the completion of the encounter to protect patient privacy. ❖

### RESOURCES

1. Frankel Ph.D., JAMA Internal Medicine commentary, November 30, 2015.

## 2017 Event Calendar

<b>April 6-9</b>	Regional Osteopathic Convention (ROC-NY 2017) <i>Hyatt Regency Long Island Hotel</i>
<b>April 20-23</b>	Medical Society of the State of New York (House of Delegates) <i>Westchester Marriott Hotel</i>
<b>April 28-29</b>	ACOG District II – 2017 Upstate Meeting <i>Turning Stone Resort &amp; Casino</i>
<b>May 9</b>	Bronx County Medical Society 14 <sup>th</sup> Annual Physician Expo <i>Mercy College, Conference Center</i>
<b>June 3</b>	NYACP Annual Scientific Meeting <i>Hyatt Regency Hotel – Rochester</i>

<b>June 15-16</b>	New York MGMA State Conference <i>The Saratoga Hilton</i>
<b>June 24-25</b>	New York State Academy of Family Physicians Annual Meeting & Congress of Delegates 2017 <i>Renaissance Albany Hotel</i>
<b>July 11-16</b>	UPMASA 32 <sup>nd</sup> Annual Grand Convention <i>The Desmond Hotel in Albany</i>
<b>July 30</b>	MYANMAR American Medical Education Society Annual Scientific Meeting <i>Sheraton LaGuardia East Hotel</i>
<b>December 8-12</b>	NYSSA Post Graduate Assembly in Anesthesiology (PGA) <i>New York Marriott Marquis</i>

For more information on MLMIC’s participation at these events and others, please contact Pastor Jorge, Manager, Marketing Services, at 212-576-9680.

# THE MLMIC Library

## Spring 2017 Update

The MLMIC Research Library's services are available to all policyholders on a complimentary basis and may be accessed via MLMIC.com by selecting the MLMIC Research Library link at the bottom of the home page under *Services & Resources*. In-depth research services are also available to all policyholders.

The following resources are newly acquired and/or pertain to topics featured in this issue of *Dateline*. Visit the MLMIC Research Library to learn more about these titles and to borrow up to five items from our extensive collection. Or, contact Judi Kroft, Library Services Administrator at the website's *Ask the Librarian* link, or telephone 800-635-0666 ext. 2786.

- **2015 MLMIC Annual Risk Management Seminar: September 25, 2015.** Medical Liability Mutual Insurance Company; 2015 (Audio CD 561-178 2015).
- **Building a high-reliability organization: Toolkit for success.** Gary L. Sculli and Douglas E. Paull. HCPro Division of BLR; 2015 (R M 151-145).
- **Decision making in behavioral emergencies: Acquiring skill in evaluating and managing high-risk patients.** Phillip M. Kleespies. American Psychological Association; 2014 (Psych 133-060).
- **Enterprise risk management handbook for healthcare entities.** Roberta L. Carroll. American Health Lawyers Association; 2013 (R M 151-131 2013).
- **Error reduction in health care: A systems approach to improving patient safety.** Patrice L. Spath. Jossey Bass Publishers; 2011 (R M 151-084 2011).
- **Essential guide for patient safety officers.** Joint Commission Resources; 2013 (R M 151-132 2013).
- **HIPAA Rules & Compliance.** DuPont Sustainable Solutions; 2013 (DVD 002-611 2013).
- **Hospital and healthcare security, 6th edition.** Tony W. York and Don MacAlister. Butterworth-Heinemann; 2015 (Safety 152-035 2015).
- **Negligent credentialing lawsuits: Strategies to protect your organization.** Amy E. Watkins. HCPro, Inc.; 2005 (Med Staff 113-081).
- **Safer hospital care: Strategies for continuous innovation.** Dev Raheja. CRC Press LLC; 2011 (R M 151-144).
- **Strengthening nurse-physician relationships: A guide to effective communications.** HCPro; 2005 (DVD 002-551).
- **Strengthening nurse-to-nurse relationships: A guide to ending horizontal hostility.** HCPro; 2007 (DVD 002-550).
- **Taming disruptive behavior. William "Marty" Martin, Phillip Hemphill.** American College of Physician Executives; 2013 (R M 151-141).

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*The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.*

*Healthcare law, regulations, and practices are continually evolving. The information presented in Dateline is accurate when published. Before relying upon the content of a Dateline article, you should always verify that it reflects the most up-to-date information available.*



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## Case Study *continued from page 11*

The staff intentionally destroyed both the consent form and operative report after realizing that the surgery was performed on the wrong patient. This could only be interpreted as an attempt to cover up the mistake.

If this case had gone to trial, the plaintiff would have likely asked for sanctions against the physician for “spoliation of evidence.” Sanctions are warranted when a party to litigation intentionally destroys evidence which is relevant to the case. A sanction can consist of the judge giving an adverse inference instruction to the jury that relevant evidence has been destroyed, and that the jury is entitled to presume that the missing evidence was favorable to the plaintiff. Alternatively, the judge could

have granted a summary judgment in the plaintiff’s favor on the issue of liability only. In that case, the trial would be limited to the amount of damages to be awarded.

Given these very real problems with the case, it was prudent to settle because the resulting verdict against the physician could have easily been in excess of the settlement actually reached.

The third case illustrated that when a radiologist can look at multiple screens showing the studies of several different patients simultaneously, the facility and radiology department need to address/develop a policy to either limit the number of films which can be displayed at one time or develop some type of

failsafe check to require that the radiologist confirm the name of the patient before and after reviewing a film. This may include reviewing the film again to confirm the patient’s identification prior to entering the diagnosis in the computer.

In summary, misidentification of patients, their tests, and specimens should not occur if the steps delineated in the accompanying article are followed. It is clear that if you fail to properly identify patients or carefully re-review and confirm that you have the correct x-rays, specimens, or test results, costly litigation, verdicts, settlements, and even patient death can result. ❖