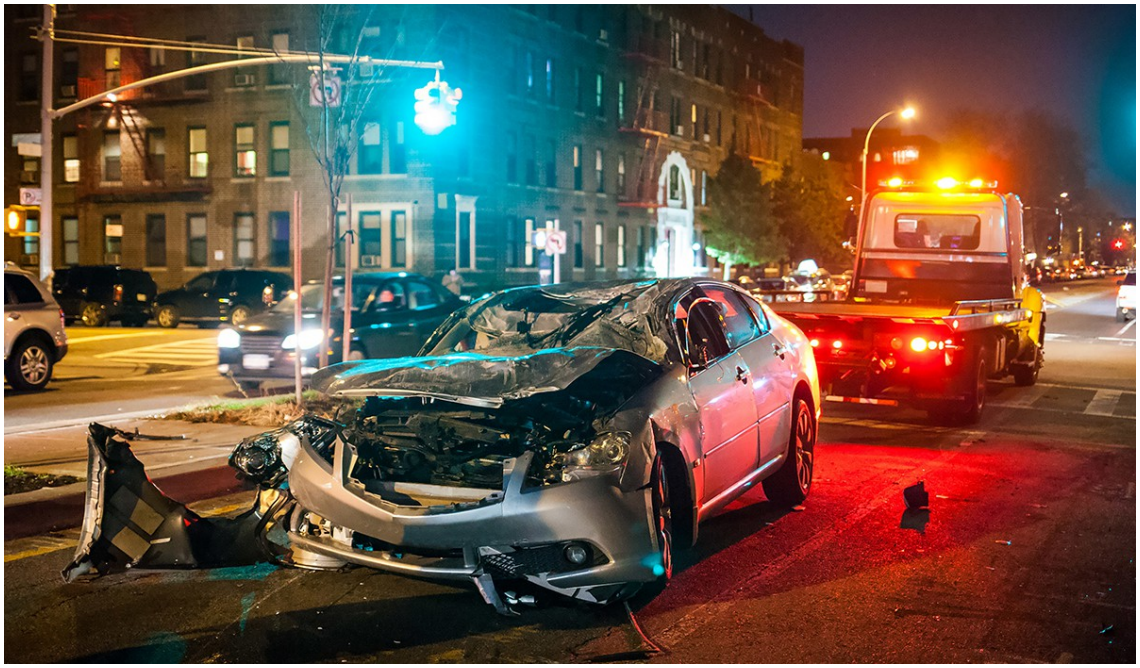
# The Physician's Dilemma When Facing Unsafe Drivers



**By Jeffrey A. Woods, JD**

Last year, Prince Philip, the 97-year-old husband of Queen Elizabeth II of the United Kingdom, overturned the Land Rover he was driving after colliding with a minivan on a rural road outside of London. Prince Philip was unhurt and the two women in the other vehicle suffered only minor injuries. This incident along with several others which have made the headlines have reignited the debate over when is it time to “hit the brakes” on the aging driver. Specifically, what role do physicians and other healthcare professionals play in making that determination?

Most physicians would prefer that this decision did not involve them because the laws vary from state-to-state on a variety of issues:

- Is it mandatory or optional for doctors to report their concerns?
- Are physicians afforded immunity for making such a report?
- If, and how, elderly drivers are assessed differently than younger ones?
- How, and to whom, physicians are supposed to make the report?

- How to strike the right balance between confidentiality and safety?
- Do physicians risk legal liability if, on the one hand, they alert the state authorities or, on the other hand, keep silent and a subsequent accident occurs potentially creating third-party liability?
- As it places the physician at odds with their patient, what are the ethical considerations ?

The following is an article originally written in 2004 by our then Vice President of Claims, Jim Howell. The recommendations outlined in this article are as sound today as they were over 15 years ago. This is due in large part to a lack of legislative action to address the problem.

> One of the most sensitive and difficult dilemmas facing physicians today is what to do about patients with diminished capacity to safely operate a motor vehicle. Patients whose cognitive or motor impairment renders them unable to drive safely represent a potential threat to themselves, as well as to the public at large. Other than a patient's family, a physician may well be in the best position to observe signs and symptoms indicating impaired ability to drive, but ethical and legal considerations present the physician with a confusing set of choices and no black or white answer. As the number of older drivers increases in the future, practitioners can expect to face this dilemma more frequently.
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> Impaired drivers may be encountered in two situations. A physician may occasionally be called upon to perform a driver fitness or certification exam for a third party, such as an employer or the Department of Safety. The rendering of an opinion concerning the capacity to drive in this scenario does not raise confidentiality concerns, and a physician's only legal exposure would be in the realm of negligence for the reasonableness of the exam and opinion. This article focuses on a more difficult situation, when, in the ordinary course of a patient's treatment, a physician encounters signs or symptoms calling into question the patient's ability to drive safely.

Conditions such as alcohol or drug abuse, poor eyesight, seizure disorders, and cognitive impairment may be encountered in a patient who regularly drives. In this situation, a physician's first duty is to protect the patient, whose own safety may be jeopardized by continued driving. If the dangerous condition cannot be promptly treated and corrected, then the patient should be honestly confronted with the medical findings and the physician's advice to cease driving. If the patient will not accept such advice, then the physician is faced with the very difficult task of balancing the patient's desires and rights of confidentiality with the interests of the public. The fundamental dilemma is whether the physician should go "over the head" of the patient and notify the appropriate safety or licensing authorities of the patient's situation.

This no-win scenario confronts the physician with potential legal action regardless of the decision made. A patient who loses the ability to drive may seek legal redress for a perceived violation of physician-patient confidentiality. On the other hand, if the patient is not reported to licensing authorities and then has an accident, the physician may face a lawsuit by victims of the accident. A brief analysis of these two potential legal exposures leads to the conclusion that a decision in favor of the public's safety may be the safer course for the physician.

Physicians must be concerned, more than ever, about keeping their patients' medical information confidential. Aside from the profession's ethical obligations, many states, like Tennessee, recognize that confidentiality is implicit in the doctor-patient relationship, and a breach of confidence can form the basis of a lawsuit. The HIPAA law and regulations also mandate confidentiality at the federal level. However, a patient cannot expect medical information to be absolutely confidential in every circumstance. For example, the Tennessee Supreme Court has ruled that a right of confidentiality also recognizes that the patient's privacy rights may be overridden in situations where a physician has a duty to warn third parties against risks emanating from a patient's medical condition.[1] Even the onerous confidentiality regulations under HIPAA contain an exception for the purpose of averting a serious threat to health or safety.[2] Ethical considerations also allow for release of medical information about unsafe drivers to licensing authorities without a patient's permission. The AMA's Code of Medical Ethics recognizes the need for reporting unsafe drivers and contains valuable guidance about when and how reports should be made.[3]

Balanced against confidentiality considerations is the physician's duty to warn. The policy of most states, including Tennessee and contiguous states, is to encourage the reporting of unsafe drivers. Unfortunately, most

states do not grant legal immunity for good-faith reports. Nonetheless, coupled with a physician's common law duty to warn third parties about risks posed by a patient's medical condition, such state policies tend to indicate that a physician would be able to successfully defend a lawsuit by a patient whose driving impairment has been reported in good faith to appropriate authorities. As a practical matter, a physician will almost certainly be better off defending a lawsuit by a patient alleging breach of confidentiality, than in defending a lawsuit by victims of an accident caused by the patient's unsafe driving. (Either lawsuit would be covered and defended under the physician's professional liability policy with SVMIC.)

Based upon these considerations, SVMIC recommends the following approach to patients whom a physician believes to be unfit to drive: Before reporting, discuss medical findings and risks of driving with the patient and, if the patient permits, with immediate family members. If appropriate, recommend further evaluation or treatment, or even referral to a driver rehabilitation specialist. Encourage the patient to self-report to the state. Such efforts may render physician reporting unnecessary. If, in the physician's best judgment, there is clear evidence of a substantial driving impairment, and if advice to self-report or retire from driving is ignored, notify the appropriate licensing authority, after informing the patient of your obligation to do so. Write a letter to the patient confirming your findings and the basis of your opinion that the patient should not drive and confirming that a report has been made to the state licensing authority. A report to the state should contain only the minimal information necessary to document the medical conditions causing the patient's driving impairment, and the report should recommend that the state conduct its own examination and assessment to determine the patient's fitness to drive.

Ultimately, the decision as to whether to report or not to report a patient rests on the judgment of the physician. If you are confronted with this dilemma and would like some guidance, please contact an SVMIC Claims Attorney to discuss your specific situation.

Note that if the patient is willing to self-report, encourage him or her to contact the local county Department of Motor Vehicles to find out what steps should be taken. If a physician is making a report, many states have Department of Safety or Department of Motor Vehicles websites which provide a sample medical form for providers to complete.  For Tennessee, this site is: https://www.tn.gov/safety/driver-services/driverimprovement.html

[1] Givens v. Mullikin, 75 S.W. 3d 383, 409 (Tenn. 2002)

[2] 45 CFR 164.512(j)

[3] AMA Code of Ethics Opinion E-8.2 "Impaired Drivers and Their Physicians" https://www.ama-assn.org/delivering-care/ethics/impaired-drivers-their-physicians

# Body Language Makes a Difference

**By Elizabeth Woodcock, MBA, FACMPE, CPC**

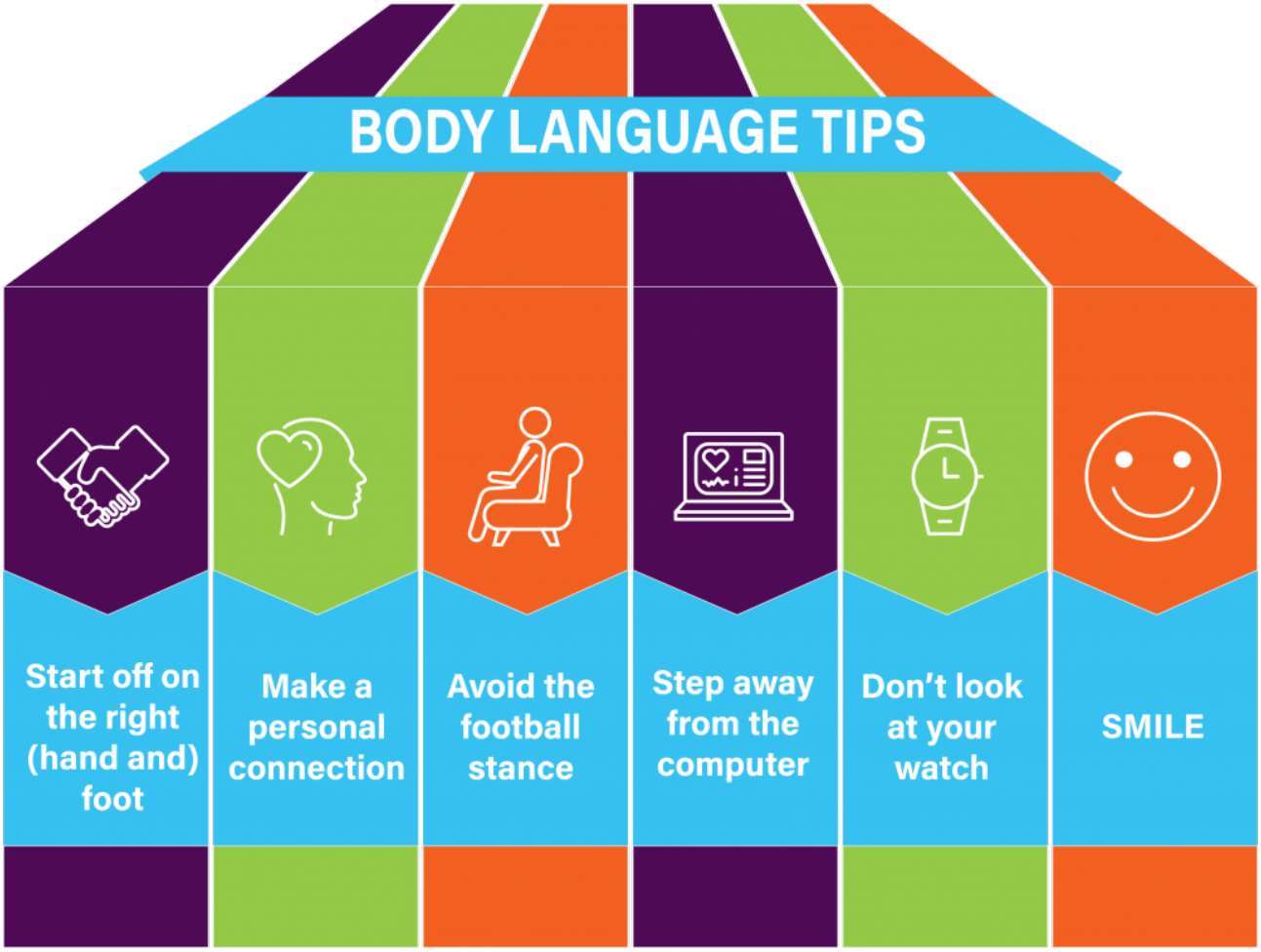
When you think about improving your patient experience scores, you might be quick to focus on your office décor or new equipment without pausing to think about the little things that can add up to a big deal in the minds of a patient. An interaction that garners high patient experience scores may be much easier than you thought. Displaying positive body language can help you make better connections, earn stronger reviews, and enjoy better long-term relationships with your patients. Try one of these tips to get underway:

- **Start off on the right (hand and) foot.** When you introduce yourself to a patient or caregiver, do so with a handshake or gentle touch, maintaining eye contact and focus on the other person. Apologize, even if the patient has only been waiting a few minutes with the recognition that, “I know your time is valuable, and I am sorry I kept you waiting.”
- **Make a personal connection.** When you initiate a conversation with a patient, try to start the conversation with a personal detail – perhaps you recall something from the patient’s last visit, such as an upcoming vacation, or you can offer a nice compliment or even a relevant comment about the weather. Don’t linger, since it is important to start the visit, however, this brief moment that serves to establish or

foster a personal relationship can be incredibly meaningful to the patient and ease discomfort over the visit itself.

- **Avoid the football stance.** Even when football season is long over, too many physicians have an ingrained habit of sitting down with knees open and back arched, with their hands on hips or arms crossed. This creates a defensive posture that doesn't invite much confidence or trust. Keep your arms open, your chest lifted, and your posture welcoming. Lean in, not out.
- **Step away from the computer.** When you get attached to a keyboard or a tablet, it is easy to follow it with your eyes, rather than making that connection with your patient. Turn off your screen and listen to your patient's concerns before launching into anything else.
- **Don't look at your watch.** While we all know that time is of the essence, patients tend to feel rushed when they see a physician looking at his or her watch. To keep better track of time, you can install clocks above the "heads" of exam room tables, or you can check your watch before entering the room.
- **Smile.** Even if the visit is covering serious information, a welcoming smile or a reassuring glance can make your patients feel that much more comfortable. In addition, eye contact is critical – no matter what information you are conveying.

Ultimately, your body language with patients may be just as important as the information you discuss and the plans you make. In order to care for your patients, your patients must perceive that you care *about* them. Most often, we are not aware of our body language, so try to understand yours – and take strides to improve it. Body language can make the difference between comfort and discomfort, good ratings and bad, a one-time visit and a long-term connection. If these "soft" skills don't come naturally to you, practice making eye contact, keeping your posture and the lines of communication open so that you invite greater trust and ease with each patient you meet.


BODY LANGUAGE TIPS
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SMILE

# 2020 Quality Payment Program Update


**By Elizabeth Woodcock, MBA, FACMPE, CPC**

Recently, the Centers for Medicare & Medicaid Service (CMS) revealed that the tool provided to look up participation status for the Quality Payment Program (QPP) was flawed. To ensure your participation status is correct for the current reporting year, please visit this link: https://qpp.cms.gov/participation-lookup/. Type in your National Provider Identifier (NPI), and the updated tool will indicate your 2020 participation status.

If you were eligible for QPP participation in 2019, the reporting period is now open. Log into https://qpp.cms.gov/login to report. There are four categories:

1. Quality
2. Cost
3. Promoting Interoperability
4. Practice Improvement

The cost category does not require reporting, as CMS makes its judgment based on claims submitted for patients attributed to you. However, the other three categories require reporting from you directly or, if applicable, an accountable care organization or alternative

payment model. The QPP reporting deadline for the 2019 reporting year is **March 31, 2020 at 8:00 p.m. EST**.

The CMS recently announced the pay-outs for 2020 (based on 2018 participation). The maximum bonus is 1.68%, slightly lower than last year's 1.88%. This decline comes as no surprise as the agency admits: "As the program matures, we expect that the increases in the performance thresholds in future program years will create a smaller distribution of positive payment adjustments." These monies are based on a six-year appropriation of extra funds from Congress; once these run out, it may be time to reconsider efforts to participate at the highest level.

However, don't take your foot off the gas pedal – the penalty for not participating in 2020 is a substantial 9%. Make sure that, at a minimum, you achieve the 45 points necessary to avoid that penalty this reporting year.

QPP is only required for a segment of health care providers. Let's review the guidelines for participation to determine your eligibility:

- Bill more than $90,000 for Part B covered professional services;
- See more than 200 Part B patients; and
- Provide more than 200 Part B covered professional services.

Eligible professionals include the following physicians:  doctors of medicine, osteopathy, podiatric medicine, and optometry. Advanced practice providers (APPs) and clinicians who are participating providers in the program include:

- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Physical therapists
- Occupational therapists
- Clinical psychologists
- Qualified speech-language pathologists
- Qualified audiologists
- Registered dietitians or nutrition professionals

If the APP is billing "incident to" the physician for Medicare services, the services would be billed under the physician's name -- and therefore, likely not qualify the APP under the thresholds ($90,000 charges, 200 services and 200 patients) listed above. More information about participation can be found at this link: https://qpp.cms.gov/mips/how-eligibility-is-determined?py=2020

CMS allows physicians who do not qualify for the program to opt in; however, it's important to note that those who qualify **must** participate. Otherwise, you face a 9% penalty on your Medicare Part B reimbursement two years from now.

# Closed Claim: What It Takes to Stay the Course

**By William "Mike" J. Johnson, JD**

The right to have “your day in court” is a highly cherished cornerstone of the American legal system. As a physician, defending your professional care is paramount. Whether to settle a case or defend it through trial is an important decision. Going to trial can have great consequences: losing can mean a finding of medical negligence by a jury and possible financial exposure over and above your coverage limits. Settlement (perhaps through mediation) offers the opportunity to resolve a case through a more predictable, private, and controlled process but usually results in a report to the National Practitioner Data Bank, which affects credentialing and possibly malpractice insurability. Although winning brings a sense of vindication and tremendous relief, it is a lengthy and arduous process. Some of the challenges are obvious, and some, discussed in this article, are not so obvious. “Staying the course” is a noble objective, but it may be easier said than done when faced with complex and lengthy litigation.

In this case, the patient, a woman in her 30’s, underwent a robotic total laparoscopic

hysterectomy and oophorectomy. After the surgery, she was treated for a wound infection and bleeding. Approximately two months later, she presented to the emergency department with abdominal pain and bloody diarrhea. She was diagnosed with gastroenteritis and discharged. She returned to the ED the next day and was tentatively diagnosed with C. diff. A colonoscopy showed pseudomembranous colitis for which the patient underwent a subtotal abdominal colectomy. The patient self-extubated but maintained good oxygen saturations throughout the incident. She continued to decline, however, and more surgery followed: a sigmoid colectomy and placement of a feeding tube. Post-operatively, the patient suffered a seizure and became unresponsive. About four months after her initial robotic surgery, life support was discontinued, and the patient died.

Suit was filed (in a state with a two-year statute of limitations) approximately 21 months later naming the OB/GYN who performed the hysterectomy, another OB/GYN who provided later care, the ER physician, two critical care physicians, and the hospital. More than six years later, the case finally went to trial against the critical care physicians. All the other defendants had either been dismissed or settled out of the case by the time it went to trial.

To “stay the course,” you must first “set the course.”

The defense of a case starts with a call to SVMIC during which the claims attorneys will review the lawsuit with the physician and work with him/her in the selection of defense counsel. The first things the defense attorney will do is meet with the physician to discuss the case, review the records with the physician, obtain the physician’s input, address concerns and goals, and most importantly, get to know the physician. Critically, the defense attorney will begin the investigation and analysis of the case along with a search for solid expert support. The relationship that develops between the defense attorney and the physician defendant is very important and symbiotic: each has a very different role, yet each depends on the other to get a good result. The defense attorney is an advocate but tempers his or her advocacy with objectivity and experience. The physician is the key witness who brings credibility, first-hand knowledge, and expertise. The attorney acts as a guide—leading the physician through a trying, difficult, and unknown legal landscape. As the attorney and physician develop a good working relationship, they can set a course based on a realistic view of the case.

In this case, the defense attorney and two of the insured physicians developed a commitment to see the case through all the way to trial.

Staying on course and getting to trial required persevering through delays, changes in the plaintiff’s theory of fault, consideration and rejection of an inopportune settlement offer, concerns for juror sympathy, the passage of time, and logistical considerations. From the date of the initial surgery to the trial, nearly nine years passed. While this time period may seem extreme, it is important to understand that the length of time from the filing of the case to the trial is heavily dependent upon the jurisdiction in which the case is filed. Some

judges set the cases pending in their jurisdiction for trial within a year or two of the filing of the suit; but other judges take a more laid back approach, and the attorneys have to be proactive in pushing for a trial date.

The case was further delayed when the trial judge abruptly continued the case one week before the scheduled trial date. This delayed the trial for approximately a year and was very costly to both sides in that a high percentage of the litigation expenses are incurred in the last few weeks before trial, including the expense and commitment to bring in expert witnesses. The stress and strain of having to prepare for trial again is also very costly in human terms, having a psychological impact on everyone involved.

In malpractice cases involving death or serious injury, a significant concern is that the jury will be so overcome with sympathy that it will not be able to hear the case fairly and impartially. The potential for jury sympathy is one of the many factors that goes into the analysis of whether to take a case to trial. To be successful, defense counsel use their skill and experience to address and mitigate jury sympathy issues in the jury selection process and during their presentation of the case to the jury. Juries are typically instructed by the trial judge to carefully consider all the evidence and to follow the law as instructed by the judge. Jurors are specifically told not to be governed by sympathy. Counsel for each party will try to determine which potential jurors may be likely to be swayed by sympathy during their questioning of them before the jury is seated. In this tragic case, the deceased patient was in her 30's and died leaving minor children behind, making the potential for jury sympathy a significant concern.

As the litigation proceeded, the plaintiff's theory of the case became a "moving target." In the earlier stages of this case, the plaintiff's theory of liability was that the patient was not properly sedated and restrained, which caused her to self-extubate on multiple occasions resulting in a hypoxic brain injury. In addition to this, the plaintiff alleged that the defendants "covered up" the fact that the self-extubations occurred, and they went so far as to argue that the defendants transferred her to a larger hospital to conceal the true cause of her death. After approximately four years, the plaintiff abandoned this theory and argued that the patient's death was caused by hyperosmolarity, hypernatremia, dehydration, and hyperglycemia which caused metabolic encephalopathy. In this case, defense counsel successfully adapted its theory of defense by obtaining additional expert support, based on the medically sound treatment rendered in this case, to counter the plaintiff's new argument.

The status of the co-defendants may change as a case is litigated. Here, some of the original defendants were dismissed while other defendants settled. In this case, an eleventh-hour settlement offer was made to the remaining physicians. The downside with such an offer so close to trial is that it can be a distraction from the preparation efforts and focus on the upcoming trial. Moreover, engaging in such negotiations so close to trial could lead to a costly continuance of the case. The remaining physicians rejected the settlement offer and remained firm in their desire to defend their care at trial.

After an eight-day jury trial, it took the the jury less than two hours to return a defense

verdict in favor of the critical care physicians. Factors that defense counsel considered to be significant in winning the case were:

- The strength, character, and medical knowledge of the physician defendants presented through their credible and sincere testimony;
- The excellent performance of the defense's expert witnesses, who were strongly supportive of the physician defendants' care and treatment of the patient; and
- The fact that some of the plaintiff's experts came across as hired guns, without much credibility, willing to change their testimony regarding the cause of the patient's death.

Although the case was tragic and the course of the litigation was long and difficult, the physician defendants and defense counsel stayed the course and worked closely together to defend their care. The sense of relief and satisfaction when the jury agreed that they had provided excellent care was very gratifying.

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