In Session
with Allied World for AACAP

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A quarterly newsletter designed to address legal and risk related issues that child and adolescent psychiatrists encounter.

INSIDE THIS ISSUE

***In Session** with Allied World for AACAP* is published in support of the American Professional Agency's child and adolescent psychiatrist insurance program, exclusively for members of the American Academy of Child & Adolescent Psychiatry.

Dear APA Member,

Welcome to the fourth issue of ***In Session*** *with Allied World for AACAP.* Since its inception in Spring 2011, ***In Session*** has highlighted the knowledge possessed by Allied World's risk management and claims teams. Together, the American Professional Agency, Inc. (APA, Inc.) and Allied World bring this valuable resource to policyholders. We hope that it continues to provide you with information applicable to your daily practice.

We have had the opportunity to meet many of you at the American Academy of Child & Adolescent Psychiatry (AACAP) Annual Meetings. It has been a pleasure to share with you the enhancements, services and support that our AACAP-sponsored medical malpractice insurance program offers. We are pleased to be a part of a dynamic team.

Charlene Glock is the Vice President of Marketing at APA, Inc. She is a registered nurse and a Certified Professional Healthcare Risk Manager. She has a background working as a nurse in a number of settings including psychiatry, hospital administration, managed care, risk/quality management and healthcare compliance. In addition, she has worked as a risk management consultant for two medical professional liability companies, including Allied World. She holds a BSN and Masters Degree in Health Science with a concentration in Business Administration.

Cynthia Tunney is the Assistant Vice President of Public Relations at APA, Inc. She has been with APA, Inc. since 1990 where she has worked on the APA program and as a supervisor of the National Association of Social Workers (NASW)-sponsored professional liability program, managing policies for over 65,000 insureds. She has also worked in underwriting and claims. In 2003, she obtained her designation as an internationally recognized registered professional liability underwriter. She holds a BA in Psychology.

In partnership with Allied World, we have built a top-notch professional liability product available exclusively to AACAP members. The program is offered in both claims-made and occurrence forms and provides 24-hour risk management hotline access. We will continue to strive to offer a superior program for you and it is of great importance that we receive feedback so that we can serve your needs. We look forward to working with you as your insurance resource. If you have any questions about the AACAP-sponsored child and adolescent psychiatrist malpractice insurance program, please contact either of us at (800) 421-6694.

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The Anatomy of Civil Litigation

By Dawn Cushman, Ryan, Datomi & Mosely, LLP

I usually start by saying, "The best thing that can ever happen to you is that you never see me again." As a defense attorney, I am hired to defend healthcare practitioners and facilities from medical malpractice lawsuits. More often than not, the practitioner sitting across from me at the conference table knows little about the litigation process – a process that can be daunting to the unfamiliar. The practitioner soon learns that, like the medical profession, the legal profession has its own unique, potentially-overwhelming terminology and jargon.

Most of what occurs during the course of civil litigation occurs outside the presence of the litigant. First, what is a **litigant**? Generally, a litigant is either the person who files suit (the **plaintiff**: often the patient or next of kin in medical malpractice suits) or is the person/entity being sued (the **defendant**: in this context, the child or adolescent psychiatrist, other healthcare provider, corporation and/or hospital). During the course of the case, attorneys are busy doing what attorneys do, most of which is foreign to the healthcare practitioner litigant. Many litigants, therefore, may not understand the process even when their lawyers send them status reports. The purpose of this article is to acquaint you with the potentially long, tedious process known as **civil litigation**. Hopefully, many of you will never need to become familiar with the system and will never see or hear from me again.

Our Phantom Litigation

Mellow Yellow Hospital (MYH) is an acute psychiatric facility. Dr. Grand is a member of MYH's medical staff and admitted Natalie S., a 16 year old female, to the adolescent inpatient psychiatry unit for treatment of schizophrenia. On June 1, 2011, Natalie was on a supervised break from group activities. She was in an enclosed patio area located on the second floor when, without warning, Natalie climbed up and onto a fenced gate that formed part of an enclosed caged staircase leading to the basement. She climbed to the top of the caged staircase where she leapt just as a mental health counselor was about to effect a rescue. Natalie fell, head first, almost three stories, to a concrete subterranean stairwell below and suffered, among other things, an avulsion fracture to the jaw. A lawsuit ensues…

The Pleading Phase of Litigation

This phantom lawsuit starts with a Summons and a Complaint. A **Complaint** is a formal document filed with the court by the plaintiff. The Complaint contains allegations detailing the acts of wrongful conduct committed by the defendant. The **Summons** is the formal document that notifies the defendant of the existence of the lawsuit and directs the defendant to come into court and to appear.

Natalie, through her parents (given that she is a minor), sued MYH and Dr. Grand for her physical and emotional damages. (In this phantom suit, Natalie and her parents are the plaintiffs, and MYH and Dr. Grand are the defendants). The Complaint asserted a number of claims. The Complaint alleged that Dr. Grand was negligent because he did not appreciate Natalie's psychiatric condition and that he failed to properly supervise her care. The plaintiffs claimed that MYH was negligent because it allowed Natalie to climb up the caged staircase in an apparent suicide or elopement attempt. The plaintiffs claimed that there was inadequate staffing to prevent the suicide attempt and that MYH improperly used unlicensed mental health counselors to supervise her. Furthermore, they claimed that MYH was negligent because the patio was not safe and should have been constructed differently.

Once the Summons and Complaint are served, the defendant has a number of options available. In cases where the formal allegations of a Complaint do not state a legally-recognized cause of action, a defendant can challenge the Complaint through a motion.

At any stage of the litigation, a variety of motions are available to the litigant. A **motion** is a written pleading filed with the court that usually presents evidence by way of declarations and documents. A motion also presents legal arguments and asks the court to issue an order. At the pleading stage, a **demurrer** is a type of motion that challenges the allegations as inadequate to state a legally-recognized claim. If the court agrees, the plaintiff is required to amend the Complaint to properly state a claim.

Ultimately, once a proper claim is pled (with the court), the defendant will file an Answer. The **Answer** is the formal document filed by the defendant that either denies or admits (in full or in part) each of the allegations set forth in the Complaint and also asserts various affirmative defenses. For example, if the lawsuit has not been filed in a timely manner, the defendant's Answer will include an affirmative defense stating that the Complaint is time-barred by the applicable statute of limitations (the statutory time period in which a Complaint has to be filed).

There are other pleadings, too, like Cross-Complaints. A **Cross-Complaint** is the assertion of a claim by a defendant against someone else who might also be culpable. More often than not, however, healthcare practitioner defendants attempt to present a united front and no Cross-Complaints are filed.

The Discovery Phase of Litigation

Discovery is a term used for the multiple forms of procedural techniques available to obtain information from the opponent. Discovery is designed to allow for the exchange of information regarding the details of the claims of the plaintiff and the defenses asserted by the defendants.

Interrogatories are written questions. The questions can be specifically designed for the context of the litigation. They can also consist of standard, form interrogatories developed to obtain basic information about contentions, damages and names of witnesses. Interrogatories are advantageous to the propounding party (the party sending the questions) because they can be tailored to the lawsuit. They are also advantageous to the **responding party** who is given time to ponder and develop a response with the assistance of his/her counsel.

I am old enough to remember when interrogatories contained 200 to 300 questions designed not so much to obtain information but to exhaust the opponent. Courts frown upon that type of sport these days. In general, interrogatories are kinder and gentler than before (although it might not seem that way to the litigant). As an aside, some attorneys still attempt to send many more questions than is customary or set forth in the rules (state or federal depending on the lawsuit). If this occurs, counsel may either answer the questions or the issue may end up in front of a judge.

Discovery allows for the exchange of information regarding the details of the claims of the plaintiff and the defenses asserted by the defendant.

Document Demands or **Requests for Production of Documents** are formal, written requests that ask the litigant to produce documents for the purpose of inspecting and photocopying the records. In actuality, a document can be any tangible thing, including electronically-stored information. In our phantom case, Natalie's Demand directed MYH to produce maintenance and construction records for the patio and enclosed staircase. The Demand also asked for an inspection of the patio and enclosed staircase itself. In that manner, experts were allowed to come on to MYH's premises for the purpose of measuring, photographing and otherwise inspecting the patio and enclosed staircase.

Requests for Admissions are another form of written discovery that ask the responding party to admit or deny certain propositions of fact or to admit or deny whether a particular document is genuine. They can be a handy tool, particularly when served concurrently with an interrogatory that asks the responding party to explain all the facts that support the responding party's denial of any Request. In that manner, the propounding party obtains an explanation for why there is a dispute over a particular fact.

Oral depositions are perhaps the most significant and effective discovery device. An **oral deposition** allows the opposing party's counsel to ask questions of the litigant but the questions are asked in person, with a court reporter present, taking down every word said in

the room, as if the parties were live and present in a courtroom. The only significant difference between trial testimony and deposition testimony is that no judge or jury is present. This is one of the few times during the course of litigation where the litigant is present and involved. Most litigants are fearful of this process, but the fears can be quelled with sufficient advance preparation with, and counseling from, an attorney. (Note: for an additional explanation of the deposition process, please see the article: "Preparing for Your Day in the Deposition Hot Seat," ***In Session*** *with Allied World for AACAP*, Volume I, Issue 3).

Most litigants are fearful of this process, but the fears can be quelled with sufficient advance preparation with, and counseling from, an attorney.

Lastly, **expert witness disclosure** is also a form of discovery. Shortly before trial, a simultaneous exchange of witness(es) occurs. The parties designate experts to testify on their behalf. These experts can include treating physicians as well as formally retained experts. Once the designation occurs, the expert witnesses may have their depositions taken (depending on jurisdiction).

Disputes occur throughout this discovery process. Discovery is intended to be self-executing in the sense that court permission is not required. Nevertheless, discovery abuses happen and court intervention may become necessary. Litigants are entitled to bring motions related to discovery. Motions often involve a litigant's attempt to obstruct discovery. Before a motion can be brought, however, the parties must attempt to resolve the dispute on their own.

In our phantom case, Natalie S. gave her deposition. Natalie's deposition testimony was significant. She admitted that at no time before going out on the patio did she intend to hurt herself, kill herself, think about leaving the hospital or think about trying to escape. Rather, Natalie admitted that she does not know why she chose to climb up on the gate and jump from the caged stairwell. She testified that she "wasn't really thinking." Natalie said it was an impulse.

Mr. Warren, the mental health counselor who almost reached Natalie before she jumped, was deposed. He explained what he saw and what he heard. Dr. Grand was deposed. The hospital's Director of Plant Operations was deposed. He testified that Natalie was the only person to ever hurt herself at the MYH facility by climbing over a wall or fence. He also testified the

caged stairwell had been constructed the year before Natalie jumped. The construction included plan review submissions to the Office of Statewide Planning & Development and the submissions had been approved.

Experts were deposed in the phantom litigation. Natalie's treating physician, a maxillofacial surgery specialist, was deposed. He testified that Natalie had injury to the inferior border, articular joints, supporting bone structure of the teeth, the right lower jaw and the left upper face. There was an avulsion fracture to the jaw. The teeth on the upper left were driven superiorly into the sinuses and there was an impact to the right anterior mandible. Natalie's prognosis was good. She was an adolescent who was expected to recover. She could communicate and talk. However, she had difficulty chewing. She incurred over $140,000 in medical expenses. Natalie was also expected to incur future medical expenses for revisions to her jaw.

Motions for Summary Judgment are particularly effective in medical malpractice litigation.

The Use of Dispositive Motions

Some motions are available to litigants that may be **dispositive** in the sense that the litigation may be eliminated altogether, without the need for a trial.

Motions to Dismiss the lawsuit can become available due to the plaintiff's failure to prosecute the case to trial over a period of time. In the context of medical malpractice litigation, it is uncommon for a plaintiff to abandon the prosecution of the litigation, but it does happen. In California, dismissal of the lawsuit is mandatory if the trial is not commenced within five years. However, this is not the case in all jurisdictions and cases may drag on for many years.

The most common dispositive motion, though, is a **Motion for Summary Judgment**. This type of motion is particularly effective in medical malpractice litigation. Motions for Summary Judgment allow for the presentation of evidence by declaration and documentation submitted to the trial court. The discovery conducted (i.e., depositions, document productions, medical records, interrogatory responses) becomes the evidence presented for the court's consideration. The Motion for Summary Judgment does not allow the trial court to try the case without a jury. Rather, the judge's function is limited. The Motion for Summary Judgment presents legal arguments for the proposition that, based on the evidence obtained, there is no fact in dispute and, therefore, the trial court may apply the law to the undisputed facts without the need for a jury to decide the facts. The judge can only look to see if there is a dispute. If there is no dispute, the judge may grant judgment. If there is a dispute of facts, the motion is typically denied. The judge may also grant part of the Motion for Summary Judgment whereby dismissing some of the plaintiff's claims. For example, if there is insufficient basis to bring forth a claim of lack of informed consent, the judge may grant a portion of the Motion but deny the portion of the Motion referring to the claim of negligence. This could limit damages in the event that the plaintiff were to recover at trial. It can also be beneficial in the event that settlement is pursued.

In our phantom litigation, Dr. Grand filed a Motion for Summary Judgment. He presented Natalie's deposition testimony. The deposition testimony of an expert witness was also included. The expert testified that he reviewed the medical records, deposition testimony, and other evidence, and determined that Dr. Grand's care was appropriate, reasonable and was in compliance with the applicable standard of care. In addition, nothing Dr. Grand did or did not do caused Natalie to leap off the staircase. According to the expert, Natalie, was being closely watched at the time by qualified staff members. In fact, one mental health counselor was within seconds of a rescue.

Further, Natalie was receiving her medication and expressed no intention to attempt suicide or to attempt elopement. Nothing in the medical records suggested suicidal ideation or a background of intending to harm herself or others. There were no signs or symptoms to forewarn anyone. Dr. Grand could not have anticipated that Natalie would climb a fence above the patio and leap three stories below. This was an impulsive act and admitted to be so by Natalie herself. The expert further testified that elopements and even apparent suicidal gestures can and do occur without negligence on anyone's part and despite care within the standard of practice. After oral argument, the judge granted Dr. Grand's Motion for Summary Judgment.

Let's assume, as part of our phantom litigation, that a question of fact remained regarding the safety of the premises and the construction of the patio and adjoining caged staircase. Now, MYH will proceed to trial.

The Mandatory Settlement Conference

The judicial system favors settlement of litigation. Therefore, many methods of alternative dispute resolution have been developed to attempt to avoid the expenditure of time and expense of a trial.

Mediation is one form of alternative dispute resolution. Private Mediation allows for the parties to select a mediator – often a retired judge – who is paid to conduct a settlement conference. The Mediation usually takes place in the mediator's office and is fairly informal. The Mediation is not typically binding on the parties. For example, the defendant may offer to settle the case for a certain sum of money, which the mediator then presents to the plaintiff who can accept or reject the settlement offer. The plaintiff can counter and the negotiation process may continue over the course of hours or an entire day.

Arbitration is another form of alternative dispute resolution and is similar in structure to that of a mediation; however, it may be binding upon the parties. In other words, the litigants present their case to the arbitrator who then decides the outcome without the case ever proceeding to trial in court.

Thank you for your continued input on ***In Session*** *with Allied World for AACAP.* We welcome your feedback and suggestions on topics germane to your practice. If you would like to see a particular topic addressed, we would love to hear from you. In addition, we are seeking contributions to future newsletters and development of educational resources. Please contact Kristen Lambert at kristen.lambert@awacservices.com.

Another form of alternative dispute resolution is the **Mandatory Settlement Conference** (MSC) and it usually occurs at the courthouse. An MSC traditionally involves a sitting trial judge (not necessarily the same judge anticipated to conduct the trial). MSCs usually occur within 90 days of the trial date so that most of the discovery is complete, allowing the parties to engage in meaningful, productive settlement negotiations. Legal briefs of the case often are submitted to familiarize the MSC Judge with the case.

Even though an insurance company representative may be paying the bill if the case settles, it is still necessary to have the healthcare practitioner litigant present. Meaningful settlement negotiations are not likely to occur without the parties present. Often, an MSC Judge or mediator can talk to a litigant in a manner where the litigant is persuaded to see another point of view beyond the attorney's point of view.

In our phantom litigation, no settlement was forthcoming.

The Trial

The trial takes place at a courthouse in a courtroom with a judge and usually a jury. (There are some cases where a jury is waived and the case is decided by a judge; however, in medical malpractice litigation, this is not typical). While it is not easy for a healthcare practitioner to disrupt a busy practice to sit through a 10-day (or more) trial, doing so is highly advisable.

Unlike episodes of Law and Order, most civil litigation trials consist of the tedious, boring and monotonous presentation of witnesses and evidence. Much of the initial time of trial is consumed with more motions. **Motions *In Limine*** are motions often presented to the court at the time of trial or shortly before the trial (without the presence of the jury). Motions *In Limine* may also be presented to the court during the course of the trial and, at times, there may be one or several Motions *In Limine* presented to the court throughout the trial. They are designed to ask the court to exclude certain items of evidence that the attorney already knows are problematic and would be improper for the jury to hear. A common Motion *In Limine* asks the court to exclude any testimony that the defendant has insurance – information considered to be automatically prejudicial.

The next step of trial is jury selection – called ***voir dire***. Jury *voir dire* can take days or even weeks. The judge and the attorneys may ask questions of the potential jurors to get a sense of what type of person will be making the decisions on the case. It is a process designed to find out whether any of the potential jurors have any bias or prejudice that would prevent him/her from being fair and impartial. It is a process that involves instinct and great care.

The next aspect of trial involves opening statements. **Opening statements** are meant to be non-argumentative, factual presentations of how the case will be presented. Both the plaintiff and defendant make opening statements. Then plaintiff presents his/her case, by calling witnesses to the witness stand and introducing testimony and documents as **evidence**. The plaintiff's case might include calling the defendant to testify as an adverse witness.

Upon the closure of plaintiff's case, the defendant has the opportunity to bring a motion for nonsuit. A **nonsuit motion** is often a speaking motion where the defense attorney verbally summarizes the evidence presented by the plaintiff and argues that insufficient evidence exists to prove the plaintiff's case. If the nonsuit is denied, the defendant puts on evidence to support his/her defense.

After the presentation of all of the evidence, another motion may be available known as a **Motion for a Directed Verdict**. The Motion for Directed Verdict is filed by the defendant arguing that there is insufficient evidence to be tried by the jury.

The parties then conclude the trial by delivering their closing arguments. Closing arguments summarize the evidence and relate the evidence to the legal concepts involved.

The Judge then reads standardized and specially prepared jury instructions that are designed to detail the legal principles to be applied by the jury during their deliberation process. The jury then deliberates until a verdict is reached. Upon reaching a jury verdict, the trial court then enters a judgment in accordance with that verdict.

With our phantom litigation, MYH obtained a successful defense verdict. However, successful verdicts don't always mean that the case is closed/over. Not only did the plaintiffs file multiple post-trial motions asking the trial court to negate the jury verdict, but when they lost those motions, they then filed an appeal. Like I said, the best thing that can happen is that you never see me again.

About the Author

Dawn Cushman is a Senior Attorney with Ryan, Datomi & Mosely LLP, a law firm containing members with a combined experience of over 60 years representing hospitals, physicians, skilled nursing facilities and other healthcare providers in matters involving medical malpractice, staff privileges and elder abuse. Ms. Cushman has been an attorney for more than 30 years and is a Certified Specialist in Appellate Law, certified by the State Bar of California, Board of Legal Specialization. She has bar memberships in California, the United States District Courts of California, 9th Circuit Court of Appeals and the United States Supreme Court. She has served as the treasurer of SCAHRM (2006-2010) and has served on the editorial board of ASHRM since 2009. Ms. Cushman is a member of the Executive Committee of the Los Angeles County Bar Association's Appellate Court section and has served as the liaison for the Annual Supreme Court Luncheon since 2004. She received her law degree from California Western School of Law and her bachelor's degree from San Diego State University.

The next issue of ***In Session*** *for AACAP* will feature an article on the appeal process in a civil lawsuit.

Culture Corner

By Kristen M. Lambert, Vice President, Healthcare Risk Management, AWAC Services Company, and **Myrna Nieves**, Senior Claims Associate, Allied World U.S. Claims Department

Psychiatrists often encounter patients and family members from diverse cultures and backgrounds. Although there are many differences and variations within a culture, we feature different cultural groups which may be of interest to you in your daily practice as well as some relevant legal issues which you may encounter. It is important not to stereotype a person from a specific culture into thinking he has the same beliefs as someone else from that same culture. Learning whether a patient considers himself typical or different from others in his cultural group is important, as there are many factors which influence how an individual views his own culture/beliefs. You may never encounter some of the featured cultures in your practice; however, we hope you find the information on the featured cultures interesting nevertheless. In this newsletter, we feature the Puerto Rican culture.

Puerto Rican

There are reportedly over 4 million Puerto Ricans living on the mainland of the United States, a number which now exceeds the population living in Puerto Rico itself.[1] This population will likely only continue to grow in the coming years and may, in turn, impact your patient population.

Major Language/Dialects: Spanish and English are the major languages spoken in the Puerto Rican culture.[2,3] If an interpreter is required, it is important to utilize a professional interpreter, not family members, to ensure that information translated is accurate.

Communication: Puerto Ricans are typically affectionate, known for hospitality and for being likeable, warm and friendly. Interpersonal relationships are often very important within the Puerto Rican culture.

Tone of Voice: Puerto Ricans are often expressive and communicative. Inflections and tone may be misinterpreted as confrontational. However, do not assume that the patient and/or family is presenting in a confrontational manner.

Consents: Non-verbal communication is vital when dealing with informed consent. Patients may nod in agreement but may not necessarily agree or may not understand. It is important to clarify by using a friendly and respectful approach. Allow the patient/family time to determine their decision with respect to consent. Family is an important part of the Puerto Rican culture and discussion among family members may be sought.

The Family Unit: The Puerto Rican culture is often very family-oriented with a nuclear and extended family structure. The oldest daughter/son may be seen as the spokesperson for the family. Several family members might be involved in decision-making. Older women often have a powerful and respected role within the family. Women usually assume an active role in caring for the ill. *La abuela(o)* (grandparents or elderly relatives) are typically figures of respect, admiration and wisdom. Children are the center of family life within the culture. Typically, both negative and positive rewards are used to discipline children, with the mother often assuming the active role in disciplining.

Concept of Health: Often being underweight or thin is a sign of being unhealthy and a symbol of economic disadvantage. In other words, *llenitos y limpios* (not being too thin and being clean) are perceived as being healthy.

Mental Illness: Mental illness may carry great stigma among Puerto Ricans (See *Lipson,* n. *2*). Many may not disclose a history or present mental illness within the family. However, this stigma may not hold true among young adults. A recent study of attitudes toward seeking therapy among Puerto Rican and Cuban Americans indicated that young adults perceived individuals with mental illness to be less dangerous and to have a higher level of social and interpersonal skills compared to how their parents perceived them. Further, they were also found to believe that mental illnesses are more treatable and they perceived there to be significantly less stigma attached to those with mental illness and who seek therapy versus their parents. Finally, the study found that young adults were also significantly more receptive to pursuing therapy for personal/emotional issues versus their parents.[4]

Depression may not be expressed by a patient due to fear of family stigma or shame.

Puerto Ricans are typically more superstitious than other groups. They may believe in *espiritismo* (spirits) and that the world is populated by spirits who can communicate with the living through dreams and may believe that every dream has a meaning. As a result of these beliefs, individuals might not seek treatment for mental illness as they are led to believe that the "spirits" are communicating with them and that it is a "gift."

Depression: Suffering of *nervios* or *ataque de nervios*, rather than depression, may commonly be described for symptoms related to depression. Depression may not be expressed by a patient due to fear of family stigma or shame. As indicated, a history of family mental illness may not be disclosed. It is important to acknowledge and confirm confidentiality with the patient.

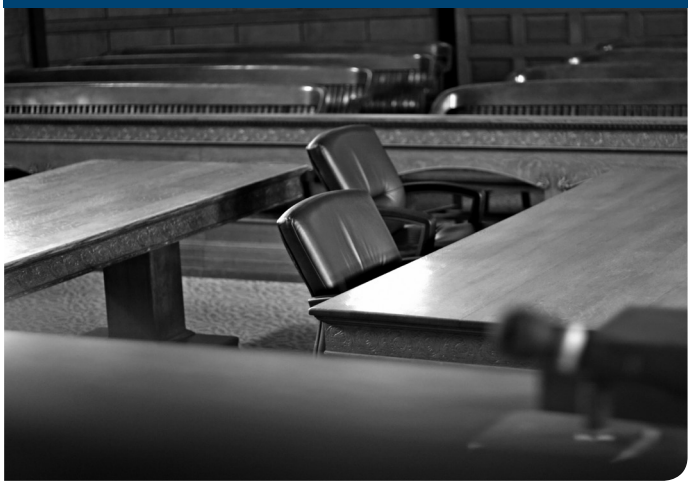
Substance Abuse: In 2007, heroin was the most common primary substance of abuse among Puerto Rican substance abuse treatment admissions while alcohol was the most common substance of abuse among other Hispanic admissions.[5]

Allied World's Experienced Claims Team: As the largest insurer for mental health providers, Allied World's analysts understand the intricacies of psychiatric claims, including the unique challenges associated with patient complexities, patient rights and various state regulations. Possessing both the legal and clinical backgrounds that are critical for handling psychiatric claims, each team member has extensive experience handling child and adolescent psychiatric claims.

About Our Co-Author

Myrna Nieves was born in Caguas, Puerto Rico, and still travels there to visit family. Myrna has worked in the insurance industry for almost twelve years. As a Senior Claims Associate, Myrna is responsible for handling General Liability claims in the Medical Liability unit, as well as all administrative matters under the American Professional Agency, Inc. program. Myrna holds her adjuster license in twenty states and is currently completing her Associates Degree as a Paralegal.

Claims Perspective: First Steps if You are Sued for Malpractice



By Susan Lynch, Allied World Claims Manager for APA

In the last issue of ***In Session*** *with Allied World for AACAP*, we described steps to take in the event you receive a subpoena for records or to appear for deposition testimony. We discussed circumstances where you were *not* a party to a lawsuit. Should a situation arise where you find that you are sued by a patient or a patient's family or guardian, your first action should be to **immediately contact your insurance agent or malpractice carrier.** Your insurer can help you avoid some of the hazards you may encounter in litigation.

Depending on the jurisdiction, most lawsuits require a response to a Complaint in either twenty or thirty calendar days. As such, prompt reporting to your carrier is critical in order to avoid having a default judgment entered against you. A **default judgment** is a judgment entered against a defendant who has failed to plead or otherwise defend against a plaintiff's claim. A default judgment can also be entered as a penalty against a party who does not comply with a court order.[6] Your carrier can also provide you with guidance regarding your preservation of the patient's treatment chart as well as how to handle communication with other parties.

When faced with a lawsuit, which may contain various allegations against you, it may be tempting to consider adding notations to the chart, or to make another copy of the record to improve its legibility. **It is critical that you do none of these things.** Do not draft any additional notes, reports or documents related to the patient's care or make any alterations to the patient's chart. **Doing so could negatively impact the defense of the case.** Instead, carefully safeguard and preserve the original, unaltered chart.

It is also important that you do not discuss the lawsuit or the underlying patient treatment with anyone other than your insurance representative and your attorney. While your first instinct may be to contact the patient, the patient's family or their counsel directly, doing so could make matters worse. You also should not discuss the patient's treatment or the lawsuit with colleagues, including other providers named in the lawsuit. Once those parties are, like you, represented by counsel, any communication will be conducted through the attorneys so that all will be protected by the attorney/client privilege during the course of litigation.

While being sued is never a pleasant experience, your insurance carrier is here to assist you with the process and to help you steer clear of potential hazards you may face. Following the guidelines below may assist you in reaching a successful conclusion to your case.

When faced with a lawsuit, for your own protection, we suggest the following guidelines:

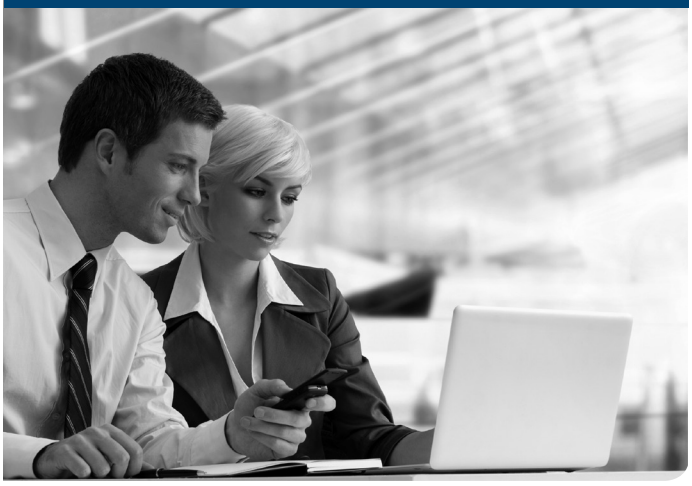
- Immediately contact your insurance agent or carrier.
- Speak to no one about the case other than your insurance representative and attorney.
- Make no changes, additions or deletions to the original chart.
- Do not draft any additional documents, reports or notes prior to speaking to your attorney.

Risk Management Services

For AACAP members who are Allied World policyholders, we provide:

- 24-hour risk management hotline access.
- Risk management seminars.
- Individual CME Education through our relationship with Medical Risk Management, Inc.
- Access to our library of risk management resources.

Safety and Security Issues with the Use of Social Media



By Kristen M. Lambert, Vice President, Healthcare Risk Management, AWAC Services Company

In the last issue of ***In Session*** *with Allied World for AACAP*, we featured an article entitled: "Doctor, Can We Be Friends?" Dr. Claire Zilber and I discussed concerns regarding the use of online social media, particularly *Facebook* and *Twitter*. As a follow-up, and given that this issue is a hot topic of discussion across the country, I thought it would be useful to specifically address safety and security issues related to the use of social media.

Social media impacts us personally and professionally on a daily basis. Most of us might not have envisioned the effect that social media would have within the healthcare sector, including the field of child and adolescent psychiatry. In the coming years, social media usage will only increase, potentially causing risk management and legal concerns within your practice. Although there is minimal caselaw or statutory regulations nationally concerning social media, it is anticipated that legal challenges will arise.

Social media refers to the use of web-based and mobile technologies to turn communications into an interactive dialog.[7] The use of social media spans across all ages and all professions, including psychiatry. Social media is used to connect individuals to each other in an online format and takes on a variety of forms including: electronic mail, *Facebook, MySpace, Google+, LinkedIn, Twitter, YouTube, Skype, Foursquare*, blogs and online dating sites. Several of these mediums were discussed in the last issue of ***In Session***; however, some were not.

Since social media is progressing so rapidly, it might be helpful to provide some background information on some of the newer vehicles:

- ***LinkedIn***, a professional networking site
- ***YouTube***, a video-sharing network (3 billion views/day, 2 days of video uploaded every minute)[8]
- ***Skype***, a software system that allows online voice calls and video conferencing (over 929 million users)[9]
- ***Blogs***, typically interactive websites (or part of a website) maintained by an individual with regular entries of commentaries and events (over 156 million public blogs in existence)[10]
- ***Foursquare***, a location-based social networking site where individuals "check-in" at certain locations via their smartphones (an estimated 3 million check-ins/day)[11]
- ***Google+***, launched in limited phase in June 2011 (already has an estimated 50 million users)[12]

Of the many issues to consider when using social media, two prime concerns are safety and security. When accessing or using a social media site to communicate with and about patients, it is critical to determine the degree of privacy and security available within that medium. As you all know, patients are entitled to confidentiality, and whichever form of social media outlet you use, privacy remains of the utmost importance.

The use of social media could potentially expose you to liability under HIPAA and state privacy laws. Consider if one of your office staff breaches HIPAA when posting information online concerning a patient. For example, your office assistant dealt with a difficult patient and later that day posts on *Facebook* about his/her interaction with that patient. Although you may not have interacted with the patient directly, may not have been in the office at the time, and may not have observed the interaction, this posting could expose you to liability.

Special Concerns Involving Skype

Another way privacy could be breached is through the use of *Skype*. Since the inception of *Skype's* video conferencing capabilities in 2006, it is becoming more widely used in healthcare, including within the behavioral health sector.[13] If using *Skype* to treat patients, there are a variety of risk management and legal issues concerning safety and security.

First, how are you visualizing the patient and what safety precautions do you have in place in the event that something adverse were to occur? Further, how do you know that it is a secure connection? *Skype* claims to be secure and encrypted; however, it is impossible to verify that the algorithms are used correctly, completely and at all times. *Skype* has been found to have a number of security issues. (Fn. 9). It is equally important to note that **using Skype in a state in which you are unlicensed to practice medicine could expose you to liability and, in the event of a lawsuit or board disciplinary action, it is likely that defense costs or an adverse verdict may not to be covered by your insurer.**

Improper Use of Email

Other issues can occur through use of email. Consider who may or may not be receiving your email on the other end. Further, what if you are communicating with a patient who believes the communication to be privileged? A recent case from California involved patient communication with a therapist through a work email account. Another party was attempting to access the records. The California Appeals Court found that the patient's communication with her therapist may lose protection under patient-therapist privilege when the transmission is sent via a workplace device.[16]

Therefore, in the event that a healthcare provider is engaging in email correspondence with a patient, parent, or guardian, it is important that it be to their personal (not work) accounts, as there may be no reasonable expectation of privacy. Further, this does not consider whether it is even appropriate to engage in an email exchange with patients or their guardians in the first place. Additionally, if you are employed by a healthcare organization, existing policy may prohibit email exchanges with patients.

Conclusion

While this article touches upon some safety and security issues when using social media, it does not constitute an exhaustive list of issues to consider. Social media is a moving target that evolves with every click, post and blog. Just as social media continues to rapidly evolve, so too do the related safety and security issues. Engaging in the use of social media should not be entered into lightly, as its impact on child and adolescent psychiatry will be far-reaching.

Of Note on the Technology Front...

On November 10, 2011, JCAHO issued a statement regarding texting orders.[15]

The question posed was, "is it acceptable for physicians and licensed independent practitioners (and other practitioners allowed to write orders) to text orders for patients to the hospital or other healthcare setting?"

The response was as follows: "No it is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare setting. This method provides no ability to verify the identity of the person sending the text and there is no way to keep the original message as validation of what is entered into the medical record."

End Notes

Culture Corner

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Safety and Security Issues with the Use of Social Media

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