

Online Supplementary Material

Hall MA, Peeples RA, Lord RW Jr. Liability implications of physician-directed care coordination. *Ann Fam Med*. 2005;3:115-121.

<http://www.annfammed.org/cgi/content/full/3/2/115/DC1>

Supplemental Appendix. Interview Details and Legal Analysis

[Authored by Mark A. Hall, JD, and Ralph A. Peeples, JD.]

Interviews

The following interview guide was adapted to fit the areas of experience and knowledge of each participant.

Who I Am

I am a professor of law and public health at Wake Forest University. This research study is part of a large effort to improve care for the chronically ill, funded by the Robert Wood Johnson Foundation, and directed at the Johns Hopkins School of Public Health.

What This Is For

There is a desire to have physicians take a more active role in coordinating care for people with multiple chronic conditions. One question physicians raise is how much this will increase their liability exposure, for instance, by holding them responsible for specialty areas they lack expertise in. Johns Hopkins has asked me to write a report that analyzes that question as best as can be done based on current knowledge. Part of that research is a series of interviews with knowledgeable attorneys, liability carriers, and risk managers—to seek their informed impressions. Your responses will be confidential and will not be attributed to you by name or organization. I am looking more for informed opinions than for hard data.

What Is Care Coordination?

A prototypical patient would be on Medicare, would have multiple chronic conditions, such as high blood pressure, high blood glucose levels, lower pulmonary or cardiac function, arthritis, etc, and would be seeing multiple specialists and taking multiple medications. The care coordinator would be a physician selected by the patient, probably (but not necessarily) his or her primary care physician. The care coordinator would be responsible for reviewing the overall management of the patient's multiple conditions, encouraging compliance and preventative measures, making recommendations for additional referrals or changes in specialist management, and resolving possible conflicts in treatment recommendations from other physicians. Best practices guidelines would be used, where available, and evidence-based medicine would be encouraged, including better access to combined medical records and outcomes data.

Care Coordinators Might Do the Following

- Recommend seeing fewer or different specialists
- Establish and monitor a comprehensive treatment plan
- Resolve conflicts between specialists' recommendations about treatment or lifestyle
- Resolve drug interaction issues

My Questions

1. Do you know of any **actual cases** being brought based on care coordination functions? What type? How many? Results?
2. If no actual claims experience, what is the **potential**, in general? Great? Small? Not much different from routine medical responsibilities? Consider each of the following:
 - Exposing primary care physicians to responsibility for greater range of problems
 - Holding primary care physicians to a specialist standard of care
 - Tendency of care coordination to measure physicians against “best practices” and ideal guidelines, rather than the prevailing standard of actual, imperfect practice
3. Are chronically ill or elderly patients more likely than average to have an adverse medical event? Are they less likely to sue over one?
4. Are the damages for any compensable injury likely to be less for chronically ill or elderly patients?
5. Are there any other relevant factors I haven’t mentioned?
6. What is the degree of liability exposure in the following **analogous situations**? Great? Small? Not much different from routine medical responsibilities?
 - “Hospitalists,” or primary care physicians with more hospital admissions than usual
 - Disease management or case management by insurers/employers
7. For lawyers, malpractice insurers, and risk managers: On balance, would you expect to have any concerns about insuring/defending physicians who took on a care coordination function?
8. Who else would you recommend I talk to about this?

The expert informants included 5 professionals with medical malpractice insurers, 3 persons working in the disease management industry, 3 physician researchers who have studied liability and patient safety, 3 law professors with expertise in medical liability, 1 hospital risk manager, and 1 physician director of a medical association. Expert opinion was also sampled from among 19 persons in the following groups who were queried more briefly (either verbally or by e-mail) about whether they had encountered liability problems relating to disease management or care coordination: 4 with large national managed care insurers, 6 working in the disease management industry, 2 researchers who have studied disease management or care coordination, and Medicaid officials in 8 states with large primary care case management programs.

Interview and research notes were coded by the lead author for major themes regarding the components of liability risk. Overall liability risk was assessed through key informants’ views and by examining existing analogues to the type of care coordination described here. Components of liability risk were assessed through legal theories that might target various aspects of care coordination and through the following risk factors associated with care coordination for patients with multiple chronic conditions: the likely patient populations, the use of information systems, and the expanded professional responsibilities of a care coordinating physician.

Existing Forms of Care Management

Key informants working in this industry said that they were not aware of any liability suits based on existing forms of care management and that, at professional or trade conferences, liability is “not on the radar screen” of important topics being discussed. Two other research teams that have studied case management and disease management recently found no indication that liability is a substantial problem area.^{1,2} One article on case management, however, speculates that full liability has not yet emerged because these functions are still relatively new and it takes time for lawyers to identify new sources of claims.³

Several participants noted that the liability risks of existing forms of disease or case management differ from the type of care coordination being examined here because disease or case management is typically not conducted by treating physicians. The expectations and responsibilities therefore differ. For instance, the role of these care managers is often only to provide suggestions and give reminders, rather than to make actual treatment recommendations,

which has a less direct impact on what actually happens to patients than would care coordination by treating physicians.

Nationwide, there are fewer than a dozen reported appellate cases that focus on the unique aspects of these established gatekeeping functions. Also, liability carriers said that they do not consider these practice environments to be higher risk for purposes of rating liability insurance. Medicaid directors of primary care case management programs, in which primary care physicians assume care coordination functions and responsibilities, said that they are not aware of liability being an important problem among their participating physicians.

Malpractice insurers who do not charge higher rates for hospitalists explained that this relatively new specialty has no clear track record of the extent of increased liability risk. They noted that the various reasons to expect somewhat higher liability has not caused them to avoid hospitalists or to charge them more. Instead, they are waiting for actuarially sound evidence of the extent of increased liability costs. Other malpractice insurers believed that some evidence exists of increased risk for hospitalists but that the extent of risk was not fully understood. These patient transfers create potential for medical error when they occur without adequate documentation of medical history or full understanding of the existing treatment plan. Interview participants noted that, whereas hospitalists increase these problems, care coordination in an outpatient setting would decrease them, because care coordination seeks to improve medical information systems and continuity of care.

Risk Factors

Key informants were not aware of any data that indicate whether patients with chronic conditions are more likely to suffer adverse events from medical error, or whether they are more likely to sue if they do suffer such events. As noted above, the elderly are much less likely to sue even though they are more likely to suffer from medical error as a result of the frailty and the complexity of their medical conditions. Using the elderly as a proxy, it does not appear that patients with chronic, complex, or more severe conditions are necessarily more likely to sue. Increasing physicians' care coordination responsibilities may also reduce litigation risk by improving care and reducing adverse outcomes. Improved care and reduced adverse outcomes are the goals of care coordination, and several professionals familiar with current forms of care management have reported that experience. In the words of one such person who works with head and spinal cord injuries, "These types of cases are often very litigious, [but] my perception is that Case and Disease Management actually help to defer 'going to court.' The entire philosophy of case management is to ... work out the 'kinks' in the healthcare system so that the patient receives the right care at the right place at the right time. I have worked on many cases involving attorneys and 'disgruntled' individuals and have never been taken to court."

Key informants noted that referring physicians already remain responsible for a certain degree of follow-up and communication based on the results of a specialist referral. Enhanced care coordination would reduce mistakes that arise from information "slipping through the cracks" or lack of clarity about which physician is responsible for follow-up. Some participants thought physicians currently are subject to liability for not acting when they see potential problems not of their own creation that could be corrected, so taking on and fulfilling this responsibility could prevent liability. This view is further confirmed by our own analysis below of legal doctrine.

The scope of responsibility under care coordination could be addressed with legal documents similar to informed consent forms that clearly explain to patients what care coordination does and does not entail. These experts explained that such documents are not an absolute defense, but they "go a long way" toward countering claims that physicians have greater responsibility than they intended. Indeed, one risk manager was excited about the potential that care coordination has to more clearly define respective responsibilities among referring and specialist physicians. He noted that these issues arise continually under conventional practice, but there currently is not a good legal vehicle for specifying physicians' respective roles and clarifying understandings with patients in writing. He thought that officially recognizing care coordination as a professional role

that patients would be asked to agree to in writing, as a form of informed consent, would provide an opportunity to pursue these risk management strategies.

Some participants noted that using good guidelines will lower overall risk because guidelines will improve care overall. They pointed, for instance, to guidelines for anesthesia or for the diagnosis of cancer. Several risk management experts noted that the biggest legal problem created by guidelines is the need to document reasons for departing from them.

Several key informants believed that the level of documentation is a more important factor in assessing liability risk than the legal standard of care, and so believed that expert systems on balance would lower liability risks. Others believed that using better information systems does increase liability risk somewhat, but not so much that using them should deter doing “what’s best for patients.”

We inquired about the liability consequences of providing a coordinating physician with information from medical records of multiple physicians. None of our key informants thought doing so raised significant liability concerns. Several participants thought that, as with other liability factors, information from medical records would reduce liability by improving care and preventing medical errors. One physician-owned insurer captured the attitude of several others, stating that its position “has always been that more information is better,” meaning that it is much better that doctors have all the relevant information than to hide from information as a way of lowering liability risk.

Two participants noted that poor doctor-patient rapport, rather than objective quality of care, is the primary driver of patients’ decisions to sue and that care coordination should reduce suits because it can improve the patients’ relationships with physicians and their satisfaction with care overall.

Legal Doctrine

Examples of judicial attitudes toward care coordination can be found in 3 state appellate court cases dealing with communication failures that led to patient injuries. In *Bass v Barksdale*,⁴ the Tennessee Court of Appeals ruled as follows:

When two or more physicians treat a patient, they are required to coordinate their efforts and communicate “in a manner that best serves their patient’s well-being.” The extent of the physician’s involvement decides what effort he must take to satisfy his obligation to communicate. This is a question of fact which depends upon the standard of care in the community.

And, in *Phillips v Good Samaritan Hospital*,⁵ the Ohio Court of Appeals ruled:

All physicians involved in a case share in the same duties and responsibilities of the primary care physician to the extent of their involvement. It is incumbent upon these medical professionals to coordinate their efforts in a manner that best serves their patient’s well-being.... The particular form of communication must depend on the facts and circumstances of the case. The fact that a physician may only be an indirect provider of medical care is but one relevant circumstance.

And, in *Nold v Binyon*,⁶ the Kansas Supreme Court ruled that, when multiple physicians have seen a patient, “the contours of the doctor-patient relationship and resulting duty in a referral system” are informed by expert medical witness testimony about prevailing professional practices rather than determined solely by the judge’s or jury’s sense of what should happen.

A comprehensive review of appellate cases arising from the treatment of diabetic patients⁷ concluded that “the courts have applied the general rules dealing with medical malpractice,” and that, although “the courts have reached different conclusions as to liability,” they have not developed any especially threatening rules based on the complexities of managing diabetes.

One aspect of legal doctrine that tends to diminish liability risk for care coordination is the rule that patients themselves can sometimes be held partially or wholly at fault for poor outcomes.

Common situations where this happens are patients' failing to keep appointments, noncompliance with treatment plans, and providing inaccurate or incomplete medical histories. These failings are also the kinds that care coordination is designed to counteract; therefore, when care coordination falls short, it will often be the case that the coordinating physician can point to patient negligence as a partial or full defense.

Generally, courts defer to the medical professions' own standard setting rather than allow juries to apply their own concepts of reasonableness, because juries lack the expertise to determine the proper balance of medical risks and benefits. Some aspects of care coordination, however, are more apt to be judged by standards set by juries than by the profession's own standards. Such functions as communication and record keeping involve less medical expertise and are more within the commonsense understanding of jurors. The Phillips case, noted above, ruled that "modes of communication [among physicians] are not so peculiarly within the expertise and knowledge of the medical profession as to necessitate expert testimony," and other courts have ruled the same for failures in communicating with patients. Other courts, however, differ on this question, holding physicians only to the standard set by other physicians. Furthermore, the cases favoring jury discretion and dispensing with expert witnesses were decided in the absence of any professionally set standards for care coordination.

Based on our legal review, as long as physicians do not try to avoid all legal responsibility, courts in general do not resist physicians' efforts to define more carefully their own scope of responsibility. Instead, courts have proven adept at tailoring the legal standard of care to the actual role that physicians play, rather than ordaining any particular level of responsibility. For instance, attending physicians who supervise residents are not held fully responsible for residents' actions; instead, attending physicians are responsible only for performing their supervising functions in a reasonable fashion. Similarly, residents themselves are often not held to the standard of practice in the specialty for which they are training but are held to the standard of other physicians in training.

The aspects of physician responsibility that are relatively new in care coordination will result in new areas of liability, but such is true for any alteration in professional roles or responsibilities. For instance, physicians who supervise residents, and even those on call, are potentially liable for failures in these capacities, but they are not liable to the full extent of treating physicians; moreover, these liability exposures are not so serious that they keep physicians from performing these differing functions. Several participants observed that every medical service entails liability risks for negligent performance, and care coordination would be no different, but if physicians are compensated fairly for their work, this fact alone should not be a serious barrier to taking on new or different responsibilities.

References

1. Short A, Mays GP, Mittler J. Disease management: a leap of faith to lower-cost, higher-quality health care. Issue Brief No. 69. 2003. Center for Studying Health System Change.
2. Gillies RR, Shortell SM, Casalino L, Robinson JC, Rundall TG. How different is California? A comparison of U.S. physician organizations. *Health Affairs*. 2003; 2(6):492-502.
3. Malpractice issues likely to plague case managers in the future. *Case Management Advisor*. 2002;100.
4. *Bass v Barksdale*, 671 SW2d 476 (Tenn App 1984)
5. *Phillips v Good Samaritan Hospital*, 416 NE2d 646 (Ohio App 1979)
6. *Nold v Binyon*, 31 P.3d 274 (Kan 2001),
7. Sharp LA. Medical malpractice in connection with diagnosis, care, or treatment of diabetes. *American Law Reports* 5th 1996; 43:87.