Controversial Cases in Malpractice and Negotiation: An Interactive Session for Clinical Medical Students

Student Version

Mackenzie Poole, MBA and James Junker, MD, FACR

Special thanks to Katherine Mathews, MD, MPH, MBA

All cases are based on real-life scenarios compiled by the authors.

Case 1

This case illustrates the poor consequences that can arise when there is a disagreement between hospital policies and those of medical specialty societies. It also provides a surprising example of how jury selection and the motives of plaintiffs may impact the outcome of medical malpractice cases in ways that are beyond the physician's control.

Key Concepts Include:

- Identification of proper resources that can be used to justify "standard of care."
- Differences between states on the number of jurors and the consensus between them required to meet a final verdict.
- The best practices and the extent of preparation physicians should take when preparing for an upcoming deposition.

Main takeaway for students: although the factors leading up to a plaintiff's decision to sue and the selection of jurors sitting for the case may be complex and convoluted, physicians can defend themselves legally by providing consistent, evidence-based documentation and being prepared to present the facts of the case at the deposition.

Case: A 70-year-old male with a history of excessive tobacco use presented to the hospital for evaluation of a cool, very painful left calf. The patient was able to obtain pain relief only if he slept with the calf in a dependent position, dangling off the edge of the bed. Vascular surgery and interventional radiology were consulted. The patient underwent an arteriogram shortly after admission which showed extensive small vessel disease. Nothing could be treated by radiology. The hospital's policy and procedure manual had been reviewed by a general radiologist. This radiologist had recently made some changes in the manual which were incorrect and not consistent with the standards of the American College of Radiology.

Three days later, the patient has a cardiac arrest and dies. The family sues the internist, vascular surgeon and interventional radiologist for wrongful death. The plaintiff's attorney was extremely aggressive and a judge was hired to moderate the attorney's behavior during the depositions. The case went to trial which started with the *voir dire* during which the librarian and the daughter of a physician were excluded from the jury pool. Their places were taken by two

maids who worked at a downtown hotel and had dropped out of high school. These women each had lawsuits pending for work-related injuries.

At the start of the trial, the patient's wife testified that he was in very good health before he was admitted to the hospital. She blamed the physicians for the death of her beloved husband. None of the physicians had ever met the patient's wife. Fortunately, the defense attorney did some detective work and discovered that the deceased's reported widow had been hired by the plaintiff's attorney to perjure herself, misrepresenting the health of the deceased. All physicians were immediately dismissed from the case, and the "widow" was referred for criminal prosecution for perjury. However, the prosecuting attorney said that his office had no time to prosecute defendants who had committed perjury. The plaintiff's attorney was referred to the Bar Association for discipline but received only a very minor write-up.

1. Describe a time when you or a colleague have been unsure whether the actions taken by the treatment team follow the "standard of care." What resources and documentation tips can providers use to justify the legitimacy of their treatment?

2. How does the evidentiary standard AND the number of agreeing jurors required to reach a verdict differ between malpractice and criminal cases? How may jury selection introduce bias into a malpractice trial (hint: this is hotly debated and without a definitive answer; you may even choose to argue against this assumption).

3. Define and describe what happens during a deposition. What is expected of physicians? How can physicians best prepare?

Case 2

This case illustrates the extent to which physicians must take legal accountability -- not simply rely on the electronic health record or the next physician coming onto the rotation -- for patients to which they have a duty of care in order to avoid career-devastating litigation.

Key Concepts Include:

- Understating the four requirements for an event to constitute malpractice can be breached at any point or multiple points along the chain-of-command.
- The extra care that temporary physicians and residents must take in ensuring adequate hand-off of patients after each encounter.
- Implications of the differences between economic damages and damages related to pain and suffering .

Main takeaway for students: performing procedures outside of the scope of one's clinical expertise or environment and/or failing to follow-up on critical results clearly breaches the expectations of the patient-physician relationship, a relationship that is law-binding at all stages of a clinical encounter.

Case: A 28-year-old Caucasian man presented to the ED with a 3-month history of a mole on his calf. The lesion was black in color and per the patient, and it bled intermittently. He was examined by a locum tenens ER physician, who decided to remove it with a football-shaped incision. The patient is told that he would get a call from the hospital if anything abnormal was found by the pathologist. The specimen was sent to the hospital's lab, where it was presumably lost. There is typically a formulaic chain-of-command within each department and within the hospital's lab to ensure that a specimen arrives at its intended destination. This chain is designed to ensure accountability for the specimen from the time it leaves the ordering physician's blade to the time it reaches the pathologist's microscope. However, because of lack of communication and documentation, it was not possible to identify where the chain was broken.

Note that this case occurred at a time when electronic health records were universally used within the hospital. The physician never checked-up on the pathology report. Soon thereafter, he went off service. Around 3 years later, the patient died from metastatic melanoma. The family sues. The hospital is aware that there have been other, similar "lost specimen" cases in the years leading up to this. The hospital will attempt to settle out of court given the unlikelihood that this case would hold up in trial.

1. Define the four requirements for an event to constitute malpractice in the law of torts. Provide examples from this case where these requirements were or were not violated, being sure to specify each individual party involved in that action.

2. Even though the EHR attempts to provide reminders, describe a time when you or a colleague has forgotten to follow-up with a result OR another team member resulting in patient dissatisfaction, a near-miss, or worse. Similar to locum tenens providers, how should residents ensure proper result follow-up when they switch services?

3. What do “economic damages” cover, and how are they calculated? Are they covered by the same caps as “pain and suffering?” Consider how this could become important depending on the plaintiff’s income or age.

Case 3

This case illustrates the extent to which accepting a poorly-written contract, particularly as it relates to malpractice coverage options, can negatively dictate a physician's personal and professional lives even once they have left the original job.

Key Concepts Include:

- Identification of best resources and average associated fees for third-party review of physician contracts.
- Differences between the types of malpractice coverage offered to physicians and their rights to negotiate these terms.
- Impact of geographic location and medical specialty on the amount malpractice coverage required and the cost of malpractice coverage.

Main takeaway for students: regardless of where or what one practices, physicians should not settle for the minimum requirements, assume that he/she has the knowledge to know what to look for when reviewing a contract – paying for a lawyer to review is always a wise investment!

Case: A newly-minted physician received his first contract and agreed with its initial contents. Because he thought it seemed fair, he decided not to have a third-party review it prior to accepting. The physician practiced in a rural town and as his family grew, his spouse and his children wanted to move to a larger city. They all really liked a neighboring metropolitan area and wanted to move there. He accepted a job in this city, but discovered that his employment contract did not have any provision for his group paying for malpractice tail coverage. Unfortunately, tail coverage in the new state can cost 3 to 4 times what it costs in in the original state. His new group in was willing to pay for his tail only if he took a significant starting salary reduction to compensate for the large payment. He admits that he had never considered this potential future issue. Had this scenario been presented to him prior to signing the contract, he would have attempted to negotiate this provision.

1. What third-parties exist for reviewing physician contracts? What are the benefits associated with having an external review? Can you find any specific prices for these legal services? It may be best to focus on a specific geographic area.

2. Define and differentiate between the way in which "occurrence" and "tail coverage" policies work. List 2 – 3 pros and cons of each. Are these negotiables within a system?

3. Based upon where the members of your group foresee themselves practicing in the future, compare these state's medical malpractice requirements. Can you find any differences in what is covered and/or the cost of coverage?

Case 4

This case illustrates that students and trainees are not immune to potential litigation and should therefore understand the extent to which they are covered by their institutions, how they may be called to testify, and where the line is drawn between protected health information and legal requirements when a lawsuit is at stake.

Key Concepts Include:

- Key differences between self-insurance versus personal malpractice insurance and the advantages/downsides associated with each.
- What defines an “expert witness” and the often voluntary nature of this role from the physician’s perspective.
- Patient access to medical records through HIPAA can provide evidence against a physician before he/she even knows that a suit is being developed against him/her.

Main takeaway for students: self-insurance is often beneficial for trainees because it provides broad protection so long as they have not deliberately performed a negligent act such as altering medical records. Be aware that expert witnesses have varying motives.

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The plaintiff's attorney sends out the case to multiple physicians, none of whom find any fault with the care rendered by the senior resident. The attorney initiates a nationwide search and finally finds a physician who will testify against all the doctors involved in the patient's care. The expert is a general surgeon who was given a general discharge from the Armed Services for using stolen credit cards and subsequently lost his license in 3 different states. His deposition is set up in a distant state. Unfortunately, the radiologists are not represented because the flight of their attorney (originating many states away) was cancelled. At the deposition, the surgeon could not name a textbook of general surgery.

This affair took almost 5 years before the senior resident was dismissed from the case. During that time, he tried to refinance a home loan but was denied because a wrongful death suit had been filed and no standard malpractice insurance was available.

1. What are the differences between self-insurance and personal malpractice insurance? Can you find which type your residency program offers with an online search? Why may self-insurance be beneficial even beyond training years?

2. Why are expert testimonies used in malpractice cases? How are physicians called to serve in these roles?

3. How are physicians notified that they are involved in a malpractice case? Describe this series of events and what stakeholders are involved. To what extent are physicians required to “hand over” private health information during these investigations?

Case 5

This case illustrates that a "good contract" is not simply defined by take-home salaries and hours worked but also outwardly considers variables that cannot be defined a numerical value, such as one's sense of purpose and career fulfillment.

Key Concepts Include:

- Ways to investigate salary competitiveness and company culture that extend beyond a generic online search.
- How employment setting and partnership considerations can impact what information should be made transparent in contracts.
- The extent to which financial records and access to professional development resources must and should be provided to job candidates.

Main takeaway for students: a physician is a health care organization's greatest asset, and as such, physicians should question whether potential employers have their best career interests in mind when they fail to be transparent about the job.

Case: A new physician her finishes training at a superb program and has excellent recommendations. She sends out her CV and gets multiple invitations to interview, followed by multiple job offers. Then, the real work started: she needs to perform due diligence on each of the groups. Her presumed dream job was at a major metropolitan hospital, and she originally expresses great interest in joining the practice at that hospital. However, unlike two of the other groups, the employment contract she is offered is quite vague about time to partnership, bonuses, etc. She repeatedly asks for more information about the business aspects of the practice, but her inquiries are not adequately answered. She decides to accept a very clear, excellent offer from another group. Approximately 10 years later, the group at that major hospital has a very acrimonious breakup. It turns out that the new employees were making just over 10% of what the senior partners were making. Real conflicts developed among the group when this was decided. The true fiscal data was hidden by a few senior partners. The group had A partners and B partners. The A partners controlled salaries, bonuses, vacation schedules, work schedules, etc. She is very grateful that she made the right decision and stayed away from that group, despite the attractive location of their practice.

1. Where can physicians go to find information about average compensation and benefits of competitors? Be comprehensive and consider more than just online resources.

2. What are the most common ways that physicians are paid? Beyond salaries, bonuses, and sign-on, what other considerations come into play when working in a partnership or private equity practice?

3. Are prospective employers required to provide information to applicants regarding salary structure, bonus potential, and promotion opportunities? What types of comments by employers may raise a "red flag" indicating a lack of transparency

Case 6

This case illustrates that physicians should not be expected to work beyond their stated responsibilities simply because they have the skills the organization needs in that instance. All doctors should be comfortable identifying ways that technology and networking can allow them to quantify their worth.

Key Concepts Include:

- Defining the idea of "mission creep" as a concept to which physicians may be particularly vulnerable in an organization.
- Accessing, analyzing, and tracking performance metric data can provide both internal and external benefits to a physician's practice.
- Open reflection on how speaking out when asked to work past one's limits is handled in healthcare by colleagues and administrators alike.

Main takeaway for students: knowing one's value as an employee, whether that be through data or status among colleagues, can be an invaluable way to leverage oneself in order to obtain a position that recognizes one's work and achievement.

Case: A physician finishes training and accepts what she considered to be her dream job with a hospital system. She is a great clinician and shows excellent leadership skills. Consequently, she is asked to take on more non-clinical/administrative responsibilities. "Mission creep" has set in. She goes to her boss and thoughtfully reviews her clinical productivity along with all her administrative duties. She then rightly asked for some compensation for the administrative duties which she does very well and which are mandated by the hospital and its accrediting agencies. This mission creep concept had not been negotiated in her contract and her boss refused her request for a raise. She then began to discretely network to find another position and was successful in her search within just a few months. The other system was anxious to hire her because of her great reputation and proven leadership skills. Her new employment contract gave her time for non-clinical duties. The first hospital system lost an all-star and the system that hired her knew that the hire would hurt their competition.

1. Often, mission creep happens not because of what "is" defined in a contract, but rather, what is left out. Based on your research and your own personal sentiment, what are relevant considerations that should be addressed in a contract to decrease the risk that this happens (ex: administrative tasks, rules regarding time off – think bigger than vacation)?

2. What common metrics can physicians track to document their productivity to both current and future employers? Where should they go to access this data? It may be helpful to generally consider a specific field (ex: primary care versus surgical specialties).

3. Describe a time when you have personally experienced or witnessed a colleague be asked to take on duties beyond what is required of them. Did they speak up? If so, what was the response? Describe where (and if!) these types of limits may be defined for resident duties.

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1. Describe a time when you or a colleague have been unsure whether the actions taken by the treatment team follow the "standard of care." What resources and documentation tips can providers use to justify the legitimacy of their treatment?
    a. Medical specialty societies publish standards of care/practice which are widely available to help guide treatment decisions and can be supported by reviews of pertinent medical literature. The ability to quote or refer to a guideline statement released by your specialty or an over-arching body like the USPSTF does not just help you sound "smart" to your colleagues, it can help keep you out of trouble. Hospital policy and procedure manuals should be consistent with these standards as well. In complex cases, consultation with other specialists with documentation of their opinions can be invaluable.
2. How does the evidentiary standard AND the number of agreeing jurors required to reach a verdict differ between malpractice and criminal cases? How may jury selection introduce bias into a malpractice trial (hint: this is hotly debated and without a definitive answer; you may even choose to argue against this assumption).
    a. Criminal cases are decided on the evidentiary standard of "guilty beyond a reasonable doubt with all jurors agreeing." Alternatively, civil cases require only "preponderance of the evidence," which is a lower standard. The majority of the jurors will need to agree, but this varies based on state as there is no national standard. In MO, 12 jurors are assigned and 9 must agree. In AZ, 6 are assigned and 5 must agree. These are just 2 examples.
    b. Attorneys attend continuing legal education courses on jury selection. In big trials, a law firm will hire an outside jury selection consultant who will be in trial with the attorney helping him or her select the jury. Most attorneys view jury selection as a critical component of the trial. Jury selection can influence the outcome of a case. However, several reviews in the field of malpractice and other civil law fields have found that jury verdicts on negligence are "roughly similar to assessments made by medical experts and judges" (PMID: 19002541). Therefore, this is a topic of debate that is unlikely to change any time soon.
3. Define and describe what happens during a deposition. What is expected of physicians? How can physicians best prepare?
    a. A deposition can be held at your office, in the hospital, or at the attorney's office. It will usually be videotaped so that it can be played at trial. Essentially, it is a form of evidence. The physician is expected to give an expert opinion, and if named in the suit, will need to be able to justify care of the patient. Keep in mind that deliberate falsehoods/changes to the records will disqualify coverage by malpractice agencies. You should only answer that which you are sure of, not projections.
    b. To prepare, the physician must thoroughly review the chart because the opposing attorney will have reviewed it. Think about not just what you did, but who you did or not talk to during the encounter (consultants, family, etc.). Consider questions you may be asked like you did when preparing for residency interviews. Do not underestimate your opponent! Your attorney should consider doing a practice deposition with you prior to the actual deposition. If they do not mention this, you should bring it up. This is also a good time to make sure you and your attorney agree on the facts of the case.

Case 2

This case illustrates the extent to which physicians must take legal accountability -- not simply rely on the electronic health record or the next physician coming onto the rotation -- for patients to which they have a duty of care in order to avoid career-devastating litigation.

Key Concepts Include:

- Understating the four requirements for an event to constitute malpractice can be breached at any point or multiple points along the chain-of-command.
- The extra care that temporary physicians and residents must take in ensuring adequate hand-off of patients after each encounter.
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Main takeaway for students: performing procedures outside of the scope of one's clinical expertise or environment and/or failing to follow-up on critical results clearly breaches the expectations of the patient-physician relationship, a relationship that is law-binding at all stages of a clinical encounter.

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Note that this case occurred at a time when electronic health records were universally used within the hospital. The physician never checked-up on the pathology report. Soon thereafter, he went off service. Around 3 years later, the patient died from metastatic melanoma. The family sues. The hospital is aware that there have been other, similar "lost specimen" cases in the years leading up to this. The hospital will attempt to settle out of court given the unlikelihood that this case would hold up in trial.

1. Define the four requirements for an event to constitute malpractice in the law of torts. Provide examples from this case where these requirements were or were not violated, being sure to specify each individual party involved in that action.
    a. In the law of torts as it relates to a medical malpractice case:
        i. There must be a doctor/patient relationship with the duty to provide care to the patient
        ii. A wrong it committed: There must be a breach of duty with the standard of care violated.
        iii. Causation: this negligence on the part of the provider must have caused harm to the patient.
        iv. Damages: the harm resulted in damages to the patient.
    b. In this case there was a doctor/patient relationship. Both the emergency room and the lab had a relationship with this patient. Certainly, the standard of care would be to follow-up with the lab results for the physician and for the lab not to lose the specimen. This negligence on the part of

both parties eventually resulted in the death of the patient from what was a treatable disease at the time of presentation.

2. Even though the EHR attempts to provide reminders, describe a time when you or a colleague has forgotten to follow-up with a result OR another team member resulting in patient dissatisfaction, a near-miss, or worse. Similar to locum tenens providers, how should residents ensure proper result follow-up when they switch services?
    a. Errors in communication between providers often result in medical malpractice suits. Well documented communication is critical. The EHR has faults, but can be helpful in reminding us to follow-up on certain issues. Notification fatigue is real, but there is little excuse to not follow-up in a timely fashion when there is a notification in your inbox that is warning you of a critical result.
    b. Some positive examples of communication include narrative charting, documenting all conversations with family, consultants, and interdisciplinary staff, naming a diagnosis and explaining your diagnostic/treatment pathway, NOT blaming or talking down on other providers/services, being extra cautious when pulling notes forward, documenting how much time you spent in an encounter, and making sure to timestamp any critical communications (ex: code status change).
    c. In teaching hospitals, consultation with your risk management/legal folks may help to establish a formal system for residents changing services. This reinforces the necessity of accurate and thorough hand-offs between residents not only at shift change, but particularly when you are rotating off a team or service. If you are not sure what the procedure is, just ask.

3. What do “economic damages” cover, and how are they calculated? Are they covered by the same caps as “pain and suffering?” Consider how this could become important depending on the plaintiff’s income or age.
    a. Economic damages are not covered by caps (top compensation that can be awarded) and are different than those pain and suffering, which do have different caps that vary by state. The economic damages are calculated often by an actuarial firm and consider the patient's age, income, potential life span, etc. In other words, there is no cut-off maximum. The economic damages can be massive. Examples include damages in pediatric and obstetric cases (lifespan) and patients with large yearly incomes.

Case 3

This case illustrates the extent to which accepting a poorly-written contract, particularly as it relates to malpractice coverage options, can negatively dictate a physician's personal and professional lives even once they have left the original job.

Key Concepts Include:

- Identification of best resources and average associated fees for third-party review of physician contracts.
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1. What third-parties exist for reviewing physician contracts? What are the benefits associated with having an external review? Can you find any specific prices for these legal services? It may be best to focus on a specific geographic area.
    a. There may be certain 3rd parties that can review physician contracts. For example, there are healthcare consulting agencies that work with physicians on multiple areas including contracts/legal documents. We strongly favor a health care attorney who has extensive experience in reviewing these contracts. An employment contract is like a prenuptial agreement. You are in love with your job. The attorney can make sure you are protected if you need to eventually transition out of that dream job. After all, remember that a contract is a law-binding document!
    b. For the first job out of residency, plan to spend $1500 to $2000 in legal fees. After you are established and changing jobs, you might be spending $5K to $7K since your needs/demands will be more complex. This may seem like a lot now, but if you taking your starting salary you will be surprised how few hours you will have to work to cover this cost. The alternatives are much worse.

2. Define and differentiate between the way in which "occurrence" and "tail coverage" policies work. List 2 – 3 pros and cons of each. Are these negotiables within a system?
    a. "Occurrence" insurance covers for any claims related to your care during the time the policy was in force, even if you are no longer insured by that company. If Smith Occurrence Company was your carrier two years ago and you switched to Jones Claims Made Company one year ago, Smith would continue to cover you for any alleged malpractice claim for care rendered during the time the policy was in force, even if the claim was made after you switched companies. For a child, where you can be sued literally years after you rendered care, the occurrence policy would still cover you.

b. The “claims made” policy coverage ends when you stop paying premiums unless you purchase tail coverage to ensure that you are protected against future claims. The tail typically costs 3 to 4 times what your annual premium costs.
c. The type of insurance is typically not negotiable but you may be able to negotiate the terms of the tail coverage when you are changing jobs (i.e., negotiating the ‘nose’ of your new insurance). During the malpractice insurance crisis in Missouri in the 90's virtually all companies offering occurrence policies left the state. Only claims made was available. If you are an employee of a system, the system might be self-insured.

3. Based upon where the members of your group foresee themselves practicing in the future, compare these state’s medical malpractice requirements. Can you find any differences in what is covered and/or the cost of coverage?
    a. Different states may require different levels of insurance. Hospital staff membership may well demand that you have $1 million/$3 million coverage, regardless of the lower coverage requirements of the state. The cost of coverage often varies between companies, with less financially secure companies offering bargains. You must choose your insurance carefully. If your insurance company goes bankrupt and you get a claim, you will be covered by the state insurance pool which has a cap of less than $500K in Missouri. If you are retiring and buy your tail from such a borderline company, your tail may not really be worth much.

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Main takeaway for students: self-insurance is often beneficial for trainees because it provides broad protection so long as they have not deliberately performed a negligent act such as altering medical records. Be aware that expert witnesses have varying motives.

Case: A 65-year-old man undergoes a cholecystectomy performed by a senior resident with the attending surgeon present. Unfortunately, the common bile duct (CBD) was tied off rather than the cystic duct. The patient became jaundiced and is referred to interventional radiology for biliary drainage with stent placement across the CBD. The senior resident is sent to meet with the patient and his wife to explain the procedure and obtain informed consent. The patient signs the consent which states potential life-threatening complications including hemorrhage, infection, and organ damage. The patient is brought to the special procedures room and is met by the radiologist prior to prepping and conscious sedation. However, the fellow walked in and stated that he will be performing the procedure. The fellow manages to penetrate the bile ducts, portal vein and a branch of the hepatic artery. The patient codes. The senior resident grabs the chart and documents all that is done during the code, since no nurse was available to perform the timely charting. The patient is transferred to the ICU and has multiple additional procedures before dying 3 weeks later. Shortly thereafter 19 physicians involved in the patient's care are sued, including the senior resident. The academic medical center is self-insured and hires their usual defense team to handle the case.

The plaintiff's attorney sends out the case to multiple physicians, none of whom find any fault with the care rendered by the senior resident. The attorney initiates a nationwide search and finally finds a physician who will testify against all the doctors involved in the patient's care. The expert is a general surgeon who was given a general discharge from the Armed Services for using stolen credit cards and subsequently lost his license in 3 different states. His deposition is set up in a distant state. Unfortunately, the radiologists are not represented because the flight of their attorney (originating many states away) was cancelled. At the deposition, the surgeon could not name a textbook of general surgery.

This affair took almost 5 years before the senior resident was dismissed from the case. During that time, he tried to refinance a home loan but was denied because a wrongful death suit had been filed and no standard malpractice insurance was available.

1. What are the differences between self-insurance and personal malpractice insurance? Can you find which type your residency program offers with an online search? Why may self-insurance be beneficial even beyond training years?
    a. Let us say that the health care system you join has 4000 physicians. Purchasing individual policies for that many doctors will be incredibly expensive. The system will probably decide to self-insure by placing the funds which they would have spent on those policies into investments and purchasing some type of catastrophic umbrella policy in case they have extraordinary losses.
    b. Most searches of universities show that they self-insure their residents (i.e., SLU).
    c. Self-insurance can be very beneficial for physicians, particularly for those in high-risk specialties. If there is to be a judgment, the self-insured entity may be able to assume complete liability for the judgment, keeping the individual physicians out of the data bank. The trial attorney wants money for his client and does not particularly care if the doctor is part of the settlement. The health care system values its physicians and does not want their names/brands tarnished by a data bank entry. In some instances, self-insurance by the system can be beneficial. In other instances, if the system has a problem with you, you may not feel that you are not being represented as well as you could be if you had your own policy. Typically, you will not have an individual policy along with the corporate self-insured policy. Note, however, that physicians that are not protected with self-insurance may have the opportunity to enroll in physician risk management programs through their insurer, particularly in their initial years of practice.

2. Why are expert testimonies used in malpractice cases? How are physicians called to serve in these roles?
    a. Expert testimonies are necessary to explain the facts of the case before the judge and jury, hopefully in terms that they can understand. Physicians may be contacted by attorneys who recognize the physician's expertise in certain areas that can help their clients
    b. These generally are not formal subpoenas in which the physician is required by law to testify. A subpoena may be required, however, if you are the single national or regional expert on a very niche topic to which the case pertains. Physician expert witnesses are well paid for their time and expertise, which can lead to abuses in some cases.

3. How are physicians notified that they are involved in a malpractice case? Describe this series of events and what stakeholders are involved. To what extent are physicians required to “hand over” private health information during these investigations?
    a. If a suit is being filed, your insurance company will typically be notified, or you may be served with the papers at your home or work site. Your insurance company will notify you that they will be reviewing the case to determine if you are covered. If you have violated the terms of your policy, you may not be covered and will have to assume personal fiscal responsibility for defending the case and potentially paying any judgment. There will be a follow-up communication from your insurance company stating that you are covered and they will be in close contact with you throughout the rest of the process, which will typically take years to resolve. Private health information will need to be turned over.
    b. The trial attorney will want access to the medical records. He or she will not have access to hospital peer review records which are protected under state laws. Keep in mind that under HIPAA, patients have the right to request their medical records and will have likely have given them to their attorney before at the beginning of the claims process. This is yet another reason to avoid altering records at all costs; the plaintiff’s lawyer will already have the original documents.

Case 5

This case illustrates that a "good contract" is not simply defined by take-home salaries and hours worked but also outwardly considers variables that cannot be defined a numerical value, such as one's sense of purpose and career fulfillment.

Key Concepts Include:

- Ways to investigate salary competitiveness and company culture that extend beyond a generic online search.
- How employment setting and partnership considerations can impact what information should be made transparent in contracts.
- The extent to which financial records and access to professional development resources must and should be provided to job candidates.

Main takeaway for students: a physician is a health care organization's greatest asset, and as such, physicians should question whether potential employers have their best career interests in mind when they fail to be transparent about the job.

Case: A new physician her finishes training at a superb program and has excellent recommendations. She sends out her CV and gets multiple invitations to interview, followed by multiple job offers. Then, the real work started: she needs to perform due diligence on each of the groups. Her presumed dream job was at a major metropolitan hospital, and she originally expresses great interest in joining the practice at that hospital. However, unlike two of the other groups, the employment contract she is offered is quite vague about time to partnership, bonuses, etc. She repeatedly asks for more information about the business aspects of the practice, but her inquiries are not adequately answered. She decides to accept a very clear, excellent offer from another group. Approximately 10 years later, the group at that major hospital has a very acrimonious breakup. It turns out that the new employees were making just over 10% of what the senior partners were making. Real conflicts developed among the group when this was decided. The true fiscal data was hidden by a few senior partners. The group had A partners and B partners. The A partners controlled salaries, bonuses, vacation schedules, work schedules, etc. She is very grateful that she made the right decision and stayed away from that group, despite the attractive location of their practice.

1. Where can physicians go to find information about average compensation and benefits of competitors? Be comprehensive and consider more than just online resources.
    a. Average compensation data can be provided by "headhunters," or professional hiring and HR agencies that specialize in recruitment. I personally believe that extensive networking is invaluable in reviewing compensation and benefit information. Do not be afraid to ask your colleagues and friends to give you an idea of their benefits. Your health care attorney can be very helpful with this as well, since he or she will have provided information to similar clients in the geographic area in which you are job-hunting.
    b. There are also a variety of online resources available for less specific, baseline metrics. These include the Medscape Physician Compensation Report, Doximity, and Becker's Hospital Review. Many healthcare consulting agencies also provide these metrics online. Consider, however, that these firms also want you to hire them to consult for you. It is then up to you to ask yourself whether you think this could bias the metrics listed.

2. What are the most common ways that physicians are paid? Beyond salaries, bonuses, and sign-on, what other considerations come into play when working in a partnership or private equity practice?
    a. Your compensation will consist of salary and benefits. Your salary will be taxed at a fairly high rate, which has you know by now, varies greatly by state. Your benefits may not be taxed in a similar manner. Please consider the value of benefits such as paid meetings, professional memberships, perhaps a corporate vehicle, etc. This is where having a list of what is important to YOU as an employee is extremely important. For many professionals, true fulfillment in one's job has nothing to do with salary, and this requires you to think in the "long term" and how this job will make you feel as an individual. The net worth of these benefits from a work-life balance perspective, not just a monetary perspective, is often much greater than a slightly inflated number on your paycheck.
    b. Please evaluate the corporate bonus structure (ex: if it is productivity based, is that productivity achievable?) and any potential partnership agreement. How easy is it to become a partner? Do not assume just because they are hiring you that this means it is the first step to becoming a partner! In the private equity arena, many of the deal offers involve the physician's vesting of stock into the practice. While this can hypothetically have a great pay-out at the end, there have been multiple instances where this stock has decreased dramatically in value. This is also shaky from a legal perspective, because there can be conflicts of interest when those running the business (ex: you as the physician) are also stockholders.

3. Are prospective employers required to provide information to applicants regarding salary structure, bonus potential, and promotion opportunities? What types of comments by employers may raise a "red flag" indicating a lack of transparency?
    a. A healthcare attorney could provide information about what information prospective employers are required to provide to applicants. A rule of thumb is that the more transparent the employer is, the better the employee will be treated. If a partnership is offered, the firm needs to give you the financial records for review by your own accountant, to be sure you are buying into a legitimate business. Proceed with caution and do not hesitate to seek legal and accounting help.
    b. Lack of information about access to professional development tools (CME, journals, conferences) can also be a warning sign. Employers that do not invest in their employees are often guilty of not recognizing those who work for them as their greatest assets.

Case 6

This case illustrates that physicians should not be expected to work beyond their stated responsibilities simply because they have the skills the organization needs in that instance. All doctors should be comfortable identifying ways that technology and networking can allow them to quantify their worth.

Key Concepts Include:

- Defining the idea of "mission creep" as a concept to which physicians may be particularly vulnerable in an organization.
- Accessing, analyzing, and tracking performance metric data can provide both internal and external benefits to a physician's practice.
- Open reflection on how speaking out when asked to work past one's limits is handled in healthcare by colleagues and administrators alike.

Main takeaway for students: knowing one's value as an employee, whether that be through data or status among colleagues, can be an invaluable way to leverage oneself in order to obtain a position that recognizes one's work and achievement.

Case: A physician finishes training and accepts what she considered to be her dream job with a hospital system. She is a great clinician and shows excellent leadership skills. Consequently, she is asked to take on more non-clinical/administrative responsibilities. "Mission creep" has set in. She goes to her boss and thoughtfully reviews her clinical productivity along with all her administrative duties. She then rightly asked for some compensation for the administrative duties which she does very well and which are mandated by the hospital and its accrediting agencies. This mission creep concept had not been negotiated in her contract and her boss refused her request for a raise. She then began to discretely network to find another position and was successful in her search within just a few months. The other system was anxious to hire her because of her great reputation and proven leadership skills. Her new employment contract gave her time for non-clinical duties. The first hospital system lost an all-star and the system that hired her knew that the hire would hurt their competition.

1. Often, mission creep happens not because of what "is" defined in a contract, but rather, what is left out. Based on your research and your own personal sentiment, what are relevant considerations that should be addressed in a contract to decrease the risk that this happens (ex: administrative tasks, rules regarding time off – think bigger than vacation)?
    a. It is often difficult to plan for every contingency such as mission creep in a contract. The contract should recognize your leadership potential and make appropriate adjustment for you to devote time to these necessary activities. It is important that the leadership of your organization knows that the physician employees are their most valuable assets and very expensive to replace. If you are someone who may be interested in taking on executive or teaching roles in addition to your clinical duties, do not be afraid to ask if there is an option to have paid time set aside for these roles if the contract does not provide enough information. Leadership needs to be on your side to protect you from burnout and foster your successful career. Organizational ethics is critical.

2. What common metrics can physicians track to document their productivity to both current and future employers? Where should they go to access this data? It may be helpful to generally consider a specific field (ex: primary care versus surgical specialties).

a. For a surgeon, case counts are critical, along with statistics on complications. For all physicians, some knowledge of RVU productivity would be invaluable to have when starting the job search. Other metrics that are gaining increasing attention are patient satisfaction scores and scores that assess care quality/value given the gradual switch to value-based care in Medicare. Some savvy physicians even look at the percent of their prior-authorization requests that are accepted for a given drug or procedure by indication to push back against denials from insurers!
b. This information should be available through the system's IT department. As soon as you start seeing patients on your own, you should strongly consider asking how you can track this data and blocking a period every month or so to review your statistics. You can even often see what conditions you treat the most, which medicines you most prescribe, and which procedures you most perform. It can be in invaluable way to help you learn how to improve your performance and paycheck.

3. Describe a time when you have personally experienced or witnessed a colleague be asked to take on duties beyond what is required of them. Did they speak up? If so, what was the response? Describe where (and if!) these types of limits may be defined for resident duties.
    a. A resident or young faculty physician is often asked to take on more duties, and they view such requests as opportunities to further their careers. Refusal to accept such duties can be viewed unfavorably. If the duties become overwhelming, you must be able to go to your chief and seek help. Again, employees need to be valued and the employer needs to be focused on ethics and safety.
    b. You should also refer to your employment contract and the information provided by the GME office regarding resident rights. The AMA has produced a Resident and Fellow's Bill of Rights that may be useful to reference although it is not endorsed by the ACGME. However, all programs accredited by the ACGME are required to give a minimum amount due process to residents when disciplinary action is taken against them. Most systems also have an oversight committee similar to the one at Office of Professional Oversight (OPO) at SLU in which complaints/concerns can be filed objectively.