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ARBITRATING MALPRACTICE CLAIMS WORTHY OF RECONSIDERATION

Pre-dispute agreements to arbitrate claims repeatedly found enforceable

By PAUL E. KNAG

In Connecticut, high costs and coverage terminations have led many physicians to get out of private practice or relocate to states with a better malpractice climate. The providers who have not left are seeking ways to reduce malpractice costs and improve coverage accessibility.

An approach that might be mutually beneficial for both providers and patients would be for providers to offer patients the option of electing arbitration before any dispute arises.

Contrary to what some assume, federal law is clear that pre-dispute agreements to arbitrate malpractice claims can be validly entered into, and that federal law preempts any contrary state law.

Connecticut has made no effort to legislate otherwise.

Under the Section 2 of the Federal Arbitration Act (FAA), pre-dispute arbitration clauses in a contract "involving commerce ... shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."

The U.S. Supreme Court has made clear in a number of cases that the FAA preempts contrary state law. So, for example, in *Doctor's Associates v. Casarotto*, the Supreme Court invalidated a Montana statute that imposed "type face" requirements on otherwise valid arbitration agreements. However, state courts are still permitted to make a determination as to whether the contract is somehow invalid because of unconscionability, lack of consent or other applicable state law concerning contract formation.

Based on FAA, the Supreme Court has repeatedly held that pre-dispute arbitration clauses are enforceable in a wide variety of circumstances. For example, it is now fairly standard for stock brokers to include a mandatory arbitration/no class action clauses in their customer contracts based on the Supreme Court's decision upholding such contracts in *Shearson/American Express Inc. v. McMahon*.

The Supreme Court has also held in

Gilmer v. Johnson Lace that mandatory arbitration agreements between employers and employees concerning employment disputes are fully enforceable.

In addition, the Supreme Court has given a very broad view of the in-commerce requirement, holding in *Citizens Bank v. Alafabco Inc.* that the test

is whether "in the aggregate the economic activity in question would represent 'a general practice ... subject to federal control.'"

Applying that test, virtually all cases involving health care providers have found the "involving commerce" requirement of the FAA to have been satisfied.

While health providers have not used arbitration with patients nearly to the extent that other industries have used arbitration with consumers,

there are many instances where nursing homes, hospitals and other providers have entered into arbitration agreements covering malpractice claims and successfully enforced them.

For example, in March of this year, the Massachusetts Supreme Judicial Court enforced an arbitration agreement entered into by a nursing home patient with a nursing home. There are decisions in a number of other Connecticut Supreme Court cases upholding arbitration clauses covering medical malpractice claims, as well.

On the other hand, arbitration agreements entered into by health care providers have been invalidated based on the lack of adequate consent by the patient, or based on "unconscionability." Among the factors sometimes cited in striking down such an agreement are: the fact that attorneys' fees are imposed on the loser, the fact that the patient is not given the option not to agree, the fact that the arbitration agreement is in the middle of a larger agreement, and pressure to sign without adequate time to understand.

Because of these cases, careful drafting is important. The contract should also specify that damages beyond those available in court cannot be recovered, in view of the Connecticut Supreme Court's recent holding in *MedVal USA Health Programs Inc. v.*

Member Works that, absent agreement to the contrary, an arbitrator can award such damages.

Because of extensive litigation over arbitrability, both the American Arbitration Association and the American Health Lawyers Association stopped accepting arbitrations involving medical malpractice based on a pre-dispute arbitration clause.

However, the National Arbitration Forum has been handling such disputes. Further, as more and more cases are decided on this issue, and the law has become clearer, the American Health Lawyers Association is looking at the possibility that it will again accept such cases.

More Predictable Outcomes

What would be the potential advantages of using arbitration?

First of all, arbitration clauses by health care providers typically include a provision requiring mediation before commencement of the arbitration. The hope is that this will provide a quick and inexpensive means for resolving many claims. Cases that should be settled can then be resolved without extensive expenditure of legal fees, and perhaps for less money than might be required after extensive court proceedings. Moreover, with a panel of arbitrators known to both plaintiff and defendant attorneys, outcomes would be more predictable than with a jury, thus facilitating settlement.

Second, arbitration would hopefully be more cost effective even if there were not quick settlement. Without the need for a jury trial, the trial could be simplified. And the scope of discovery could be less.

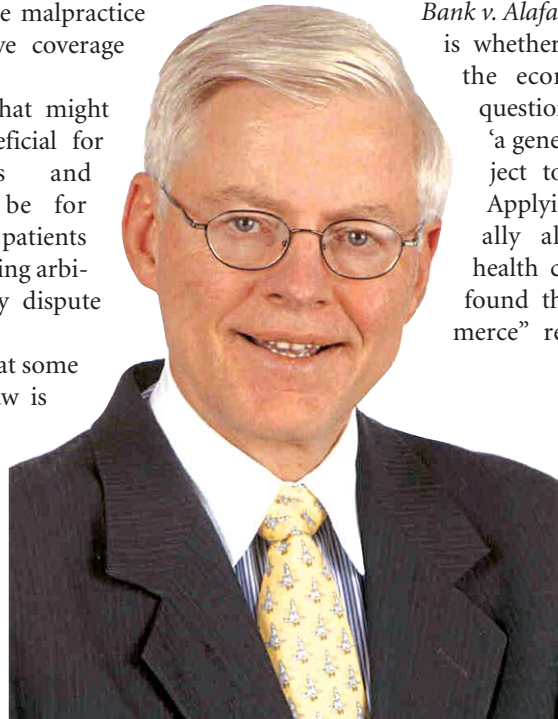
Third, arbitration could be quicker than litigation.

Fourth, if arbitration is quicker and easier, it may encourage plaintiff attorneys to accept cases that they might not accept under the current system. That, of course, would be good for the patient and a negative for the provider.

Fifth, if more than one provider is targeted in connection with the same incident, it may be necessary to sue one provider in court and another in arbitration. This might deter plaintiffs from claiming against parties who are not likely to be responsible.

Based on the foregoing, it would seem that consideration should be given to using arbitration agreements to resolve health care disputes. If that were to be attempted in a limited way, the experiment could provide data as to the future utility of the arbitration approach. ■

As the law has become clearer, the American Health Lawyers Association is looking at the possibility that it will again accept such cases.



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Technology **BARRIERS****ELECTRONIC MEDICAL RECORDS GAIN SUPPORT**

New laws pave way for hospitals to bring physicians into computer networks

By **MINDY S. TOMPKINS**

The use of electronic health records holds great promise for the health care industry to promote efficiency in both health care delivery and data management. But the financial burdens of implementing electronic health records often pose significant barriers for many providers.

An electronic health record (EHR) is a complete collection of health care information about a patient that is available electronically. An EHR ideally would be available whenever and wherever a patient receives care. Advocates of EHRs state that a national network will save costs, promote more efficient medical care and, through better information, reduce the incidence of unnecessary tests and adverse drug reactions.

Nevertheless, the implementation of EHR systems has been slow, especially among physicians. One reason is

that the costs of software, hardware and computer networks are prohibitive. They include recurring costs for upgrades, software and hardware support, connectivity fees and training. Many providers do not have technology support readily available for an EHR system. Additionally, providers are wary of investing in such electronic records until a standardized technology for interoperability exists.

Slowly, the barriers to implementing EHRs are being removed. New federal and state regulatory initiatives are intended to ease the financial burdens of implementing EHR systems. Additionally, the federal government has numerous programs to support a national EHR network and develop standardized technology.

The federal government's goal is to establish a national system of electronic health records. In January 2004, President George W. Bush outlined a plan to provide all Americans with an EHR by 2014.

The Department of Health and Human Services (HHS) is leading the initiative to build the National Health Information Network, which will electronically connect all patients' records to health care providers, insurers, pharmacies, labs and claims processors by 2009.

Additionally, HHS is working actively to develop a standardized technology for interoperability. The Certification Commission for Health Information Technology has been designated to provide private sector certification that health information technology products meet HHS's criteria for EHRs. Those initiatives should decrease concern about interoperability and reduce related investment risks.

In Connecticut, Gov. M. Jodi Rell proposed the eHealth Connecticut Initiative to develop a statewide integrated health information network in January 2006. The eHealth Initiative plans to establish an electronic network to store and share medical records, subject to safeguards to ensure privacy. A pilot program has been established in Waterbury. Other programs are under consideration in other Connecticut municipal regions. In addition, Connecticut was recently awarded a federal grant of \$5 million to be used to expand the use of EHRs.

Outdated Laws

Despite the governor's EHR initiative, current state laws on medical records were created in an era of paper records. As a result, the health care system remains paper-focused. The Public Health Code requires retention of original records by physicians and requires that all entries on medical records be signed. Connecticut General Statutes 19a-25a and 25c authorize hospitals and other health care institutions to use EHR in lieu of paper records and authorizes hospitals to use electronic signatures in medical records.

Physicians, however, are not included in

these authorizations and are still required to maintain a paper record system, which decreases the efficiency offered by EHR. Further, the Connecticut Uniform Electronic Transactions Act, which allows for electronic signatures and electronic records in lieu of paper originals, offers no relief because it applies only to commercial transactions. Revisions of these laws would help physicians and health systems implement EHR systems.

Regulatory Exemptions

New regulations allow hospitals and other health care institutions to make available EHR systems to physicians, which may alleviate the financial burden on physicians. This activity was previously prohibited under Stark and the Anti-kickback statutes. The Stark statute prohibits a physician from making referrals for defined designated health services, such as clinical laboratory services, radiology or hospital services, to an entity if the physician has a financial relationship with the entity. (42 U.S.C. §1395nn; 42 C.F.R. §411.353.) The Anti-kickback statute prohibits the knowing and willful offer, pay-

ment, solicitation or receipt of remuneration in return for referring, purchasing, leasing, ordering or arranging for any item or service that is reimbursed under a federal health care program. (42 U.S.C. §1320a-7b.)

As a result, these statutory schemes have limited hospitals and health care institutions seeking to increase efficiency by coordinating the use of EHR systems with physicians.

In October 2006, the Center for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) issued new exemptions to the Stark and the Anti-kickback statutes, respectively. The regulations allow hospitals to donate electronic medical records systems to physicians upon meeting certain criteria. The Stark exemption and the OIG safe harbor for EHRs have nearly identical provisions. In particular, the regulations require the following:

- Donations may include software, training and connectivity services. Software must be interoperable with other computer systems and must have electronic prescribing capabilities. Donations may not include

■ See **ELECTRONIC** on PAGE 12

New regulations allow hospitals to make available electronic health record systems to physicians, many of whom can't afford to take on the additional financial burden that such systems pose.

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Softening **STANCE**

GAINSHARING AGREEMENTS GAINING ACCEPTANCE

Hospital regulators move toward more relaxed view of joint cost-saving efforts

By **NICOLE M. BERTRAND**
and **THOMAS S. MARRION**

As healthcare costs continue to rise and providers search for ways to reduce expenses, an increasing number of hospitals and physicians are exploring the possibility of “gainsharing.” Under such arrangements, hospitals and physicians jointly implement cost-saving measures and the hospitals pay the physicians a share of the savings attributable to their efforts. These arrangements allow physicians and hospitals to improve operational efficiency and reduce costs through the use of standardized procedures and practices.

The Office of Inspector General (OIG) of the U.S. Department of Human Health and Services, which provides guidance to the health care industry to prevent fraud and abuse, initially took a dim view of gainsharing arrangements. In a Special Advisory Bulletin issued in 1999, the OIG concluded that such arrangements violate the Federal Civil Monetary Penalties Act (CMP Act), which prohibits any payment by a hospital to a physician as an inducement to reduce or limit items or services to Medicare or Medicaid beneficiaries under the physician’s direct care.

In that regard, the OIG expressed its concern that gainsharing arrangements could potentially influence physicians to reduce costs to the detriment of patient care. The office also suggested that gainsharing arrangements may implicate the Anti-Kickback Statute, which prohibits the solicitation or receipt of remuneration in exchange for the referral of medical services.

Evolving Approach

For a number of years after 1999, proponents of gainsharing had little cause for encouragement. Although the OIG issued an advisory opinion on the subject of gainsharing in 2001 that appeared to reflect a softening of its position, that opinion provided only limited relief to healthcare

providers.

Since 2005, however, the OIG has issued seven advisory opinions that appear to reflect a continuing, though gradual, relaxation of its original stance. Although the OIG continues to take the position that gainsharing arrangements implicate both the CMP Act and the Anti-Kickback Statute, in each of the opinions issued since 2005 the OIG has permitted the parties to proceed with their proposed arrangement.

The OIG’s approvals of gainsharing arrangements have been narrowly tailored and closely tied to the specific facts of each case. The 2005 opinions addressed a series of similar arrangements that involved such cost-saving prac-

tices as product standardization of certain devices, limitations on the use of certain devices, performance of certain procedures only as needed, opening packaged items only as needed and substituting less costly items for items currently being used.

More recently, the OIG issued Advisory Opinion 06-22. That opinion, issued in November 2006, addressed an arrangement involving a group of cardiac surgeons who proposed to implement certain cost-saving operating room procedures, in exchange for which they would receive 50 percent of the first year’s resulting savings.

The cost-saving measures included limiting the use of certain surgical supplies (the “use as needed” practice), the substitution of less costly items for those currently in use and the product standardization of certain cardiac devices, where medically appropriate.

Although the OIG concluded in Advisory Opinion 06-22 that the “use as needed” practice and the product standardization measure both implicated the CMP Act, the OIG decided not to impose sanctions in light of the following safeguards inherent in the arrangement:

- Cost-saving actions and resulting

savings were clearly and separately identified, which provided transparency of the arrangement allowing public scrutiny and accountability of the physician and hospital;

- The hospital provided credible medical support for its conclusion that the arrangement would not adversely affect patient care;

- Payments to physicians were based on all surgeries, regardless of the patient’s insurance coverage;

- Objective historical and clinical measures were used to establish baseline thresholds, beyond which no savings to physicians accrued;

- The product standardization measures allowed the same selection of cardiac devices to be available after the implementation of the arrangement as were available before the implementation;

- Written disclosures of

programs;

- The arrangement eliminated the risk of rewards for referrals, as the group was the sole participant and was composed only of cardiac surgeons;

- The arrangement set forth the specific actions related to the cost savings and was reasonable in amount, duration and scope.

The Future Of Gainsharing

The OIG’s continuing approval of carefully structured gainsharing arrangements appears to justify some cautious optimism for healthcare providers. Although each of the OIG’s opinions has been narrowly drawn, together they offer a number of useful guidelines for structuring gainsharing arrangements:

- 1.) Specificity—payments to physicians must be tied to specific, identifiable, and verified cost savings on an item-by-item basis as opposed to basing payments on overall cost savings.

- 2.) Limited time and scope—the arrangement must be limited in time and must include reasonable limitations on the payments that physicians are entitled to receive, so that incentives to

limit patient care will be controlled.

- 3.) Limited participation—the arrangements should be limited to physicians already on the medical staff of the hospital.

- 4.) No impact on patient care—the proponents of the arrangement must reasonably demonstrate that the arrangement will not have an adverse impact on patient care.

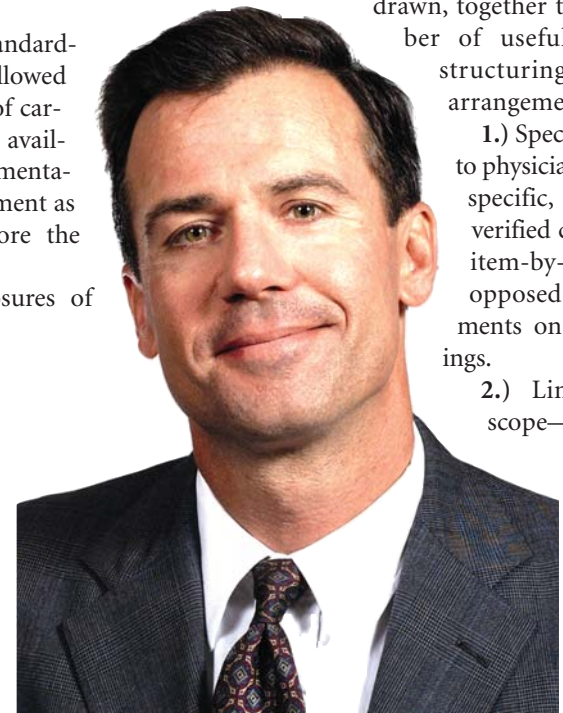
While hospitals and physicians may find it tempting, in light of recent developments in this area, to implement gainsharing arrangements without obtaining the OIG’s blessing, the prudent course would be to look before leaping. In other words, request an advisory opinion before embarking on a gainsharing arrangement, no matter how closely the arrangement may replicate those described in the recent advisory opinions.

Proponents of gainsharing will surely hope for further, and perhaps more definitive, guidance and encouragement in this area. ■



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the arrangement were provided to all patients affected by the arrangement;

- Financial incentives in the arrangement were reasonably limited in duration and amount, as the term was limited to one year and certain caps were established;

- Payments regarding cost-savings connected with Medicare and Medicaid were capped to the number of admissions into the arrangements in the previous year;

- Profits were distributed per capita to the physicians so the incentive to generate disproportionate cost savings was mitigated.

Similarly, the OIG declined to impose sanctions for potential violations of the Federal Anti-Kickback Statute, citing the following safeguards:

- Participation was limited to those physicians who already had medical privileges at the hospital, and savings derived from procedures from federal program beneficiaries were capped based on the prior year’s admission into those federal

EXPERTS OBTAIN COURTS' BLESSINGS

Recent rulings: expert witnesses need not have mirror-image credentials as defendant doctors

By **ELLIOTT B. POLLACK**

Determination of the standard of medical care in malpractice, physician discipline and managed care reimbursement proceedings is critical. Typically, expert testimony is necessary. What credentials are sufficient to entitle a proffered witness to testify as an expert?

The determination often can be straightforward. For example, a pediatrician who offers to testify about the proper standard of care in a case involving the diagnosis and treatment of pediatric Lyme Disease should not be allowed to testify if she knows nothing about the disease and has never diagnosed or treated her patients for that condition even though she is a pediatrician.

The issues become more complex with a physician who possesses significant knowledge about a given practice area but who is not credentialed identically or even similarly to the individual whose care is being challenged.

A pair of March decisions, one in New York and the other by Connecticut Superior Court Judge Gerard F. Esposito in the Judicial District of Ansonia, highlight the inquiry nicely.

Related Expertise

In the Connecticut ruling, the estate of Lawrence Manende brought a malpractice action against Griffin Hospital and the vascular surgeon who cared for the decedent. Before his death, Manende had been admitted to the hospital for a carotid endarterectomy in 2002. Confused and prone to climbing out of bed, Manende required restraints. Before the operation, he received medication that tended to cause lethargy and confusion.

After the surgery, the patient fell while attempting to get out of bed and suffered a fractured hip. He had to undergo a curative procedure. The parade of horrors ended with the patient's death two weeks after he was admitted to the hospital. The attending physician was charged with failing to see to it that Manende was properly cared for and restrained and that his medication was properly monitored.

The plaintiff disclosed as its medical expert a physician who was board certified in cardiology and internal medicine. The defendants sought summary judgment because the disclosed expert was not a "sim-

ilar health care provider" as provided in the applicable statute. How could the proffered expert who had "never performed the operation undergone by Manende and [who had] never written post-operative orders for such surgery;" hold the necessary training, experience and knowledge in vascular surgery to qualify as an expert, the defendants asked.

Judge Esposito agreed with the assertion that the cardiologist could not speak to the appropriate standard of care for a vascular surgeon. He pointedly noted that the defendant-physician did "not step out of his shoes as a vascular surgeon the moment he [put] down the knife."

Since the expert was certified only in internal medicine and cardiology, he did not meet

the "similar health care provider" statutory predicate.

That was not the end of the inquiry, however.

Another section of the Connecticut statute authorizes expert testimony if, "as a result of practice or teaching in a related field of medicine," the court concludes that the proffered expert "possesses sufficient training, experience and knowledge ... so as to be able to provide such expert testimony as to the prevailing professional standard of care in a given field of medicine."

The Appellate Court's benchmark decision in *Friedman v. Meriden Orthopedic Group* and several Superior Court decisions convinced Judge Esposito to hold that, while not certified as a vascular surgeon, the proffered expert occupied a field "related to" the expertise of the defendant-physician.

Tellingly, the expert demonstrated a knowledge of post-operative care by testifying that he had "monitored and attended to many patients having undergone the same surgery as the plaintiff ..."

New To Medicine

A trial-level decision released by a New York State Supreme Court justice 11 days before Judge Esposito's ruling in *Manende* came out exactly the same way.

Moshe Assaf brought a malpractice suit against his cardiothoracic surgeon and a number of other professionals at New York Presbyterian Hospital following his 2001 coronary artery bypass graft surgery. Here, as in *Manende*, a major issue was whether

there were serious deficiencies in his post-operative care.

The expert put forth by Assaf was a very recent medical school graduate, not yet board certified, who was licensed to practice in New York three years after the surgery in question; she completed her three-year internal medicine residency in June 2006.

As in *Manende*, the defense asserted that the plaintiff's expert could not testify because she was not a specialist in the same field and, moreover, was still in medical school when the alleged negligence occurred.

The plaintiff responded that most of his proposed expert's rotations during her residency took place in the intensive care and cardiac care units at Jacobi-Einstein Medical Center "where she was often Unit Chief."

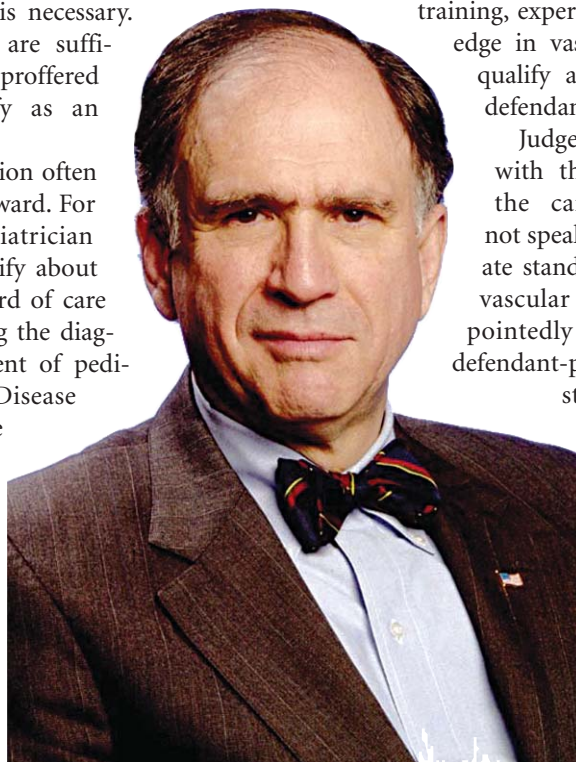
As to the fact that she had only recently commenced medical practice, the court noted that, by dint of her training, she had fresh experience in the very area of medical care at issue. Moreover, her qualifications demonstrated a strong "conversance with the medical issues" presented.

As to the issue dealt with by Judge Esposito in Connecticut, the New York court concurred. The proposed expert's certification in internal medicine, not in cardiovascular surgery, was not determinative. "A doctor does not need to be a specialist in a particular field to be considered a medical expert," it ruled.

As these decisions show, witnesses seeking to qualify as experts in civil actions where the standard of medical care is at issue need not possess qualifications which are carbon copies of the professionals whose actions are being challenged.

While patients often wonder why medicine has become so sub-specialized and why they get ping-ponged around for care so frequently, the courts find it easier to take a broader view in the litigation context. ■

While patients often wonder why medicine has become so sub-specialized and why they get ping-ponged around for care so frequently, the courts find it easier to take a broader view in the litigation context.



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MED MAL REFORMS NOT ONE-SIDED

Legislative changes have pros and cons for both doctors and plaintiffs' lawyers

By ISABELLA M. SQUICCIARINI

Medical malpractice legislation has been a source of great controversy in states all over the country. Not only has the issue been raised in the legal community, but it is also discussed extensively in the media. While the issue of "caps," or limitations on damages awards, has been greatly debated, both on and off the legislative floor, caps on damages awards have *not* been instituted here in Connecticut. However, in an attempt to address the certain other concerns regarding medical malpractice actions, a number of legislative changes took effect on Oct. 1, 2005.

Pursuant to Public Act No. 05-275 (Substitute Senate Bill No. 1052), "An Act Concerning Medical Malpractice," the state legislature enacted a number of changes to existing medical malpractice law, including, but not limited to, the following:

Contingency Fees. Traditionally, in a claim for personal injury, wrongful death or damage to property, "the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) the settlement amount received pursuant to a settlement agreement."

The contingency fee is calculated as follows: "(1) Thirty-three and one-third per cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars."

However, effective October 2005, Connecticut General Statute §52-251c now allows a claimant (plaintiff) to *waive* this contingency fee structure in matters that are "so substantially complex, unique or different from other wrongful death, personal injury or property damage claims." Factors considered in determining whether it is appropriate to waive a contingency fee in a particular matter include that the matter: "(1) involves complex factual medical or legal issues, (2) involves serious permanent personal injury or death, (3) is likely to require extensive investigation and discovery proceedings, including multiple depositions, or (4) requires independent expert witness testimony." The change in the law directly impacts the net amount recoverable by plain-

tiffs in medical malpractice cases by increasing the amount of the contingency fee.

Certificate of Reasonable Inquiry. Connecticut General Statute §52-190a previously required that a Certificate of Reasonable Inquiry be included with a complaint for medical malpractice. Connecticut General Statute §52-190a now requires a "Certificate of Reasonable Inquiry" to be attached to apportionment complaints.

Apportionment complaints may be filed by defendants (i.e. healthcare providers) in order to claim an apportionment, or share, of damages against another party (i.e. another healthcare provider

involved in the treatment of a patient). In order to file an apportionment complaint, it is now necessary to file a certificate of reasonable inquiry, or a statement signed by the attorney stating that there are "grounds for a good faith belief that there has been negligence in the care or treatment of the Claimant," as well as a written report by a "similar healthcare provider," stating that there appears to be evidence of medical negligence, including a "detailed basis for the formation of that opinion."

Offer of Compromise. Offers of compromise (formerly known as offers of judgment) can be filed in an attempt to settle a claim for a certain sum. Connecticut General Statute §52-192a provides that they may be filed by either the plaintiff or the defendant. §52-192a further requires in actions to recover damages "resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider," an offer of compromise "shall state with specificity all damages then known to the plaintiff or the plaintiff's attorney upon which the action is based."

At least 60 days prior to filing such an offer, the plaintiff or the plaintiff's attorney "shall provide the defendant or the defendant's attorney with an authorization to disclose medical records that meets the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)," and "disclose any and all expert witnesses who will testify as to the prevailing professional standard of care." The plaintiff must also file a certification to the court that the plaintiff "has provided each defendant or such defendant's attorney with all docu-

mentation supporting such damages."

If an offer of compromise is filed by the plaintiff, and *not* accepted by the defendant, *and* if there is a verdict in excess of the amount stated in the offer of compromise, the plaintiff is entitled to interest on that amount at the rate of 8 percent per annum, in matters accruing on or after Oct. 1, 2005. In matters accruing prior to Oct. 1, 2005, the interest rate remains 12 percent per annum.

Further, according to the statute, if the offer of compromise was filed no later than 18 months from the filing of the complaint, "the interest shall be computed from the date the complaint in the civil action was filed." However, if the offer of compromise was filed later than 18 months from the date of filing of the complaint, "the interest shall be computed from the date the offer of compromise was filed."

Judicial Review of Non-Economic Awards. In actions involving personal injury or death against a healthcare provider, if the jury awards non-economic damages in excess of \$1 million, the court is now *required* to "review the evidence presented to the jury to determine if the amount of noneconomic damages specified in the verdict is excessive as a matter of law in that it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake or corruption."

According to C.G.S. § 52-228c, if the court concludes the amount is excessive, it shall order a *remittitur*, or reduction, of the amount of the non-economic award. If the plaintiff does not remit that amount, the court shall set aside the verdict and order a new trial.

Evidence of Apology. "I'm sorry for what happened." Or "I wish the outcome were different." Doctors often say these things, or wish they could, but fear such a statement suggests a mistake was made for which they feel culpable, which will then be used against them in a medical malpractice lawsuit. C.G.S. §52-184d now provides: "statements, affirmations, gestures or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion or a general sense of benevolence" made by the healthcare provider or their employee to the patient, family member or representative, that relate to the "discomfort, pain, suffering, injury or death" of the patient as result of an "unanticipated outcome of medical care," shall *not* be admissible in any civil action or arbitration proceeding.

Although there are many other statements that may be used against a physician or other healthcare provider in such an action, the statute limits the types of statements (or gestures) that may be used.

Although medical malpractice legislation reform will be a contested debate for years to come, the state of Connecticut has enacted the above statutes in an attempt to address some of these issues. ■

Doctors can now say, 'I'm sorry' without those statements being used against them in a civil action or arbitration proceeding.



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GOING AFTER PHYSICIANS' ASSETS

Propriety of PJRs in question, especially when used as a negotiating tool to coerce settlement

By **JAMES ROSENBLUM**
and **JAMES BIONDO**

How much professional liability insurance should physicians have and how much can they afford? These questions plague physicians and others. Even if physicians had unlimited resources for liability insurance, there are limits on the amount of insurance that carriers provide. Consequently, potential exists for verdicts exceeding insurance limits.

Traditionally, plaintiffs have not pursued personal assets, but it is also traditional for plaintiffs' counsel to threaten to proceed against personal and/or business assets. Such threats are daunting, where a lifetime of savings, tuition for college education, or accounts used to operate the business aspect of a

medical practice may be frozen or evaporate. Physicians rightfully fear that such

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actions could essentially put them out of business, exposing their patients to potential risk.

Consequently, information about "asset protection" has become a hot topic in medical circles. However, asset protection is easier said than done. There are limits—substantial costs and risk—of off-shore trusts in the Cook Islands. Basic financial planning is a valuable way to preserve assets, but is complicated, time-consuming and often deferred, while other activities take priority. Therefore, many physicians have personal assets that are potentially exposed.

Plaintiffs' counsel have obligations to their clients—not to defendants, and not to society at large. However, courts should consider the implications of laws, and of course the legislature can balance competing interests. The purpose of this article is to raise the question as to the

propriety, or at least the scope, of prejudgment remedies against physicians, especially when used as a negotiating tool to coerce settlement or where the impact can interfere with their practice of medicine.

To obtain a prejudgment remedy, plaintiffs must show, with specificity, probable cause of their claims' success, on the merits, considering defenses and potential set-offs to any verdict. Connecticut General Statutes §52-278d requires hearings for prejudgment remedy applications. Under the statute, such hearings "shall be limited to a determination of (1) whether or not there is probable cause that a judgment in the amount of the prejudgment remedy sought, or in an amount greater than the amount of the prejudgment remedy sought, taking into account any defenses,

counterclaims or set-offs, will be rendered in the matter in favor of the plaintiff, (2) whether payment of any judgment that may be rendered against the defendant is adequately secured by insurance, ... and (4) if the court finds that the application for the pre-



judgment remedy should be granted, whether the plaintiff should be required to post a bond to secure the defendant against damages that may result from the prejudgment remedy or whether the defendant should be allowed to substitute a bond for the prejudgment remedy."

The use of a PJR in a medical liability case was addressed in 2005, in *Smith v. MAA*, 2005 Conn. Super. LEXIS 2434. In that case, the PJR application was made on the eve of trial, and appeared to be a negotiating tactic. The judge denied the application, stating: "[I]t became apparent that the PJR application had been submitted at this time largely because settlement negotiations between the plaintiffs and [defendants] were not going smoothly, as the claimed deficiency in insurance coverage had been known since the earliest days of discovery." The court also noted that the affidavits submitted with the

■ See **QUESTIONS** on PAGE 12



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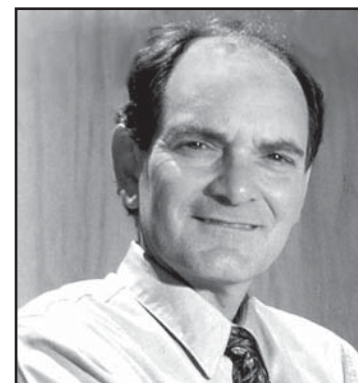
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REPRESSED *Mobility*

PHYSICIAN RESTRICTIVE COVENANTS ENFORCED SOMEWHAT RELUCTANTLY

Ability to restrain competition from departing physicians increasingly the subject of litigation

By **PATRICK J. MONAHAN II** and **ROY W. BREITENBACH**

The disposition of legal issues involving the enforceability of restrictive covenants restraining a departing physician's ability to practice after leaving a group practice or other company have become increasingly significant over the last 20 years.

That is largely due to the increased mobility of physicians. Before 1990, fewer than 2 percent of physicians changed jobs during their career. Physicians entering the profession after 1990, however, switched employers on average about three times before 2000. More recent studies indicate that approximately 10 percent of physicians change jobs annually.

As the opportunity for mobility has increased, physicians have become justifiably concerned with preserving their ability to change practices when it suits their professional and personal interests. Medical practices, too, have become increasingly concerned with protecting their good will and business when physicians leave. Thus, disputes over the enforceability of physician restrictive covenants have often been litigated over the last 20 years, both nationally and in Connecticut.

Connecticut, like the majority of states, generally, but somewhat reluctantly, permits the enforcement of physician restrictive covenants. As the Connecticut Supreme Court stated last year in *Deming v. Nationwide Insurance Co.*: "By definition, covenants by employees not to compete with their employers restrain trade in a free market. Consequently these covenants may be against public policy, and, thus, are enforceable only if the imposed restraint is reasonable, an assessment that depends upon the competing needs of the parties as well as the needs of the public."

Under Connecticut law, the party challenging the enforceability of a non-compete has the burden of proving that it is

not enforceable. The state Supreme Court has held that a court should consider the following five factors in evaluating the reasonableness of a restrictive covenant ancillary to an employment agreement: 1.) The length of time the restriction operates; 2.) The geographical area covered; 3.) The fairness of the protection accorded to the employer; 4.) The extent of the restraint on the employee's opportunity to pursue his or her occupation; and 5.) The extent of interference with the public's interests.

The first two factors in determining reasonableness are the length of time the restriction operates and the geographical area covered. These factors are derived from the principle that a restrictive covenant, as a restriction or limitation on competition, must be narrowly tailored to protect the practice's legitimate competitive interest in preventing unfair competition.

With regard to duration, the restrictive covenant can last only as long as it needs to ensure that the physician is competing on the basis of his or her own skill and efforts, and not on the basis of material to which he or she had access at a former practice. That requirement recognizes that, even if a physician's initial practice is entirely dependent on the good will, access and materials obtained while employed at a former practice, over time the physician's ability to retain and enhance a patient base is dependent on his or her own skill and efforts.

Court decisions regarding the reasonableness of the duration requirement in and outside Connecticut suggest a general rule of thumb for maximizing the prospect of enforceability: the covenant should last either the same amount of time as the term of the contract containing the restrictive covenant, or two years, whichever is shorter.

With regard to reasonableness of geographic scope, the covenant should only prohibit a physician from practicing in the same geographic area from which the practice draws a majority of its patients. That means a practice that provides a unique or advanced specialty—or a practice in a rural area—may generally impose a broader geographic area restriction than an internal medicine practice or a practice in a large

metropolitan area.

Finally, to the extent that a court finds that a restrictive covenant is reasonable under all the factors except duration or geographic area, it may apply the "blue pencil rule," which allows a court to redraw the duration or geographic area restrictions to make them reasonable and, therefore, enforceable. Under Connecticut law, however, courts likely will apply the blue pencil rule only if there is a specific provision in the operative agreement authorizing the courts do so.

Fairness To The Employer

A non-competition covenant is fair to the employer to the extent it is designed to protect a legitimate competitive interest. That requirement is important because federal law, in our free-market economic system, generally does not tolerate attempts by entities to restrain or limit competition among providers of goods or services.

Accordingly, a court in general will permit a restraint or limitation on competition only if it serves some important purpose. Over the years, courts have recognized that a limitation on competition is acceptable if it protects a party from unfair competition. A physician engages in unfair competition when he or she obtains confidential or competitively sensitive information about a practice or its patients, when working for the practice, and then uses that information to compete against the practice.

To prevent unfair competition, courts have allowed parties to enforce restrictive covenants provided that the covenants are narrowly tailored to protect a party's legitimate interest in preventing unfair competition. That means, to satisfy the legitimate competitive interest requirement, a practice must show that the departing physician had access to competitively sensitive information or such close contact with patients that there is a risk the physician could use the information.

For most medical practices, the legitimate competitive interest requirement should be relatively easy to meet. It is hard to imagine a physician who does not have access to competitively sensitive information or such close contact with patients that there is a risk the physician could use the

information after departure to compete against his or her former practice.

Burden On The Physician

The next major requirement that must be met before a restrictive covenant will be deemed enforceable is that the covenant cannot unduly harm or burden the physician against whom it is sought to be enforced. Of course, any restrictive covenant burdens the physician against whom it is enforced. The question really is whether circumstances changed since the physician signed the restrictive covenant such that enforcing it would place a significant and extraordinary burden on him or her. As the Connecticut Supreme Court has stated: "[A] restrictive covenant is unenforceable, if by its terms, the employee is precluded from pursuing his occupation and thus prevented from supporting himself and his family." Reasonableness of the

limitation depends on the nature of the restriction, the length of the limitation and the geographic scope of the limitation.

The final requirement for enforcement of the restrictive covenant is that it does not unduly harm the public. In *New Haven Tobacco Co. v. Perrelli*, the Connecticut Appellate Court articulated the standard for determining whether a covenant not to compete violates the

public's interests. The three factors are: (a) "the interest sought to be protected by the employer"; (b) "the scope and severity of the covenant's effect on the public interest"; and (c) "the probability of the restriction creating or maintaining an unfair monopoly in the area of trade."

Applying these factors, a court is more likely to find a restrictive covenant covering a physician harmful to the public if there is a shortage of the physician's specialty in the area where the physician practices. For example, if the physician is an interventional radiologist and there is no other interventional radiologist in or even near the restricted area covered by the restrictive covenant, then enforcing the restrictive covenant most likely would be deemed to harm the general public because there would be no interventional radiologists to provide services to those in the affected area. ■



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PREVENTATIVE *Medicine*

EARLY IDENTIFICATION OF LOSSES CRITICAL TO ENSURING COVERAGE

Failure to give timely and proper notice to insurers can leave claim DOA

By **MARIA PEPE VanDerLAAN**

The primary concern of healthcare providers is providing quality care to patients. The primary concern of risk managers for healthcare providers is implementing and overseeing facility policies and procedures to ensure quality care and to reduce risk.

Risk, whether managed or not, leads to legal claims and lawsuits. A critical aspect of effective risk management is understanding a facility's insurance program and the importance of timely and proper notice under the terms of all potentially applicable policies.

Even the best risk management techniques will not eliminate the need for adequate insurance and for the knowledge of how insurance works (or does not work). In this time of increased volume of lawsuits and rising verdicts (along with rising self-insured retentions), it is even more critical that healthcare providers and risk managers look beyond the anatomy of patients to the anatomy of insurance programs, and to diagnose and treat potential problem areas.

Effective management of insurance programs and practices is not unlike the effective management of personal health—you must be proactive, and early detection of critical issues or concerns is the key to ensuring that insurance dollars are available when needed.

This article focuses on professional liability and general liability policies, two vital organs of any healthcare provider's insurance program. It addresses the importance of properly identifying the type of loss involved, as well as the importance of providing notice sooner rather than later under all policies that may be triggered by a loss, even when an insurer rejects the notion that a particular policy covers the loss.

Broader Than Expected

A healthcare provider should identify the type of loss that is being asserted against it as early as possible. This is critical, because any delay in doing so could jeopardize coverage due to late notice.

Professional liability policies will cover

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losses caused by medical incidents resulting from "professional services," which are generally limited to incidents brought about by those who possess a specialized skill, education or experience in the field of healthcare. Doctors, nurses and physicians' assistants are obvious examples of those included in this category.

The scope of the term "medical incidents" may vary by policy. In general, it is defined as "acts or omissions arising out of the providing, or failure to provide, professional medical or dental services."

It is important to note that healthcare professional liability coverage may be broader than expected. For example, in certain cases, language of professional liability policies was interpreted broadly to find coverage for incidents not typically thought of as medical incidents: improper over-billing of prescription medication, administering excessive levels of anesthesia and thereby facilitating patient molestation, failing to disclose medical records to a patient's lawyer, exposing patients to hepatitis C, and a fertility specialist's use of his own sperm for artificial insemination.

In those cases, the healthcare providers did not have precedent for whether their losses were covered under their professional liability policies. However, by promptly giving notice to their insurers, they set in motion the process that ultimately resulted in coverage for the damages alleged.

Dual Coverage?

General liability policies typically exclude coverage for incidents caused by those with specialized skill, education or experience in the field of healthcare. Healthcare providers should closely scrutinize whether a loss is covered under general

liability policies, especially since they often do not have large deductibles or self-insured retentions.

An initial question that should be asked in that regard is whether the incident was caused or brought about by a person or persons while exercising specialized skill, education or experience in the field of healthcare. If so, then the loss will likely be covered only by the professional liability policy. If not, the general liability policy may cover the loss.

In some instances, the allegations of a particular claim may be mixed and implicate both professional liability and general liability policies. Take, for example, the hypothetical claim brought by a patient who, while receiving inpatient services at a hospital, is assaulted by a family member of another patient. The patient suffered a concussion as a result of the assault and also claimed that the concussion was not properly treated, resulting in permanent injuries. In such a case, notice of the loss should be provided to both the hospital's professional liability and general liability carriers, as both policies should cover the claim.

A common assumption that is often made about coverage is that a loss is cov-

ered only under a professional liability policy, because all of the incidents take place within a hospital or office setting and some component of the loss may require a professional medical standard of care analysis. In the hypothetical case, the assault was conducted by non-medical personnel, not a hospital employee with specialized skill, education or experience in the field of healthcare. That distinction should be identified as soon as the claim is brought, and notice of loss to the general liability carrier should be immediately provided.

The involvement of two policies and various insurers may complicate the handling of the claim due to such issues as including the proper management of defense, allocation and proper timing of notice to excess carriers. However, insurers should understand these issues, and healthcare providers, as policyholders, should request direction from insurers early in the process.

Because direction is not always provided and is sometimes inaccurate, healthcare providers should have an understanding of how their insurance should work for them. This is just good preventative medicine. ■

Effective management of insurance programs and practices is not unlike the effective management of personal health—you must be proactive, and early detection of critical issues or concerns is the key to ensuring that insurance dollars are available when needed.



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OIG Intrigue

THE DANGERS OF CULTIVATING LOYALTY

Hospitals may face sanctions for punishing or rewarding cherry-picking staff physicians

By **STEPHEN E. RONAI**
and **LOUIS B. TODISCO**

Hospital and medical staff relationships may become strained when staff members acquire ownership interests in competitive outpatient ancillary facilities, such as ambulatory surgery centers or cardiology and orthopedic specialty hospitals, and divert certain hospital-based ambulatory surgical procedures (endoscopy, cosmetic surgery and diagnostic radiology) to these facilities.

To sustain the flow of essential revenue, hospitals may offer staff members ancillary joint venture ownership opportunities to revive staff "economic loyalty," or they may apply restrictive economic credentialing criteria to physicians who seek or wish to retain staff privileges.

In offering collaborative financial arrangements, such as joint ventures with physicians, hospitals must be careful that the arrangements do not contravene fraud and abuse statutory prohibitions, and are not outside the Internal Revenue Service charitable activity and community benefit restrictions imposed on Section 501(c)(3) tax-exempt hospitals. Attention also must be paid by joint venturers to the illegal remuneration provisions of the federal Anti-Kickback Statute (AKS).

Individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration, in order to induce patient referrals for which payment can be made under a federal health care program, can be subjected to a panoply of sanctions, i.e. criminal penalties, the imposition of civil monetary penalties or exclusion of the

provider from Medicare and Medicaid reimbursement programs.

The Department of Health and Human Services' Office of Inspector General (OIG) has issued Advisory Opinions to provide guidance to providers as to whether or not staff joint venture compensation arrangements may result in sanctions, if the arrangements do not fit precisely within the four corners of the AKS safe harbor prescriptive regulations. 42 Fed. Reg. Section 952.1001 et seq. If the OIG concludes that transaction terms strictly conform to the fair market value and commercially reasonable safe harbor requirements, the transaction will be insulated from an OIG/AKS investigation. (Commentary on the OIG's Advisory Opinion analyses of the Hospital/Physician Joint Ventures AKS/Safe Harbor compliance issue is outside the scope of this article).

Two issues need to be addressed with respect to hospital/staff member economic credentialing:

1.) Whether a hospital's board of directors, acting under its corporate bylaws, can override the quality patient care staff bylaw membership criterion (historically the sole basis for the determination of staff privileges), by adopting a "conflict of interest" policy and thereby denying staff membership to, or terminating staff privileges of, economically "disloyal" physicians, in order to preserve the institution's financial stability?

2.) Whether the addition of certain staff patient admissions and revenue volume performance conditions to the grant of clinical privileges can constitute a violation of the AKS?

A hospital board's adoption of an economic credentialing or "conflict-of-interest" policy displaces the traditional quality care membership provisions originally developed for a hospital staff by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The American Hospital Association (AHA), unlike the American Medical Association, supports economic credentialing/conflict-of-interest provisions, consistent with

patient care concerns. The AHA notes that hospitals must "take into account the benefit to patient care and hospital operations of having a physician staff which is as integrated as possible into the daily routine of the hospital," as integration means that staff ownership of outpatient facilities is a discordant diversion of profitable surgical procedure revenues needed to cross-subsidize the hospital's provision of essential but unprofitable charity care and community health services.

Hospital boards began in the 1970s to use economic credentialing criteria by contracting with integrated physician groups to deliver hospital-based services (anesthesiology, radiology and pathology) pursuant to exclusive service contracts developed to meet scheduling, administrative efficiencies and other hospital "business" or "financial" needs. Those exclusive contracts closed certain departments and enabled the hospital board to cede the use of hospital facilities to a specialist professional service entity that received exclusive departmental economic benefits to realize both economic as well as quality patient care goals.

Hospital Board Backed

Hospital advocates seeking to advance the board's authority, beyond achieving administrative and patient service scheduling benefits obtained under exclusive department service contracts, can rely on the South Dakota Supreme Court's decision in *Mahan v. Avera St. Luke's*. In *Mahan*, the hospital board closed the staff to new orthopedic applicants as staff members of a specialty practice diverted substantial surgical revenues to their "day surgery center."

The South Dakota Supreme Court held that the staff bylaws provided the staff members of that practice with contractual rights to use the hospital's facilities, but that the staff privileges contract did not circumscribe the board's ultimate corporate authority to preserve the hospital's financial stability, as such business decisions "were within the power of the Board ... as [i]t surely has the power to attempt to ensure

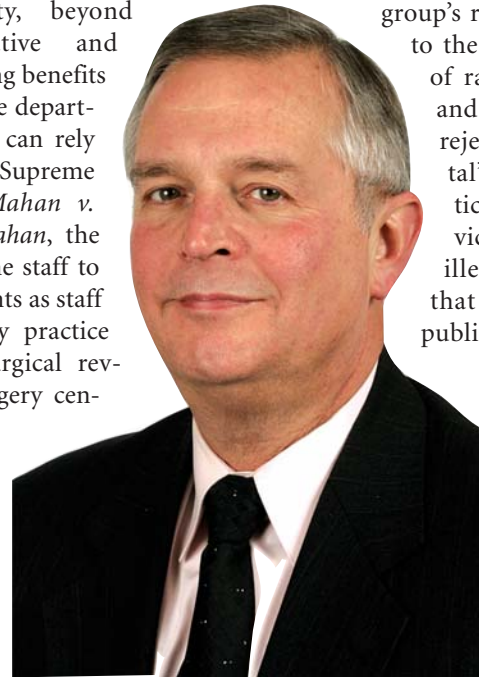
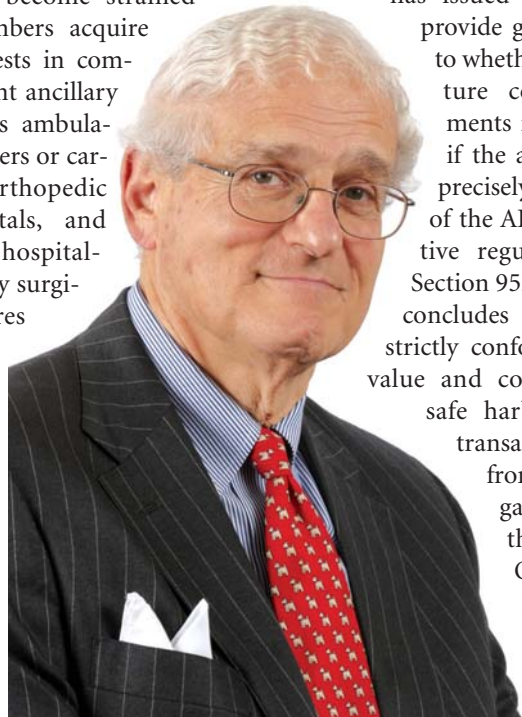
[the hospital's] economic survival."

Following the *Mahan* "business decision," the OIG issued a Solicitation of Public Comments on Certain Credentialing Practices in December 2002, in response to information that an increasing number of hospitals had attached "remuneration" and "patient volume" admission conditions to their staff privileges, and that staff privileges were denied to physicians who owned competing health care facilities or who failed to generate a specified number of admissions to the hospital.

In the OIG's Public Comment Solicitation, it inquired whether "hospital medical staff privileges [constitute] remuneration" and responded by noting that "remuneration" means anything of value. It noted that "conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raises substantial risks under the [anti-kickback] statute."

In *Virginia Radiology Assocs. v. Culpepper*, the court echoed the OIG's concerns when it sustained the hospital's termination of a radiology group's exclusive contract and privileges, based on the group's refusal to contribute to the hospital's purchase of radiology equipment and because the group's rejection of the hospital's proposed "practice management services" contract was an illegal AKS violation that was contrary to public policy.

A hospital board's future use of its supervening institutional corporate authority to reward or punish "cherry-picking" staff physicians may heighten the OIG's Anti-Kickback investigative efforts, unless the hospital and physician joint venture participants adhere to arms-length transactional arrangements and fair market value principles to avoid the onset of OIG/Anti-Kickback liability exposure. ■



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IN-HOUSE LAWYERS IN HEALTHCARE SECTOR FACE GROWING EXPOSURE

Traditional D&O liability policies may not provide full scope of protection

By **SUSAN F. FRIEDMAN**

Attorneys working in the healthcare and not-for-profit sector have seen their responsibilities expand at the same time traditional professional protections have eroded. As a result, their potential exposure has increased dramatically.

Beginning in 2005 and continuing today, a number of governmental bodies, including the Senate Finance Committee, the House Ways and Means Committee, the Internal Revenue Service and the Office of the Inspector General, have focused their attention on the management and oversight of healthcare institutions.

Furthermore, many state governments, which are predominantly charged with regulating the not-for-profit sector, have attempted to enact legislation in an effort to enhance their oversight powers, particularly with respect to financial reporting and general corporate governance. The driving force behind attempts to legislate and regulate is funding, because government grants represent a primary source of funding for many entities in the healthcare sector.

Notwithstanding that Sarbanes-Oxley applies directly to publicly traded companies, it has influenced the healthcare industry and shifted the landscape for these organizations as well. Yet, many attorneys employed in the healthcare sector have only recently begun to understand the implications of these changes.

Perhaps the most significant change is that in-house counsel are now the gatekeepers of the organization with respect to business conduct, governance and regulatory matters.

In addition to the threat of claims set forth by the government and regulatory bodies, in-house counsel of healthcare entities may also be confronted with claims lodged by their corporate employer, other employees, and outside third parties. In fact, claims against in-house attorneys in general by outside third parties are growing in number.

In part, this is due to an increase in judicial recognition of the in-house counsel's duties to non-clients. Courts have been more apt to find an attorney-client relationship, thereby conferring standing to sue, where the outside third party has relied upon representations made by the in-house counsel to their detriment or where the outside

third party is a foreseeable beneficiary of the services performed by in-house counsel.

An increasing group of courts have held that non-clients should be permitted to rely upon the representations made by another entity's attorney for equitable reasons.

By way of example, a health care entity seeking to sell off certain assets provided the due diligence conducted by its general counsel to a potential purchaser, who ultimately consummated the deal. Later, the purchaser believed that it had bought a lemon and brought an action for negligence and legal malpractice against the seller's general counsel. The matter settled to the benefit of the purchaser, because it had compelling arguments grounded in detrimental reliance.

What can in-house counsel do? Traditional directors-and-officers liability policies may not provide the full scope of protection necessary for in-house counsel. As such, certain insurance carriers now offer employed-lawyers professional liability insurance specifically designed to respond to the work performed by in-house counsel.

More important, certain best practices can help in-house lawyers minimize their risk of winding up in trouble.

Avoiding Trouble

To stay on the right side of the road, in-house lawyers in all industry sectors need to remember that the duty owed is to the entity and not to any one individual. Further, in-house counsel should not ignore possible wrongdoing by the entity or any of its employees.

Make certain that material transactions are reviewed and approved in accordance with established procedures. Alert management and the board of directors to all relevant factors underlying a decision to proceed with a certain course of action that may pose heightened risks. Advise management and the board where appropriate of the possible consequences of a mistake in judgment.

These steps can help keep in-house attorneys out of trouble.

In case trouble does come your way, it is prudent for in-house attorneys to familiarize themselves with their employer's indemnification policies, the laws that govern such policies, and the insurance coverage that the employer has purchased as protection.

The intent of directors-and-officers liability insurance is to provide insurance coverage to directors and officers for their negligent acts, errors or omissions in the running of the cor-

poration or nonprofit organization. If in-house counsel is acting within his capacity as an officer of the entity, D&O insurance should provide coverage for any claims that arise. If coverage is expanded under the D&O policy to include all employees, as is the case for many health care and non-profit D&O policies, even those in-house counsel who are neither directors nor officers are eligible for coverage.

Leading D&O insurers, however, warn that claims containing allegations of legal malpractice or negligence in rendering legal advice do not fall within the coverage provided. Further, many D&O policies contain professional-services exclusions that preclude coverage for legal services.

D&O insurers specifically advise that it is not their intent to provide coverage for claims arising from a wide variety of activities performed by lawyers. These legal activities include rendering formal or casual legal opinions, managing litigation (including exhibiting "bad faith" when litigating), reviewing or drafting legal documents upon which a third party relies, providing legal services to employees in connection with employment termination or corporate restructuring, approving contracts with vendors or clients, reviewing literature published by the company, and creating press

releases or giving interviews in the lawyers' capacity as in-house counsel.

In short, a D&O policy might not cover claims arising from much, if not most, of what in-house lawyers typically do.

Employed-lawyers professional liability insurance, however, is designed to provide insurance coverage for claims of legal malpractice that arise from the legal work performed on behalf of the corporation or nonprofit organization by in-house attorneys and their support staff. This once-sleepy product line has gained momentum as the exposures of in-house counsel multiply.

Employed-lawyers insurance typically pays defense costs for claims brought by the employer as well as providing coverage for claims by regulators, investigators, employees who in-house counsel is assigned to represent, outside third parties, moonlighting and *pro bono* work.

Overall, in-house counsel must realistically assess their exposures to determine what types of protections are needed. There has been a slow but steady increase in the number of claims against in-house counsel and, in particular, general counsels. The next few years will be very telling with respect to the impact of the growing exposures for in-house counsel in the healthcare sector. ■



Susan F. Friedman is a senior vice president at Marsh, an insurance broker and risk services firm, where she is the national practice leader for insurance coverage for in-house counsel.

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QUESTIONS RAISED OVER PJRS' PROPRIETY

■ From **GOING AFTER** on PAGE 7

application did not establish probable cause.

As a second ground to deny the application, the court relied on its inherent power to control its docket.

On July 29, 2005, the court met with all counsel at a trial management conference at which time there was supposedly a complete discussion of what needed to be accomplished, and when, to permit a trial in the case to commence on Oct. 4, 2005, a date scheduled with the consent of the parties in December 2003.

A full-scale PJR hearing prior to trial would essentially mean having large segments of the matter heard twice. In light of the logistical difficulties of scheduling and going forward with such a proceeding, and the apparent motivation of the timing of the application as a negotiating stratagem, the court declined to entertain the PJR at such a late date.

As noted, when PJRs are sought on the eve of trial, they appear to be negotiating tactics, rather than what they are generally intended to be. Further, they require a trial prior to the trial with expert testimony to establish probable cause and often prove to

be costly delays to resolving cases.

Physicians are required by law to have professional liability insurance. Most have insurance above mandatory minimum requirements. There are usually substantial funds to address potential judgments.

Consequently, there are protections for plaintiffs, which was the intent of the legislature in requiring minimum liability insurance coverage for physicians. Therefore, PJRs should not be necessary.

Where a potential verdict could exceed available insurance coverage, the courts are empowered to attach personal and business

assets without any showing by the plaintiff that the resident defendant physician is attempting to defraud or frustrate the enforcement of a potential judgment.

Without such evidence being deemed necessary, the courts should balance the need or risks of the individual plaintiff against the effect the proposed order could have upon the defendant physician and/or the public at large. PJRs effect more than the defendant physician. They can unjustifiably interfere with the physician's colleagues, practice, family and ultimately patient care. ■

ELECTRONIC RECORDS

■ From **ELECTRONIC** on PAGE 3

hardware or staffing.

• Under the Stark exemption, donors may include individuals or entities that provide designated health services. Under the Anti-kickback exemption, they may include individuals or entities providing services covered by a federal health care program.

• Under the Stark exemption, recipients may include physicians. Under the Anti-kickback exemption, they may include individuals or entities engaged in the delivery of health care services covered by a federal health care program.

• Donors may not consider the volume or value of the physician's referrals or other business generated between the parties when choosing to whom to donate EHR capability. Donors, however may consider: the total number of prescriptions written by the physician; the size of the physician's medical practice; the total number of hours that the physician practices medicine; the physician's overall use of automated technology in his or her medical practice; whether the physician is a member of the donor's medical staff; the level of uncompensated care provided by the physician; and other reasonable and verifiable matters that don't take into account the volume or value of referrals or other business generated between the parties.

• Donors may *not* limit the use of the system or its interoperability, and physicians may not condition doing business on the receipt of EHR technology.

• A written agreement shall specify the donated items, services and costs.

• Physicians must contribute 15 percent of the cost, and all donations must be made on or before Dec. 31, 2013.

The new exemptions may alleviate the financial burden for physicians in implementing such systems. While barriers still remain, including the need for updated state regulations and adoption of interoperability standards, the pieces are coming together to facilitate use of electronic records. Those wishing to implement EHR systems should consider how best to coordinate with affiliated providers and how any specific initiatives might be treated under the aforementioned state and federal laws. ■

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- corporate compliance
- survey and complaint issues
- civil and criminal investigations
- white collar defense
- guardianship proceedings and discharge planning
- resident and family issues
- reimbursement/Medicare and Medicaid issues
- managed care
- litigation
- real estate
- medical/legal issues
- technology agreements
- licensing and accreditation
- EPA/environment
- complex transactions
- contracts
- personal services & estate planning
- capital formation
- tax issues
- fraud and abuse
- elder law
- bankruptcy
- audits
- antitrust
- government relations
- medical staff matters
- clinical research compliance

For more information, contact Patrick J. Monahan II at **(203) 316-0483** or visit our website at www.gwtlaw.com

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